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Barriers toward help-seeking among young men prior to suicide

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ABSTRACT

This study explores barriers to help-seeking among young men prior to suicide. We analyzed 61 in-depth interviews with parents, siblings, friends, and ex-partners of 10 young men (aged 18–30) with no record of mental illness, as well as 6 suicide notes, using interpretative phenomenological analysis. Three barriers emerged: (a) a total defeat; (b) no room for weakness; and (c) fear of mental disorder. The shame from falling short of standards (own/significant male others') could be a considerable barrier to help-seeking in a suicidal crisis.

Young men in transition to adulthood constitute one of the highest risk groups for suicide in most countries, and effective suicide prevention efforts are lacking (Pitman, Krysinika, Osborn, & King, 2012). Many nations and communities have developed suicide prevention programs, and often the health care services play a key role in these programs (Mann et al., 2005; World Health Organization, 2016). Still, we have not seen any subsequent reduction in suicide rates among young men (Pitman et al., 2012).

A major challenge in this field is that most young men who take their own lives do not seek help from health professionals prior to their death (Judd, Jackson, Komiti, Bell, & Fraser, 2012). As few as 15% of those under the age of 35 years have contact with mental health services in the last month of their life, and only 23% consult their general practitioner (GP) in the same period (boys and men far less often than girls and women; Luoma, Martin, & Pearson, 2002). Previous research on barriers to help-seeking in relation to suicide mainly focuses on mentally distressed young adults in the general population, students with suicidal ideation or individuals who have attempted suicide (Hom, Stanley, & Joiner, 2015). Although these studies identified barriers such as maladaptive coping strategies, stigma toward mental illness and lack of expressed need, extrapolation from these groups is problematic because they minimally overlap with individuals who take their own lives (De Leo, 2004). Another problem with much of this research is that it often surveys individuals at a single point in time, thus treating barriers as static phenomena. Help-seeking for mental problems defined

as “The behaviour of actively seeking help from other people ... in response to a problem or distressing experience” (Rickwood, Deane, Wilson, & Ciarrochi, 2005, p. 8) is a complex process with intentional, personal, and interpersonal aspects. Thus, factors influencing help-seeking may not only change over time but also depend on the problem situation (Addis & Mahalik, 2003; Connell, 2005). From a suicide prevention perspective, there is an alarming need for a deeper understanding of suicidal men’s reluctance toward help-seeking (Gunnell, 2015), which was the present purpose.

The psychological autopsy method (PA; Shneidman, 1993) is a primary approach for studying suicide. Despite a large number of PA studies, only a few studies exist on barriers to help-seeking among people who end their lives. In one study, personal barriers to seeking medical help in the final month prior to suicide included being “help-resisters” by nature, distrusting the medical profession, and/or concealing distress (Owens, Lambert, Donovan, & Lloyd, 2005). Family barriers to seeking medical help included habituation to psychological disturbances within the family, and/or ignoring or avoiding problems. However, one major problem with the findings is that only one informant (in most cases a close family member) for each suicide participated in the study. Although a close family member may be a good informant, their stories also represent survival tools that may have led to defendant narrative constructions as a way of protecting themselves (Owens, Lambert, Lloyd, & Donovan, 2008). In addition, because interpersonal conflicts play a significant part in many

suicidal crises (Shneidman, 1993) and the informant may be a part of the conflict, there may be a gradient of “blindness” in interpreting the complexity of factors impeding help-seeking.

In another study, barriers to mental health treatment among adolescents (13–21 years, both genders) who died by suicide included believing that nothing could help, seeing help-seeking as a sign of weakness, reluctance to admit that they had mental health problems, and/or being too embarrassed to seek help (Moskos, Olson, Halbern, & Gray, 2007). Although this study included data obtained from many informants for each of the deceased persons, the study focused on barriers toward accepting prescribed mental health treatment among a sample of adolescents with a relation to mental health services. Thus, it provides little information about barriers to help-seeking in relation to the problem situation leading up to suicide, or about suicidal men’s reluctance towards help-seeking.

Research findings on men’s help-seeking behavior (Addis & Mahalik, 2003; Vaswani, 2011) shows that a man is less likely to seek help for problems that he sees as unusual, especially when he also perceives them as central to his character or personality. He is also unlikely to seek help if he perceives the issues to be his own fault, if groups of men who are important to him endorse norms of self-reliance or other norms that suggest his problem is non-normative, or if he fears rejection from important significant others. Among 52 young Irish men who had attempted suicide, a barrier to help-seeking was shame from failing to live up to the standards and ideals of their significant male figures (fathers and brothers; Cleary, 2012). The decision to end their lives became the only perceived option left that enabled the men to avoid disclosing weakness in their relationship with significant other men. Thus, the problem situation leading up to suicide is suggested to be of central importance for the suicidal individual’s reluctance toward help-seeking (Rudd, 2006; Shneidman, 1993). Yet, the complexity of internal and external factors that might impede help-seeking in relation to suicide has been largely unexplored.

Suicide in young adults, particularly those unknown to mental health services, is often described as an impulsive response to an acute negative life event and thus with little time to reflect on help-seeking. However, suicide among young adults is rarely impulsive (Orbach et al., 2007; Owen et al., 2012). In a previous publication from the present data set (Rasmussen, Haavind, Dieserud, & Dyregrov, 2014), we analyzed the vulnerability of suicide in the developmental history among young men who unexpectedly took their lives in the transition to adulthood. We found that a weakened

capacity to regulate emotions like shame and anger seemed to make these men vulnerable to suicide in the face of rejections and perceptions of failures. The young men had no record of mental illness, and prior to their death, they did not seek help from professionals or from family or friends.

Here, we explore the suicides of these young men further by investigating their significant others’ perceptions of what impeded the young men from consulting a health professional prior to deciding to end their lives. Such knowledge is essential to promote and facilitate help-seeking among young men in emotional crisis.

Method

This PA study includes 10 suicides carried out by young men between 18 and 30 years of age. The young men had no prior mental health treatment and no previous suicide attempts. Detailed information about the young men, the participants, the procedures for inclusion of suitable suicides and for conducting the interviews, as well as of interpretative phenomenological analysis are described elsewhere (Rasmussen et al., 2014).

Participants

We interviewed 61 persons closely connected to the deceased young men, five to eight informants for each suicide. All informants were over 18 years old. In addition, six of the young men left suicide notes. For further description, see Rasmussen et al. (2014). We also analyzed the six suicide notes.

Procedure, interviews, and analytical strategy

See Rasmussen et al. (2014) for where, and how, we collected data. Also, see Rasmussen et al. for a description of the interviews and ethical considerations. The data material was rich and gave us the opportunity to investigate a number of different issues related to suicide. In contrast to Rasmussen et al. (2014), the main focus of the present analysis was on barriers to help-seeking.

Results

Three inner barriers emerged: a total defeat, no room for weakness, and fear of mental disorder. Quotes substantiate each of the themes.

A total defeat

Informants related the young men’s absence of help-seeking to failure of not living up to their own or other

significant male figures' standards/expectations in the period leading up to the suicide. Thus, it appeared that the deceased person experienced strong feelings of unmanageable shame. More specifically, the informants felt that the shame related to, what the deceased young man saw as, unacceptable behavior, such as having behaved in an immoral way and/or having lost control shortly before the suicide. This failure left them totally defeated.

A month before the suicide, a male friend prevented one of the youngest men from an action that the informant(s) understood as suggestive of attempting suicide. This action occurred shortly after acting aggressively in public. His family then made several appointments for him with his GP. He never showed up to any of them. His friend pointed out that seeing a professional on top of this unacceptable behavior was "out of the question." The informant explained in detail how the shame from exposing himself, with all his flaws, left him totally defeated, "he must have felt so embarrassed ... so embarrassed he would rather die." The awareness that his male friends saw him that night made it impossible for him to meet them again. He took his life on the very day avoidance was no longer possible. For this young man, help-seeking was probably never an option. Once he had exposed what he may have perceived as his inferior self, he could not undo it.

According to another group of informants, the deceased person had openly for many months cheated on his partner of 5 years. The informants thought the deceased person made a fool of himself. When his partner discovered his infidelity, he immediately moved in with his new girlfriend without offering his former partner an apology. A few months later, left alone after his new love relationship failed, he took his life without turning to professionals, family members, friends, or ex-girlfriends for help. One informant understood a barrier to help-seeking as relating to how the deceased person, unable to establish a life on his own after his new love relationship failed, must have felt like a total failure in this self-inflicted situation. She interpreted what he wrote in his suicide note: "He regretted what he had done ... He really felt like a failure, something he had caused himself. He didn't want to involve others ... It was the way he had done it, yes, and that he should never have done it." This informant described the deceased person's lack of emotional capacity to deal with feelings of shame, worthlessness, and of being a failure. Thus, self-blame may have exacerbated the emotional distress the deceased person was already experiencing, and contributed to his experiencing the situation as irreparable. Similarly, one friend commented, "He has been ruminating about the mistake he

made ... could not take it any longer ... did not know how to deal with the situation ... he was going around in circles, it was escalating."

For all these young men, the crucial impact of failing to live up to a desired standard seems to have been central for why help-seeking was not an option. One friend believed the deceased person did not seek help from professionals, friends, or family due to the self-inflicted situation that triggered the suicidal crisis: "the mistake he made ... he knew ... he was unable to live up to ... he felt like a loser." One friend commented on the deceased person's failed work situation: "clearly he must have felt, must have felt it was a real defeat ... he lied about it ... this was not an act of impulse ... according to this letter ... he had been thinking ... for a while, it was well considered." In yet another situation, male informants thought that the potential exposure of dependency issues prior to the deceased person leaving for the army, seemed to have been experienced as a total defeat. The deceased person told his male friends the night before the suicide that he looked very much forward to joining the military service. However, he left a suicide note saying that it was the worst day of his life and that he wanted others/his loved ones to forget he had ever existed. Postsuicide, the informants learned that the deceased person had applied for exemption from the army, after the deadline. The army declined the application the day before he took his life. Awareness of the impossibility of meeting his significant others' standards of being an adult man may have left him feeling too ashamed and worthless to even be worthy of remembrance.

Most informants pointed out how the young men concealed their despair and/or faked reality in their last conversations. However, two former ex-girlfriends described the young men contacting them shortly before the suicide and appealing for emotional safety. One man, described as excellent at his job, was unable to handle a setback a month before he killed himself. He quit his job without telling anyone, pretending he still worked. According to his ex-girlfriend, he contacted her in the middle of the night a few days before he killed himself (several months after their break-up), and told her that, "he had argued heavily with his boss ... his work situation was going to hell ... everything was just shit ... he would just go and shoot himself." She continued: "He felt that he could not face people ... he was an utter failure ... He was not feeling well at all ... I was scared stiff ... I urged him to get help ... and suddenly he made a move to get me back."

In this example, she felt that his invitation to reunite was not real. He already had a new girlfriend. Her urging this young man to seek professional help may

have felt like a rejection. Two days later, instead of seeking professional help, he took his own life. For these young men, professional help-seeking seemed out of the question, as it could indicate that their earlier failure was reversible, which in their minds it was not. Thus, a barrier to help-seeking was strong feelings of unmanageable shame, failure, and worthlessness, stemming from the perception of falling below standards via an unacceptable self-inflicted mistake.

No room for weakness

Why did he not seek professional help? ... His childhood was a difficult one, but he was brilliant at school, got the highest marks. He was extremely successful ... There was no room for, no room for anything but success ... The expectations towards him were enormous ... how could he disclose to his father that he had problems and considered suicide?

This statement came from an informant who had known the deceased person and his family since childhood. This informant, as well as many childhood friends and siblings, and in some cases ex-girlfriends, identified a barrier to help-seeking as a lack of room for weakness in the deceased person's relationship with their father or other father figures. These informants described how the young men covered up their problems (i.e., not tolerating aloneness after break-up, unable to deliver a successful project at work, afraid to leave for the army/university, etc.) to the bitter end, and they took their life when disclosing weakness was no longer avoidable. As one sibling put it,

He was going to meet dad the day after ... Why did he not call anyone or ask for help? I do not think he saw help-seeking as an alternative ... there was no other way out of it for him, all other ways out were eventually blocked.

Lack of room for weakness in the adult father-son relationship could have inhibited help-seeking in many ways. First, these men could not speak up about their problems. Second, suicide was their only solution when threatened by disclosure of weakness. According to these informants, the suicide was not a sudden impulse but related to the deceased person's upbringing. More specifically, informants pointed to a long history of unmanageable problems in the young men's relationships with their fathers. Their unrealistic expectations left them never feeling good enough. Over the years, they became very dependent on their fathers' confirmation. As one sibling stated, "he ... never felt he was good enough ... in his work and other things he did, it was all to impress his dad, to show him that ... he

was capable." One male childhood friend said, "He was under so much pressure to perform ... It was internalised, right from the beginning. Had to do well." An ex-girlfriend explained,

He never felt he was valued ... only if he achieved, so he became very dependent on, very inspired by his success and the confirmation he got from other people ... and very concerned about proving to the world that in a way, he did well. So he was very ... it meant a lot to him to succeed in a way, to be able to show people and be good enough.

He never accepted weakness in himself ... to ask for help was regarded as weakness.

These informants pointed to how the deceased persons, since childhood, searched for emotional security. They strived to live up to their fathers' standards, without ever making it. They exaggerated the importance of success to compensate for a deep sense of worthlessness and a fear of rejection. One brother, talking about why the deceased person covered up an academic failure, said, "to be accepted as the person he was ... including being weak ... he had a deep fear of not being accepted."

One deceased man made a minor mistake at work some weeks before the suicide; this mistake seemed to leave him in a condition of unbearable weakness. He got the job after a recommendation from his father. According to all male informants, finding a solution to a problem that his employer would accept kept the deceased person preoccupied in the weeks before the suicide. Two days before he took his life, he told his father that he had resolved the problem to his employer's satisfaction. The success at work turned out to be untrue. The deceased person left a suicide note stating that he could not live like this anymore, and that he should have done things differently. Only in the suicide note could he speak up for himself and tell his father of his work failure. His sibling explained, "In the end, there was only one solution left, to make it end ... inside him there must have been a feeling, an uneasiness or something, that he could not live with ... the letter he wrote ... something job related ... it was not a cry for help.

Similarly, one young man who planned to start at university a few months later was about to go on a trip with his father the day he took his life. The previous day, he told friends and family that he had packed and was looking forward to the trip. Instead, he took his life. He left a note, writing that he was sorry and that he could not find a way in life. In his apartment, there were no packed bags or other signs of preparations for the trip. One informant said that for the deceased person to speak up and disclose to his father that he was neither capable of starting at the university nor traveling with him, was

not an option: “Well, no way, he could not admit a thing like that ... even commenting on a painful knee would have been too much for him.” For this young man, help-seeking was probably never an option. Only in the suicide note was he able to tell his father that he was incapable of traveling with him.

All the young men took their lives on the very day they could no longer cover up weakness in the relationship with their father. Thus, a barrier to help-seeking was a lack of space for weakness in the deceased person’s father–son relationship.

Fear of mental disorder

In half of these men, informants wondered if the deceased person feared mental illness before the suicide. The informants described how the deceased person lost control and aggressively acted out toward a partner and/or significant male figure shortly before the suicide, which could indicate crossing a line that scared them. This fear of mental illness could not only have prevented them from help-seeking, but could also have led them to withdraw from their relationships. One ex-girlfriend said,

He was never violent. However, we had a quarrel ... and his eyes went completely black ... he was so angry ... I had to go on a sick leave for a week ... he was just very closed up afterwards ... Something was lose [sic] that he could not stop ... could not control ... he did not allow any feelings related to difficulties ... Help-seeking was out of the question. He feared this could be used against him.

According to these informants, fear of mental illness was not the result of the scary and shameful episode(s) of loss of control. Rather, it was the perception that the deceased person learned early in life to survive by keeping negative emotions in control, so feared his overwhelmingly strong emotions and rejection from significant others.

One informant, who had known the deceased person and his family for many years, described his fear of mental disorder as a barrier to help-seeking. She knew he feared rejection if he let others see “his true self.” She had witnessed him turning to psychology books for help:

A lot comes from his childhood ... his father’s alcohol abuse and violence ... he was very angry with his father, but did not feel he had the right to be ... he tried to cover up his anger ... that was his dark secret ... Eventually he became more and more like his father ... the person he hated the most ... he really had no control ... He deeply feared to be let down ... He really

feared that other persons could see through him ... I think that’s why he bought all those self-development books ... to be able to understand a bit more of himself.

Several informants, in different deceased men, thought that exposure to their father’s frightening, humiliating, and/or shameful episodes of loss of control could have built up a damaging tension. Helplessness from being unable to stand up for themselves and confront their fathers, as well as protect their mothers, could have led to deep shame, trapped anger, self-contempt, and fear of being rejected. Realizing that in some ways, they had the potential to become, or actually had become, like their father, probably inhibited help-seeking.

Such fear of rejection for disclosing mental problems and/or of being in need of professional help, according to the informants, related to how mental problems and weakness was unacceptable in the deceased’s family. One informant described how the deceased person must have felt that he had no other option but to withdraw from their relationship in the last weeks of life to protect himself. The informant imagined the deceased person was thinking something like:

The same thing is happening to me (violence towards girlfriends) ... like my father’s behavior towards my mother ... I had promised myself not to behave like this. Another issue in this family is social status, the façade had to be perfect. They talked very negatively about mentally ill people. At the same time they had their own mental dysfunction ... For him, having mental problems was a massive downer ... mental problems was taboo in his family ... it is simply not accepted ... It seemed that he pushed me away intentionally, to prevent me from seeing.

For several of these young men, growing up in an environment where mental problems were unacceptable, but the family had its own dysfunctionality (i.e., alcohol abuse, lack of communication, neglect, family secrets, and violence), seems to have created an insurmountable barrier against help-seeking. One informant said, “In our family you have to be successful. You have to be well dressed, and have no problems. Problems belong to patients in mental hospitals, or people seeing psychologists.” Or, as one brother suggested, the deceased person’s “fear of disclosing who he really was may have made talking to others about his situation out of the question. ... maybe he felt he would be looked upon as a weirdo and ... then it’s better, yes, to keep the façade all the way until he could kind of escape from it all.” Likewise, one of the mothers said, “His father had drinking problems ... I imagine it had an effect on him ... he observed it all ... his father had mental

problems ... Maybe he feared he would end up like his father.” Thus, in several of the suicides, barriers to help-seeking might have been related to an underlying fear of mental disorder.

Discussion

Taken together, these barriers refer to a weakened capacity to tolerate a failure among young men who end their lives. Being unable to live up to desired standards/expectations (own/significant male figures’) in the period leading up to the suicide (a total defeat), and being unable to stand up for themselves or disclose weakness (no room for weakness), the deceased young men may have experienced having no other option but to take their lives (fear of mental disorder).

Consistent with a cognitive-behavioral model of suicidality (Rudd, 2006), in this study, we found that “a total defeat” as a barrier to help-seeking was closely connected to the problem situation that activated the suicidal mode; an intense negative affect (shame, worthlessness, being a failure, helplessness) as a result of falling short of standards (own/significant male figures’). The young men blamed themselves for some unacceptable behavior; they interpreted a perceived failure as a function of characteristics within their self. This finding is consistent with Addis and Mahalik (2003), as well as Vaswani (2011), who suggested that a man is least likely to seek help for problems that he perceives as central to his character or personality or to be his own fault. Thus, one may assume that a significant factor in the suicidal crisis for our young men, and the avoidance of help-seeking in this situation, were related to how falling short of standards symbolized their perceived inadequacy.

We argue that the “lack of room for weakness” in the young men, which may have acted as a barrier to help-seeking, is associated with experiences of shame from being unable to meet significant others’ standards/expectations (fathers and brothers). This finding is consistent with Cleary’s (2012) research of young men who had made suicide attempts. De Leo (2004) and Shneidman (1993), among others, also underscored the crucial role of shame in suicide. Contrary to Moskowitz et al. (2007), who suggested that stigma associated with mental illness inhibits help-seeking prior to suicide, we find that the stigma of mental illness is insignificant if there is no room for any weakness in the relationship with significant male figures. In line with Cleary (2012), our findings indicate that the decision to end their lives was probably the only perceived option left in the suicidal crisis of the ten young men. This finding may explain why none of the young men in

the present study secretly sought medical help. Thus, our identified barriers to help-seeking were linked to how the suicide was neither impulsive nor a cry for help. Rather, suicide was the only perceived solution that enabled the young men to protect themselves from disclosing intolerable weakness, particularly in the relationship with significant male figures (fathers/brothers/male friends). This finding is consistent with some elements of Shneidman’s theory that (1993, p. 4), “suicide is a conscious act ... in a needful individual who defines an issue for which the suicide is perceived as the best solution.” This self-protection from disclosure of intolerable weakness in the relationship with significant male figures is also in line with the suggestions of Addis and Mahalik (2003) and Vaswani (2011). According to them, the fear of rejection by important significant others may be crucial for the willingness (or unwillingness) to seek out and disclose the problem situation. Moreover, our finding of a lacking room for weakness may contribute to a better understanding of what causes individuals to act on their suicidal thoughts (Gunnell, 2015).

Further, using the cycle of avoidance model (Biddle, Donovan, Sharp, & Gunnell, 2007), fear of mental disorder was a barrier because help-seeking would have transformed emotional distress from a private reality, into something public and official, and thus as something real. Not seeking help may thus have been a coping strategy for normalization.

One major challenge in suicide research is obtaining suitable data (De Leo, 2004). Data based on interviews from third parties and related to a small number of suicides clearly has its limitations. In addition, this sample was limited to young men who had no known history of psychiatric problems or of suicide attempts. Our study is, to our knowledge, the first to explore barriers to help-seeking in relation to suicide among young men unknown to mental health services, through analyzing in-depth interviews with many informants around each suicide, as well as suicide notes. A further strength of this study is that the participants were not specifically asked about issues related to the absence of help-seeking. Rather, this information spontaneously arose in the dynamic in-depth interview, thus reflecting the importance of this issue for the informants. As most young men who take their lives do not contact mental health services or their GP prior to their death (Luoma et al., 2002), what family and friends perceive probably constitutes an important suicide prevention focus.

Contrary to suggestions of a causal link between mental illness and suicide, depression in particular (i.e., Mann et al., 2005), few informants in the present study mentioned signs of depression or other mental

illnesses in the period leading up to the suicide. This finding may have serious implications for health care professionals' ability to offer optimal help in a suicidal crisis, as well as for the tailoring of suicide prevention strategies. What mattered in the suicidal crisis was rather the lack of coping strategies to handle relational difficulties and regulate overwhelming feelings of shame, failure, worthlessness and helplessness. This finding is consistent with central theories of suicidal behavior (Rudd, 2006; Shneidman, 1993), which suggest that depression per se, even if it is there, does not, in itself, cause suicide. In line with Shneidman (1993), Rudd (2006), and Orbach et al. (2007), our findings suggest that suicidal individuals should receive help specifically related to his/her crisis/problem situation. Diagnosing and treating an underlying mental illness, which is the logic in the medical model of suicide, may not be sufficient in saving the lives of suicidal individuals. That is, if the problem situation is relational difficulties and overwhelming mental pain, but GP offers the suicidal patient screening for depression and/or treatment for mental illness (i.e., Mann et al., 2005), the suicidal patient can lose trust in the GP's ability to help them. In addition, deep shame for being the person one is would greatly influence how they present themselves to the GP.

The present findings point to the importance of informing/educating the general public, work places, military services, schools/ universities, as well as GPs, about the specifics of suicidal behavior that go beyond the medical model (Rudd, 2006; Shneidman, 1993). Gatekeepers should learn that certain young men may ambitiously enter adulthood in a way that makes it impossible for them to disclose their defeats and thus seek help from others (professionals/network) when they become suicidal. Further, professionals working within health services need to be aware of young men's reluctance to seek professional help and they should always take calls of concern from parents and/or social networks of young, seemingly successful, men seriously.

The current study explores suicide among young men unknown to mental health services. The findings add important insights to the reluctance of help-seeking among a unique population and may help in the planning of national prevention plans for this group of suicides among young men.

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