Factors that influence help-seeking behaviours in young men aged 25 to 30 years

Meredith Bolland

Edith Cowan University

Recommended Citation

This Thesis is posted at Research Online.
https://ro.ecu.edu.au/theses_hons/1245
Copyright Warning

You may print or download ONE copy of this document for the purpose of your own research or study.

The University does not authorize you to copy, communicate or otherwise make available electronically to any other person any copyright material contained on this site.

You are reminded of the following:

- Copyright owners are entitled to take legal action against persons who infringe their copyright.

- A reproduction of material that is protected by copyright may be a copyright infringement. Where the reproduction of such material is done without attribution of authorship, with false attribution of authorship or the authorship is treated in a derogatory manner, this may be a breach of the author’s moral rights contained in Part IX of the Copyright Act 1968 (Cth).

- Courts have the power to impose a wide range of civil and criminal sanctions for infringement of copyright, infringement of moral rights and other offences under the Copyright Act 1968 (Cth). Higher penalties may apply, and higher damages may be awarded, for offences and infringements involving the conversion of material into digital or electronic form.
USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.
Factors that Influence Help-Seeking Behaviours in Young Men aged 25 to 30 Years
Meredith Bolland

A report submitted in Partial Fulfilment of the Requirements for the Award of Bachelor of Science (Psychology) Honours, Faculty of Computing, Health and Science, Edith Cowan University.
Submitted October, 2010.

I declare that this written assignment is my own work and does not include:
(i) material from published sources used without proper acknowledgement; or
(ii) material copied from the work of other students.

Signed ____________________________

Dated 14th December 2010
Abstract
Using Heidegger's (1962) hermeneutic phenomenology informed by van Manen (1984) and Gadamer (1975), this qualitative inquiry has been an exploration, analysis and interpretation of the lived experiences of the help-seeking phenomenon in young men aged 25 to 30 years. A purposive sample of thirteen young men, 25 to 30 years of age, living in urban areas of Perth, were interviewed using in-depth, semi-structured interviews. The ultimate aim of this study was to discover meaning and enhance the understanding of the essential experiences that influence help-seeking behaviours of these young men. The findings of this inquiry indicate a sophisticated emotional discourse around help-seeking and mental health issues. It also exposes the tensions and complex interplay between the masculinity stereotype, problem type and available sources of help, stigma, and the strong societal expectations of competency that these young men experience. In many areas of help-seeking behaviours, there was a structural division that separated this group of young men into those willing to engage in early professional support, the “early seekers”, and those who would delay formal help until crisis point, the “delayed seekers”. Contrary to the literature, these factors were independent of the young men’s emotional competence and literacy. Overall, the study findings showed that there were significant, complex and unique factors influencing their help-seeking experiences. Future research could explore and seek to confirm the results of this study for delayed seekers in a broader age bracket.

Name: Meredith Bolland

Supervisor: Dr Andrew Guilfoyle
COPYRIGHT AND ACCESS DECLARATION

I certify that this thesis does not, to the best of my knowledge and belief:

(i) Incorporate without acknowledgment any material previously submitted for a degree or diploma in any institution of higher degree or diploma in any institution of higher education;

(ii) Contain any material previously published or written by another person except where due reference is made in the text of this thesis; or

(iii) Contain any defamatory material.

(iv) Contain any data that has not been collected in a manner consistent with ethics approval.

The Ethics Committee may refer any incidents involving requests for ethics approval after data collection to the relevant Faculty for action.
Acknowledgements

Numerous people have been instrumental in helping me complete this research project. I would like to thank the participants or co-researchers, as this study would not have been possible without you and your invaluable insights, honesty and trust. It has been a privilege to share in your experiences. I will do my utmost to present your experiences with authenticity and honesty. I would like to thank Dr Andrew Guilfoyle for kindly agreeing to supervise my research and being so generous with his time, support, guidance and incredible expertise, and for redefining the word “patience”. He was particularly skilful at pulling me back on track when I was “going native”. He has actively provoked my interest and intrigue into the diverse realms of qualitative research. I would also like to thank my peers and the psychology staff at Edith Cowan University who have always been so helpful in sharing opinions, advice and knowledge with me.
## Table of Contents

Title Page................................................................. i
Abstract ........................................................................ ii
Copyright and Access Declaration ................................ ii
Acknowledgements..................................................... iv
Table of Contents........................................................ v

**THESIS**

Introduction ..................................................................... 1
Literature Review .............................................................. 2
Research Design .............................................................. 11
Methodology ................................................................... 11

- Participants ................................................................ 16
- Materials .................................................................... 16
- Procedure .................................................................. 17
- Data Analysis .............................................................. 19

Findings and Interpretations ........................................... 22

- Theme 1: Emotional Competence ................................. 22
- Theme 2: Stereotype of Masculinity .............................. 24
- Theme 3: Sources of Help ........................................... 25

Discussion ...................................................................... 38
Conclusions ................................................................. 40
Strengths, Limitations and Future Directions .................. 40
References ................................................................. 43
APPENDICES

Appendix A: Comparison of Trends in Suicide between 1997 and 2008 ................................. 52
Appendix B: Reflective Journalling .................................................................................... 53
Appendix C: Information Letter .................................................................................... 63
Appendix D: Statement of Informed Consent ..................................................................... 64
Appendix E: Interview Schedule ...................................................................................... 65
Appendix F: Details of Counselling Services .................................................................... 67
Appendix G: Table of Themes .......................................................................................... 68
Appendix H: Glossary ........................................................................................................ 69
Factors that Influence Help-Seeking Behaviours in Young Men Aged 25 to 30 Years

One of my friends ended his life on Tuesday. He was 26. Crazy world, eh? I'm OK, just sad for his family and my mate who found him.

A young man contacted me two days before his interview with this penetrating and sobering message ... a mere glimpse of meaning from the depths of silence.

The Australian National Survey of Mental Health and Wellbeing was conducted from August to December, 2007, with a representative sample of people aged 16-85 years (Australian Bureau of Statistics (ABS), 2008). The information it collected included the lifetime and 12-month prevalence of selected mental health concerns, namely, anxiety and affective issues, and substance use disorders. It also assessed barriers to help-seeking. The survey, based on an instrument developed by the World Health Organization, has been run in 32 countries and revealed the need to address, globally, the relatively poor help-seeking behaviours in young people, and particularly young males.

Rickwood, Deane, Wilson, and Ciarrochi (2005) conceptualise the help-seeking process as “translating the very personal domain of psychological distress to the interpersonal domain of seeking help, embracing a willingness to disclose degrees of psychological distress” (p. 1). They add that seeking help is an intensely personal process. Sayers, Miller, and the Ministerial Council for Suicide Prevention (2004) describe help-seeking as “a process aimed at problem-solving through requesting advice and/or material, and emotional assistance from professional and non-professional sources” (p. 2).

Developing an enhanced understanding of help-seeking behaviours is essential to identify factors that have the potential to improve engagement in help-seeking processes, especially at critical times, when a person is psychologically distressed or suicidal. The relevance and
implications of not seeking help have social, health and psychological consequences, all relevant concerns for the discipline of clinical psychology. Without an understanding embedded in the perceptions of those who have experienced help-seeking processes, there is no justification or rationale for intervention (Wilson, Deane, & Ciarrochi, 2005).

Literature Review

The relationship between help-seeking behaviours and psychological health has been reported extensively in the literature (Hunt & Eisenberg, 2010; Lee, 2009; Quinn, Wilson, MacIntyre, & Tinklin, 2009). There is also now a growing literature describing the factors that facilitate or hinder help-seeking activities for psychological issues in young males, especially for those up to 24 years of age (Cunningham & Wuthrich, 2008; Lee, 2009; Rickwood, Deane, & Wilson, 2007). The consistent overarching theme in this body of research is that these help-seeking behaviours of young men up to the age of 24 years are driven by the problem type (personal-emotional, depressive and suicidal) and the available sources of help (formal or informal / professional or non-professional). Most of the studies also describe a reluctance of these young men to seek help from all sources, due to a multifaceted blend of internal and external factors.

Models of help-seeking. Dunning, Heath, and Suls (2004) suggest that people shape various models of illness that determine their response to symptoms, their compliance to therapies and their strategies for seeking help. Models of help-seeking include an information-processing model (Vogel, Wester, Larson, & Wade, 2006). For example, some people may believe that some disease indicators they commonly experience are normal or harmless and therefore do not warrant asking for help. For others, internalised beliefs acquired as children dictate their help-seeking behaviours (St. Claire, 2003). The medical model is based on the concept that health solutions are proposed by experts, and patients are expected to be compliant.
People can therefore avoid the responsibility of proactive participation in the management of disease (Pettigrew, Donovan, Pescud, Boldy, & Newton, 2010). The health belief model (Becker, Maiman, Kirscht, Haefner, & Drachman, 1977; Rosenstock, 1966) suggests that individuals are less likely to use mental health services (MHS) if they believe a mental health condition is not amenable to treatment. The clinical pathway model for utilising MHS (Howard et al., 1996) describes the need for individuals requiring psychotherapy to self-identify as someone experiencing a mental illness before being willing to access MHS. Therefore, a lack of awareness of symptoms or a reluctance to self-identify due to perceived stigma will result in the decreased likelihood of seeking help. The decision to use MHS is complex, especially when considering the diverse range of disciplines and behavioural contexts. However, there is increasing recognition that efforts to encourage optimal uptake of MHS need to consider the views of potential users of these services (Pettigrew et al., 2010).

In a Queensland study of 3092 young adults, aged 15–24 years, Donald, Dower, Lucke, and Raphael (2000) found that 39% of the males and 22% of the females reported that they would not seek help from formal services for personal, emotional or distressing problems. Furthermore, 30% of males, compared with only 6% of females, reported they would not seek help from anyone. Reluctance to seek help provides a major obstacle for the prevention of suicide and self-harm, as well as presenting a challenge to effective early intervention approaches (Rickwood et al., 2007).

Rickwood et al. (2005) carried out a range of studies in New South Wales, Queensland and the Australian Capital Territory, using both qualitative and quantitative approaches. Data from a total of 2721 participants aged 14–24 years were gathered. Barriers they identified included lack of emotional competence, the help-negation effect related to suicidal thoughts (refusal to accept or access available help), negative attitudes about help-seeking, and fear of
Gillon (2007b) proposes that one of the greatest barriers to seeking help was young men's socialisation to be independent, emotionally restrained, and to conceal their vulnerability. Young men in particular appeared afraid of the stigma attached to mental health difficulties and feared that it would be seen as a sign of weakness and perhaps affect their future career prospects. In other studies, Quinn et al. (2009) and Whitley and Drake (2008) reported that young men aged 18 to 24 years cited lack of money as the reason they did not go to the doctor. Other treatment barriers surfacing in these studies have included the potential lack of confidentiality, geographic isolation, poor access to therapists, and discomfort with traditional therapy procedures and formats (Department of Health & Ageing (DHA), 2005). The facilitators (or approach factors) for seeking help revealed in these studies included positive past experience and supportive social influences (Ciarrochi, Wilson, Deane, & Rickwood, 2003). They concluded that young men's behaviour invariably appeared to be a by-product of their belief system around help-seeking which included the notion of their masculine identity.

There is good reason why young men in the age range up to 24 years have been the focus of investigation. The Public Health Group (2005) in Victoria and McGorry, Parker, and Purcell (2006) have reported that for young people aged 15 to 24 years, psychological disorders are the single greatest cause of years of healthy life lost. This situation has been replicated in the United States (US) (Kessler, et al., 2005). Furthermore, they reported that psychological disorders accounted for nearly half of the disease burden for young adults in US, and most lifetime psychological disorders have their first onset by age 24 years. While young people have the greatest need for mental health interventions, they are often the least likely to seek help. Additionally, the mental health problems most commonly experienced by young people (depression, anxiety and substance use) act to negate help-seeking by increasing social
withdrawal and the preference to keep their distress to themselves (Rickwood et al., 2007).

In spite of this backdrop to the mental health status of young people, there has been a significant recent downward trend in deaths registered due to suicide, Australia-wide (ABS, 2010). Interestingly, between 1997 and 2008, the largest drop in suicide rates for men (47%) was observed for 25 to 29 year olds (see Appendix A). This is followed closely by those aged 20 to 24 years, for which the suicide rate fell by 41%. This general decreased trend has been credited to better preventative health programs in the community and earlier detection of mental health problems. In a recent qualitative study of 111 West Australians, aged 40 years or over, Pettigrew et al. (2010) found that the participants considered that younger males today were far more likely to ask for help than previous generations. This trend aligned with a prior American study by Mojtabai (2007) who found that help-seeking for mental health issues has become more acceptable over the past decade, and the perceived stigma associated with it had declined.

There has been extensive research on the impact of emotional competence on the help-seeking activities of young men under 25 years (Hunt & Eisenberg, 2010; Planned Parenthood of Toronto, 2005; Rickwood et al., 2007). Furthermore, psychological and mental health literacy has been reported to be a factor influencing help-seeking behaviours in men generally, up to 35 years of age (Möller-Leimkühler, 2009; Sayers et al., 2004). However, attention to the emotional competence and literacy specifically for 25 to 30 year olds, and their relationship to help-seeking behaviours has not been considered in the research reviewed here.

Ciarrochi et al. (2003) describe emotional competence as an integrative capacity for “identifying, describing, and managing emotions” (p. 1). They intentionally avoided the use of emotional intelligence in their paper due to concerns about the psychometric properties, and the questionable assumption that their study measured individual differences in a type of intelligence. Their primary focus was on individual differences in people’s skills at recognising, interpreting,
managing and responding to their own and others' emotions. Giardini and Frese (2006) agree that the label *intelligence* is neither necessary nor warranted. They regard the term competence as more suitable and more theoretically promising as sound empirical evidence points to a concept useful for understanding emotions, cognitions and behaviour. Saarni (2004) asserts that the term additionally embraces an ability to use and understand the vocabulary of emotional expression, a concept called emotional or mental health literacy by other authors. Sayers et al. (2004) maintain that mental health literacy includes the attitudes that promote and determine appropriate help-seeking processes.

**Lifecourse issues.** From a lifespan perspective, Rickwood et al. (2005) have proposed that help-seeking patterns reflect key developmental and transition points in people's lives and the links between different life phases. They believe that different sources of help are more or less important at different stages of the lifespan. Friends, for example, assume greater importance during adolescence, while intimate partners are especially important for adult men (Australian Centre for Agricultural Health and Safety, 2005). In a later study, Rickwood et al. (2007) reported that friends as well as partners became more influential for young adult men. However, it would appear that further research is required to map developmental trends in help-seeking across the whole lifespan, focusing on discrete age brackets from childhood to old age.

Up until now, the majority of the research papers investigating the help-seeking behaviours of young men have been quantitative (Hunt & Eisenberg, 2010). Studies using a qualitative methodology have invariably investigated young men up to the age of 24 years (Quinn et al., 2009). One exception that included men between the ages of 16 and 35 years was a qualitative study by Ritchie (1999), who used focus groups to inform a media campaign aimed at encouraging the help-seeking behaviours of these young men. However, only 4 of the 18 participants were from 25 to 30 years, and the only rationale given was poor access to a sample of
young men aged 16 to 24 years old. Therefore, the lack of differentiation into age categories has precluded the close scrutiny of help-seeking behaviours in 25 to 30 year olds.

Numerous reports confirm the continuity and intensifying of psychological health issues as young men develop beyond 24 years (Hunt & Eisenberg, 2010; Rutter, Kim-Cohen, & Maughan, 2006). The younger age bracket of 15 to 24 years represents a critical period for intervention due to increased risk factors and incident rates of harm, and the need to develop immediate preventative strategies. However, McGorry et al. (2006) report that, regrettably, intervention rarely occurs during this period and young men often reach the age of 25 years with unmet needs for their psychological health. Consequently, by the age of 25 years, many men sit on the brink of a particularly challenging period, during which their help-seeking behaviours will shape and impact the rest of their lives.

For many young men, this age group of 25 to 30 years represents a time of considerable stress and social expectations, and embraces the early stages of their employment or career entry (McGorry et al., 2006). In 2007, in developed and developing countries, the average age for a man’s first marriage lay between 25 and 30 years of age. In Australia, the mean age was 31 years (United Nations, 2009). Not only is marriage related to a person’s physical and psychological health, the preparation for marriage is also seen as a major stressor and disruption to a person’s life (Brittle, 2007). Further reasons for exploring the obstacles and facilitators that are associated with help-seeking in the 25 to 30 year old age group include the challenges of potential fatherhood (Centres for Disease Control and Prevention, 2009) and the associated increase in responsibilities and financial pressures. These young men have survived the age period of increased risk and harm (that is, up to 24 years) with societal expectations assuming that they can now deal with any emerging challenges. Perhaps it is more a case of further entrenchment of unresolved emotional needs and a potential pattern of non-help-seeking which may be set for life.
What is significant, therefore, is that the 25 to 30-year-old age group is a potentially neglected category of young men in the literature. No qualitative studies reviewed here have reported exclusively on the help-seeking behaviours of young men of that age. The strongest and most academic rationale for this study is the need to fill a gap in the research. There is also a need to give a voice for those not heard in the literature (Creswell, 2007). It is vital, therefore, that a spotlight be focused on these potentially demanding and challenging few years immediately beyond 24 years. It may be that these years embrace a critical intervention period.

There is, however, some research to guide us. As part of a significant longitudinal study that began in 1972 in Dunedin, Nada-Raja, Morrison, and Skegg (2003) examined the help-seeking behaviours of a group of 965 young adults (471 women, 494 men), representing 95% of the surviving cohort. This has been the only study reviewed here, albeit a quantitative study, that has investigated young men within the age bracket 25 to 30 years. All participants were 26 years of age. A striking trend that surfaced was the reluctance of the young men to seek any help and support. Significantly more women (two to three times) than men consulted professional sources of help, such as counsellors, general practitioners and psychologists. This tendency also applied to informal sources, such as partners, family and friends. This often resulted in men seeking help only when they were already in deep crisis. The obstacles to help-seeking that emerged in this study were basic and unexplored functional issues. They included practical issues (transport, cost, time), attitudinal blocks (they thought they could handle the problem) and stigma-related barriers (they were afraid of what others may think). One argument for the approach used in this current study is to go beyond these basic barriers and fully explore the deeper issues of young men’s experiences of help-seeking.

Ritchie (1999) described an exploratory, qualitative study examining the barriers to help-seeking attributed by young men aged between 17 and 35 years. Her study demonstrated a
process of enculturation of the notion of masculinity which restricted help-seeking choices in a crisis. The stereotype of masculinity was expressed as a fear of self-disclosure and a dominant gender identity embracing independence, strength and emotional restraint. These traditional views of masculinity were also found in other studies which included 25 to 30 year olds (Möller-Leimkühler, 2009). White and Cash (2003) go as far to say that delay in seeking help appears to be a key factor in men’s greater death rate in comparison with women, and ties in with the socially imposed model of the man as a person who is independent, strong and in control. They suggest that the focus now must be directed towards determining exactly what aspects of men’s health beliefs and behaviours obstruct their help-seeking. Perhaps it is a reminder that our efforts should be directed towards the role of early detection and prevention. For White and Cash, this involves a profound and comprehensive exploration of men’s decision-making practices around help-seeking.

Another relevant line of investigation for help-seeking behaviours in men was revealed by Campbell (2004) who reported that more men participated in online support groups than women in the US, United Kingdom (UK) and Australia. While women outnumber men in face-to-face counselling, men are tending to use online services, or E-mental health services, in greater numbers than women. This is an important discovery for other programs providing on-line, anonymous requests for support, information and advice. These services include Men’s eHealth Network (MEHN), a program developed jointly by Vario Health Institute at Edith Cowan University in Perth and the Prostate Cancer Foundation of Australia. Other projects include Men’s Domestic Violence HelpLine, Mensline, and beyondblue, a whole-of-community intervention. An online counselling service called Rural WA – eheadspace (Australian Government, 2010), is an initiative of the Australian and Western Australian Governments and offers anonymous, free
and confidential assistance to young people in rural areas. It is designed to provide early intervention, rather than waiting until they are in crisis.

In 2004, Sayers et al. used a qualitative and quantitative methodology to look at factors that facilitated and inhibited help-seeking behaviours in young men aged 17 to 35 years. Like many other studies, the role of traditional views of masculinity emerged as a significant barrier to seeking help. While the researchers differentiated these factors into age groups of 17-19, 20-24, and 25-35, I could find no clear rationale or theoretical base for their decision. Rather, review of the literature found a global convention, seemingly for ease of collation, that groups the socio-demographic variable of age into ten year brackets of 15-24, 25-34, 35-44, and 45-54 years. While the rationale of increased risk and harm emerges for the frequently used target population of 15 to 24 year olds, there appears no explicit health-related rationale in the literature for the age brackets beyond 25, and I propose that they are applied too loosely.

A qualitative inquiry is the ideal research methodology for revealing and forging a comprehensive understanding of the meaning of personal lived experiences of a phenomenon (Streubert & Carpenter, 1999). As a result, qualitative research is a better fit for the current research inquiry. The purpose of this qualitative inquiry is to explore, discover, understand and interpret, within the context of phenomenology, how young men, aged 25 to 30 years of age, experience the factors that influence their help-seeking behaviours. I have argued that these young men are entering an age bracket of considerable challenges, while concurrently facing the social expectation of an all-embracing competency. Understanding the factors that impact their help-seeking behaviours is essential to gain insight into the approaches needed to improve engagement in formal and informal help-seeking options. This involves transcending the basic practical barriers investigated by many researchers, and delving deeper into the young men’s experiences of the phenomenon of help-seeking. It is anticipated that the findings may have the
potential to highlight lifestage issues, and themes and insights that could better inform those responsible for the development of initiatives in the psychological health arena.

The research objective is to explore, discover and understand the phenomenon of the help-seeking experience in young men, in this unexplored age category of 25 to 30 years. The research question for this proposal grew out of the investigator’s personal history of having three sons in the researched age group. This has brought the core of the phenomenon into focus. The research question asks: “What are the essential factors influencing help-seeking behaviours in young men, aged from 25 to 30 years, and how do they experience these factors?”

Research Design

Theoretical Framework

Phenomenology is a philosophy initiated at the beginning of the 20th century, by Edmund Husserl, acknowledged as the “founding father” of the phenomenological movement (Giorgi & Giorgi, 2003). However, its evolution has resulted in diverse and intersecting schools of thought (Dowling, 2007). Spiegelberg (1982) asserts that phenomenology is a moving philosophy with many parallel currents. On a similar vein, Owen (1996) highlights that phenomenology “is a reminder that all knowledge is human made, and not timeless and unchanging”. As a method, phenomenology is far from a unified approach under one canopy. However, a common theme among the various phenomenologies is concern for describing lived experience and ultimately for interpreting those meanings so they can inform the practice and science of psychology.

Methodology

The phenomenology applied here is based on the principles of Heidegger’s (1962) hermeneutic phenomenology. It was further guided by the work of van Manen (1984) and Gadamer (1975). The contemporary phenomenologic method is grounded in the belief and assumption that core truths are embedded in lived experience (Spiegelberg, 1982) and that human
experience makes sense to, and can be consciously expressed by those who live it (Dukes, 1984). Therefore, in this study, phenomenology is well-suited to explore the holistic questions of meaning that are embedded in the human experience of help-seeking. This inquiry seeks to gain an understanding and deep insights of the phenomenon from the unquestioned personal life-world perspective of the experiencing person; that is, how help-seeking is actually lived rather than conceptualised or categorised (Munhall & Chenail, 2008; van Manen, 1984). In an attempt to understand the experience of help-seeking, phenomenology will help search for and reveal the essence of experience, or its inner essential nature. Van Manen (1984) proposes that “the essence or nature of an experience has been adequately described ... when the description reawakens or shows us the lived meaning or significance of the experience in a fuller or deeper manner” (p. 1).

Phenomenology becomes hermeneutical when its approach is interpretive, rather than purely descriptive or transcendental in its phenomenology. While there is an interest in Husserl’s (1970) phenomenology in this inquiry, it is the hermeneutic phenomenology of Heidegger (1977) and a concern with human experience as it is lived, that drives the current study. Heidegger differs from Husserl in his views of how the lived experience is explored. Heidegger maintains that every form of human awareness is interpretive. Similarly, Gadamer proposes that interpretation permeates every activity (Koch, 1999). Therefore contemporary hermeneutics which embraces everything in the interpretative process is applied in this inquiry. This includes verbal and non-verbal forms of communication (Todres & Wheeler, 2001). Heidegger argues that we necessarily interpret everything in terms of our language and experience (Hein & Austin, 2001).

In order to defend the validity or objectivity of interpretation, Husserl (1970) believed that any prior preconceptions, assumptions or beliefs held by the researcher should be examined, acknowledged, and then suspended (put to one side) or bracketed. This process is often referred
to as *reduction* in phenomenology (Koch, 1995; Lowes & Prowse, 2001). There has been a general consensus amongst researchers to acknowledge that our background and experiences shape our interpretations of lived experience, and many support the need for reduction in some form (Depraz, 2007). However, Husserl’s view of bracketing and reduction is not without its critics (Dahlberg & Dahlberg, 2004). The notion of being able to bracket prior beliefs, values and knowledge has been, and still is being questioned by philosophers and researchers. Lowes and Prowse (2001) argue that it is an illusion that researchers, seeking objectivity to demonstrate rigour, can “stand outside the interview process” (p. 478).

While drawing upon various aspects of the philosophies, methodologies and theoretical assumptions of Heidegger (1962), van Manen (1984) and Gadamer (1975), this current inquiry departs from traditional attempts at “bracketing”. It will embrace the concept of the lived experience as an interpretive process, helping people understand human experience and the way it is immersed in contexts. However, the present study assumes that the interpretations of the phenomenon of help-seeking flow from the researcher’s personal, social, cultural and historical experiences and beliefs. This reflects Caelli’s (2000) proposal that it is impossible for individuals to think *aculturally*.

In line with this position and in an attempt to be transparent and credible, and fitting with a hermeneutical approach, the researcher’s role has been comprehensively accounted in the entire research endeavour. This has included detailed and extensive journalling (see Appendix B), and memos and note taking during the whole research process. An overview of the approach, adapted from a phenomenological study by Lauterbach (1993), is outlined in Figure 1.
Figure 1. Model of approach to this hermeneutic phenomenology inquiry. Adapted from "In Another World: A Phenomenological Perspective and Discovery of Meaning in Mothers' Experience of Death of a Wished-For Baby", by S. Lauterbach, 1993, National League of Nurses, 19, p. 145. Copyright 1993 by the American Psychological Association.
The investigator's personal experience with three sons in the researched age range has provided the impetus for this study and guided its framework. Furthermore, an interest in psychoanalytical psychotherapy and its attempts to uncover hidden meaning, as well as the phenomenological paradigm in family therapy training, has provided further direction for hermeneutic analysis. This approach, guided loosely by the literature, was used to create an understanding of young men's essential experiences of the nature of help-seeking, embracing what was experienced, as well as how it was experienced.

To support this phenomenological methodology, semi-structured, in-depth interviews were conducted to provide a detailed collation of individual perceptions and experiences of help-seeking in young men from 25 to 30 years of age. In-depth interviews draw on the interpretative theoretical framework, where meanings are continually constructed and reconstructed during interaction from the social and cultural contexts of the young men (Flick, 2009).

Choosing in-depth interviews is congruent with interpretivism and phenomenology and is additionally important for theoretical rigour (Liamputtong & Ezzy, 2007). Furthermore, carefully delivered, in-depth interviews have the potential to provide a private, respectful and sensitive space to clarify relevant issues and facilitate intimate disclosures that might otherwise be unavailable from this group of young men. This was achieved by approaching participants respectfully and sincerely, being sensitive to the participants' needs and concerns, ensuring confidentiality, by active listening and adhering to the guidelines of Edith Cowan University (ECU) Ethics Committee. Attention to these factors consolidated the evaluative rigour of the study (Kitto, Chesters, & Grbich, 2008).

Each participant was seen as the experiential expert on the subject and allowed maximum opportunity to tell their own story, and could enter novel avenues that the investigator had not thought of. At the same time, the interviewer was able to ensure that the discourse stayed close to
the agreed domain. Consequently, each interview was experienced as a co-determined and co-constructed two-way interaction.

**Participants.** A purposive sample of thirteen young men aged 25 to 30 years were recruited for interview by convenience sampling and snowballing. Purposive sampling is a method shared by descriptive and hermeneutic phenomenology, and was chosen because it could purposefully inform an understanding of the central phenomenon of the research (Kitto et al., 2008). Recruiting was initiated through the researcher's three sons, aged from 25 to 30 years of age. In addition, the content and format for the interviews was piloted with a young man of 27 years of age. Composite meaning was anticipated with 8 to 12 participants. Data collection and analysis occurred concurrently and was guided by saturation of recurrent patterns, when no new information was emerging from the interviews (Liamputtong & Ezzy, 2007). This occurred after thirteen interviews. The young men, all Perth residents, reflected a wide range of educational qualifications, from year twelve to PhD level. All participants could communicate in English, with ethnic backgrounds including European, Chinese, Maltese, Polish, and Indian. The range of socio-economic status was from average to high. None of the young men was married, but eight of the thirteen were currently in relationships of two years or more.

**Materials.** Each participant was provided with an information letter (see Appendix C) and a consent form (see Appendix D). The interview schedule (see Appendix E) consisted of six questions that were drawn from various sources in the literature including the *General Help-Seeking Questionnaire* (Rickwood et al., 2005). Multiple probes and prompts were used where necessary to encourage elaboration and depth of information, such as “tell me more about that” or “how was that for you?”. A digital audio-recorder was used to record the interview to ensure a more accurate account of the dialogue for transcription, enhancing credibility (Liamputtong & Ezzy, 2007). A notebook was used by the researcher as a reflective journal of thoughts and
observations during and between interviews, thereby enhancing interpretive rigour by creating a more comprehensive narrative of the participants’ and researcher’s experiences (Kitto et al., 2008). A computer was also mandatory equipment. Details of counselling services were available (see Appendix F).

Procedure. After ethics approval was granted from the ECU Ethics Committee, recruitment of the young men was facilitated by convenience, by asking the researcher’s three sons to distribute the information letter to friends and colleagues who fitted the gender and age criteria (25 to 30-year-old males). This process took advantage of an opportunistic access point for a group of young men who are often inaccessible. Potential participants were invited to contact the researcher by phone or email, in confidence, to voice their willingness to take part. The consent form was posted to each of the thirteen respondents. These documents described the research project and its aims, the interview process and the rights of each participant. The voluntary nature of current and future participation was stressed. It was also made clear, based on ECU policy, that there was to be no payment for their involvement. Each interview was arranged at a time, date and venue that suited each participant, to ensure maximum comfort and convenience for each person in a private and non-threatening environment. It was crucial that rapport and trust were established to reduce the motive and opportunity for deception (Smith, 2003). Ten of the interviews took place in the participants’ homes, two in the researcher’s home and one at a participant’s workplace. The interviews took place between 29th May and 10th August, 2010.

To collect data, an in-depth interview with each young man was conducted by the researcher to allow participants to articulate their lived experience in detail. Interviews lasted between 25 minutes and 1 hour. Each interview was digitally recorded to reduce the risk of researcher bias, preserve authenticity and to allow the interviewer to attend to, and interact with
each participant more fully. Minimal notes were taken during each interview to allow full immersion in the conversation, while being mindful of non-verbal communication that might point to signs of discomfort or agitation (Liampittong & Ezzy, 2007). The researcher introduced herself and the participant was briefed about the process. Each person was informed of his right to exit the interview at any time without consequence. Before starting each interview, full consent was confirmed including that for recording, and a guarantee of confidentiality of information and their participation was given. Each participant was asked if they had any questions before commencing. All but one of the interview questions was open-ended. Due to the sensitive nature of some of the questions, such as reasons for not seeking help, and indeed just by being interviewed, there was a possibility that participants could feel ill-at-ease or experience varying degrees of intrusion, discomfort or distress. Additionally, exploring a person’s help-seeking behaviours had the potential to tap into personal experiences not previously shared with anyone and may have led to self-discovery. For this reason, contact details for free counselling at ECU were made available (see Appendix F). None of the young men requested referral to the services, so no follow-up communication regarding counselling was required. This included the young man whose friend committed suicide four days prior to his interview. However, to really listen to people is to empower them (Way, 1997) and the opportunity to verbalise and be appreciated for sharing often has therapeutic effects (Munhall & Chenail, 2008).

Upon completion, participants were debriefed according to their individual needs. They were thanked for their participation and reminded of the possibility of being consulted subsequently with their permission and via their preferred method, to clarify and validate the researcher’s understanding of their experiences and insights. This process can have the effect of restoring any power imbalance in the relationship. They were also offered to be sent a summary of results. Another verification procedure used was repeatedly checking with respondents during
interviewing that the researcher’s understandings of what the young men were saying was consistent with the meanings they intended.

All audio-recordings were deleted after transcription and only the researcher had access to the data which was stored securely in locked facilities. Electronic versions of data and all paper forms will be destroyed after five years.

Data analysis. Data analysis, based loosely on Colaizzi’s (1978) phenomenological method, began with the interviews being transcribed verbatim by the researcher and stored on a password-protected computer. A coding system was used to identify participants, and any personal information with the potential to identify the participant was deleted to ensure confidentiality. Completed transcripts and interpretations were reviewed by the supervisor for possible misinterpretations and incongruencies, thus strengthening interpretive rigour (Kitto et al., 2008).

Inherent in the total process of analysis, was continuous and scrupulous reflexivity and review, which has been comprehensively journalled (see Appendix B). Reflective journalling began in January, before the process of data collection started, and then after and between interviews, as well as during data analysis. It involved describing and clarifying the researcher’s own experiences, which were used to shape, guide and substantiate interpretations. Subsequent steps taken to achieve further interpretive rigour and reader confidence included:

1. To gain a sense of each participant’s description of their lived experience of help-seeking, each digital recording was listened to twice. Written transcripts were reviewed repeatedly to familiarise the researcher with the interview texts and to capture an intuitive universal feel for the data (Colaizzi, 1978), an approach called “holistic reading” by van Manen (1997). Manual transcription and analysis, as opposed to use of a computer program, facilitated continued immersion in the data, making it a fluid and dynamic process. In hermeneutic phenomenology,
sustained engagement with the interview scripts facilitates the exposition of implicit meanings from the participants' lived experiences (Crotty, 2003). Any thoughts or feelings that surfaced during this stage were journalled. The back and forth dynamics of continual immersion in the data, reading, reflecting, re-reading and returning to the published literature is called the hermeneutic circle (Gadamer 1976).

2. Significant and meaningful statements, sentences or phrases from the transcripts that provided an understanding or essence of the lived experiences of young men's help-seeking were identified and highlighted (Moustakas, 1994).

3. The resultant formulated meanings were then clustered into central interpretive themes, grouped into categories and subsequently integrated into a comprehensive portrayal of the phenomenon. Participants' quotes were used to support common themes identified. The final interpretation of the young men's experiences was checked against the extensive journalling, in a validation process called triangulation (Creswell, 2007).

4. Six participants were contacted a second time to validate interpretations of the initial transcripts, check for perceived accuracy and ask questions generated by their interview. This enhanced procedural and interpretive rigour (Kitto et al., 2008). This practice of reviewing and validating interpretations with the participant is called member checking, and is Colaizzi's final step in his process of analysis (Creswell, 2007). In this study, member checking was achieved by face-to-face review, email or telephone from 21st September to 7th October, 2010. While participants felt that I had accurately represented their experiences of the help-seeking phenomenon, additional qualifying data was collected, which also required inclusion and interpretation. For example, an articulate profile of the "alpha male" was described during the member checking process (see Appendix B, Journal Entries 30 & 40).
A peer review process was organised by the supervisor, where the transcripts, emerging themes and sub-themes were shared, discussed and reviewed with five peer researchers. This validation and verification process, referred to as the “phenomenological nod” by van Manen (1997), also contributed to methodological rigour (Meadows & Morse, 2001). Novel issues were identified which added a fresh perspective to the data, while discussion of identified themes helped to guide and substantiate interpretations (see Appendix B, Journal Entry 25). Additionally, being mindful of pertinent news items and suicide events, all recorded in the reflective journal (see Appendix B, Journal Entries 26 & 30) has the potential to contribute to the reader’s confidence of the account.

An audit trail or decision trail is one of the crucial strategies for consolidating interpretive rigour and reliability (Liamputtong & Ezzy, 2007). It can minimise researcher bias, and facilitate authentic interpretations (Sanders, 2003). It involves memos and detailed field notes, and coding of data that can assist in analysis. The paper trail is checkable (auditable). Extensive journalling involving interpretations of thoughts, feelings and reflections recorded during analysis helped to promote the credibility of this study. The journal entries could also be checked against the final portrayal of the phenomenon.

As the detailed richness of the dialogue emerged, it became apparent that greater depth and focus could be achieved by extending the interview schedule. Another open question relating to the socialisation of young men to be strong and independent was appended to the interview schedule (see Appendix E). This question was posed to the last five young men interviewed. These additional responses validated the researcher’s initial feel for the strong emerging theme of the entrenched enculturation of the male stereotype, expressed by the first eight participants, as a strong and independent image of masculinity. It emerged as a key factor in the help-seeking experiences of these young men.
Findings and Interpretations

From thirteen verbatim transcripts, ninety-six significant statements capturing the essence of young men’s reported lived experiences of help-seeking were identified. The formulated meanings ascribed to these revealed three major themes and associated sub-themes emerging as an interpretive platform for guiding the discussion of the research question (see Appendix G).

Emotional Competence

Overall, the young men in this study provided rich and articulate accounts of their experiences of help-seeking (see Appendix B, Journal Entries 11, 13 & 27). They revealed a sophisticated emotional discourse which expressed the inner tensions they experienced between a masculine ideology, their life stage, and when and where they might seek help.

Ciarrochi et al. (2003) describe emotional competence as an integrative capacity for “identifying, describing and managing emotions” (p. 1). Furthermore, Saarni (2004) believes that emotional competence links to mental health literacy. This includes an ability to recognise mental health problems, knowledge and beliefs about risks, causes and effective treatments, and knowledge of how to seek mental health information and services. Additionally, Sayers et al. (2004) found from their study of 17 to 35-year-old males, that mental health literacy includes the attitudes that determine help-seeking behaviours. This cohort of thirteen young men showed a great capacity to articulate their emotions and had a good knowledge of mental health issues. However, this was independent of their willingness to seek professional help (see Appendix B, Journal Entry 20). This digressed from general trends in the literature where emotional competence (lack or presence) was revealed as a barrier or a facilitator to professional help-seeking activities.
One young man delivered a thoughtful and meaningful discourse on his recent experience of separation from his girlfriend:

*I went out to lunch with a girl I just broke up with and we had a really good chat. We both got upset ... I said, “I understand what you’re talking about and how you see that, but while I can do it mentally, my heart’s not in it. So you want certain expectations from me ... I can give that to you face value, but I can’t ... I don’t feel it” ... and likewise, there was a deal breaker for me ... so we made the decision to break up and I really believe it was the right one and I think we did a great job. We’re still friends. You know we were together a fair time ... all good and for the right reasons, that’s cool, so I’m getting better at doing things like that.*

These young men had a discourse inclusive of terms such as isolation, coping skills, depression, suicide, social stigmas, primal emotions, ego states, wearing a mask, major life traumas, early intervention, and blunted mood. Their insights were clear:

*Some young men feel it’s an attack on their ego to admit to another person they’re deficient in some way. A person is not going to ask for help if they’re faced with that internal challenge and I suppose people will resist the urge to challenge the ego until such time, it becomes so serious that their whole life is about to fall apart. The ego is a wonderful tool for keeping people distracted.*

This extended to a healthy vocabulary for mental health issues:

*There’s potential for talk and gossip at work. I wouldn’t hold it against anyone, but I know there’s one lady who has bipolar; she has her manic days and her depressed days and she’s hard to deal with and I know people talk about her.*

Ellis and Conboy (2004) describe emotional curiosity as “a deep and passionate desire for self-knowledge, and for insight into how others navigate through their emotional currents as
These young men expressed a curiosity and a thirst for seeking out information to help them understand themselves, and to make sense of their experiences:

_I think you have to expect to have an initial reaction, which is pretty primal, be it love, hate, jealousy, whatever, and then try to take a step back and go, “well why am I feeling like that?” and then really try and interpret it from the other person’s perspective ... that’s if it’s an event with a person._

**Stereotype of Masculinity**

One of the strongest and most pervasive themes to surface in this inquiry was the deeply entrenched enculturation of the stereotype of masculinity. Just as Ciarrochi et al. (2003) found, the young men’s experiences of help-seeking invariably were influenced by their self-perception and needing to sustain their masculine identity. This deep-rooted enculturation pervaded the young men’s descriptions of their lived experiences of asking for help. In the analysis below, it was how this enculturation force played out that was interesting and significant.

What was also common to the experiences of these young men was that the inner tensions of masculinity, already alluded to above, were often accompanied by strong societal expectations for this age bracket of young men. All of the young men in this study invariably commented that they were at a life-stage where they were “bombarded with expectations”. “It’s a time in your life when you’re meant to be getting everything sorted” or “You feel like you have to start getting your act together”. The tension of one young man was captured in this account:

_Constantly talking about my depression you know makes me feel a little bit embarrassed, so therefore I keep it to myself sometimes. There’s a greater pressure on me now that I’m this age to not talk about it as much. This is definitely the age where like I feel, after all these years you know of being stupid and doing stupid things, that I’ve finally learnt all_
my lessons, but I kind of feel that I’m pretty far from that ... but it’s certainly this feeling that you should be on top of things, and not ask for help.

Sources of Help

Another shared experience for this group of young men was the deep meaning and value placed on their friends and family as a resource for advice (see Appendix B, Journal Entries 10, 15 & 19). From a lifespan perspective, Rickwood et al. (2005) have proposed that informal help-seeking patterns are related to developmental processes, and that different sources of help are more or less important at different stages of the lifespan. They found that friends assume greater importance during adolescence, and intimate partners are especially important for adult men.

Similarly, for one young participant:

I’ve been with my girlfriend with just over 8 years and I’ve definitely spoken to her about anything and everything really, emotional stuff ... I mean she’s generally the one that I’ve usually gone to if I’ve had to talk about anything.

Rickwood et al. (2007) later reported that friends as well as partners became more influential for young adult men. The young men reflected this:

After going through my initial channels of dealing with it myself and consulting friends, if it still didn’t feel right, if it still didn’t work internally with me, and I was still confused, I would do that (ask for professional help); or if it was a subject that I thought was even too much to talk to friends about, I would do it. But I don’t think there’s anything that I couldn’t ... wouldn’t chat to my friends about.

So professionally, no ... from my mates, it just comes through normal general conversation. I guess we almost do it on a daily basis ... you’re always asking for help ... like it may not appear as if you’re asking for help directly.
With the widespread development of online support groups in the US, UK, and Australia, young men are tending to use online services in greater numbers than women (Campbell, 2004). All the young men in this study acknowledged that they could now ask for help for a range of issues in a free, anonymous and secure space. It appeared to remove several of the most formidable barriers experienced in professional help-seeking, such as tensions associated with the masculinity stereotype, stigma and cost:

*Definitely the internet you can hide behind ... a lot easier in terms of the anonymous factor ... you know you’re just another email in the system.*

Despite these shared experiences in several areas of their help-seeking activities, clear differences emerged in this group of young men when professional help-seeking behaviours were considered. A clear structural division was revealed that needed clarification. Initially, however, the complexity of the help-seeking phenomenon in these young men hindered the detection of this cleavage which became apparent and was reinforced through the continual process of hermeneutic circling (see Appendix B, Journal Entry 48). One subgroup of participants had been prepared to engage early in professional help-seeking, for issues such as relationship concerns and mild depression, before a situation escalated to crisis point. These young men will be categorised as “early seekers” in this enquiry. This is commensurate with the emphasis on preventative strategies and early intervention in Australia’s health model (Gillon, 2007b). Of great concern was the other subgroup of young men who would not seek professional help until crisis point, for example, for issues relating to suicide, severe depression or domestic violence. This subgroup will be referred to as “delayed seekers”.

**Stereotype of Masculinity: Delayed Seekers**

There were complex forces, tensions and contradictions in play for the young men in the category of delayed seekers. One of these was a strong discourse about the stereotypes of
Help-Seeking Behaviours

masculinity (see Appendix B, Journal Entries 9, 10, 12, 13, 14 & 30) which complicated their willingness to engage in early professional help. Ciarrochi et al. (2003) found that young men’s experiences of help-seeking were invariably influenced by needing to sustain a masculine identity. In the present study, a strong and pervasive enculturation of the stereotype of masculinity was indeed ubiquitous in the young men’s descriptions of their lived experiences of asking for help. It was this socialisation which significantly impacted the subgroup of delayed seekers:

*I don’t think Australian culture lends itself to young men getting counselling and one of the reasons is due to the stereotype that getting counselling is not manly.*

Socialised stereotypes of masculinity also originated from the media and their affect on help-seeking behaviours was subtle as one delayed seeker described:

*I think culture has a lot to do with it. I mean this is my perception based on television and internet. In America and UK, it’s far more mainstream to have a therapist. I think we’re a lot more liberal than the US in many ways, but I think as far as counselling goes, we’re more conservative and I think there’s the stereotype of the Aussie male who is always portrayed as a blue-collar / physical labourer. Ads that target young men never seem to put white collar business men; they put bricklayers, electricians and mining workers. That’s the manly man image and that obviously doesn’t go hand in hand with counselling.*

Alarmingly, alongside this discourse describing images of masculinity, there was a refusal by the delayed seekers to ask for help until a situation reached crisis point:

*It’s not the easiest for me; I think I’m a pretty independent sort of person. It would have to be something pretty desperate for me to seek professional help ... not wanting to show*
Help-Seeking Behaviours 28

weakness or not wanting to show emotions ... it's kind of the expectation that you're a rock and stuff doesn't affect you when you're a guy of this age.

It depends on what the issue was. If I was having suicidal thoughts, I'd consider it, but if it was about a general or relationship issue, I don't think a counsellor or psychologist would have any better advice than I could give myself.

For these delayed seekers, there was an inner tension associated with exposing their vulnerability. Spinelli (1994) differentiates between a developed sense of self, or self-structure, and the actuality of lived experiences. He argues that some people disassociate from those experiences that do not fit with the believed-in self. The young men in the delayed seeker category perceived themselves as strong, independent and invincible, thus unable to acknowledge their feelings of vulnerability:

I think being mid to late 20s you still think you're a little bit invincible, so me personally, it would have to be something pretty serious to seek professional help; it would have to be upsetting me quite a bit even to seek help from anyone really.

This is interesting because drawing from Gadamer (1975) and Heidegger (1977), the interpretation made here (see Appendix B, Journal Entry 18) is that delayed seekers may be obscuring a reality. From an early intervention point of view, this is a significant point to consider in planning programs and policy. The data supported this idea for those unwilling to seek early professional help. In the following statement, this delayed seeker describes his own “analytical” process. In doing so, he obscures his real position with the logical and the masculine, which he endorses:

I would probably never go to anyone. I'm belligerent when it comes to what I know. Like I said, I don't think it's pride, but it's ... ah, I don't think it's pig-headedness or
stubbornness, I just think I know it all ... in a non-arrogant way ... I think I'm analytical enough to go through everything in my head, without going to anyone for help.

It seems that for this man, the more unyielding his self-structure and the more analytical he becomes, the less likely the potential to seek help.

In Ritchie’s (1999) study, which investigated help-seeking behaviours of 17 to 35-year-olds, the entrenched stereotype of masculinity was defined directly as an independent, strong and autonomous male identity. Gillon (2007b) and Ritchie (1999) also reported that one of the greatest barriers to seeking help, especially in a crisis, was young men’s socialisation to be strong and independent. For those not prepared to engage in early professional support, or the delayed seekers, the thought of seeking help conflicted with their drive to maintain this self-image of masculinity. One young man reported:

I want to portray myself in a certain way, as a 28-year-old, strong and independent person. I wouldn’t want to ask for help, because I would be jeopardising my image, meaning they might see me as someone who’s emotionally needy. So it’s ego and even giving off the appearance that I’m in control and capable is very important, especially in social dealings.

Rickwood et al. (2007) found that young men, from adolescence up to 30 years of age, were less likely to seek help if they believed they should be able to sort out their psychological issues on their own. For the delayed seekers in this study, it appeared that the tension experienced between help-seeking and masculinity was a powerful force in wanting to cope with issues on their own. The model of independence interfered with their willingness to consider seeking early professional help, and it was disturbing that this extended across many realms for some of the delayed seekers:
I think strength of character would be a guy who can solve his own problems, whether it be emotional problems, physical health problems, or work problems and I view myself as a strong character in that way, so me seeking (professional) help would be almost be conceding I can’t do it on my own and that wouldn’t sit particularly well in my mind.

Echoing the idea of not seeking help until crisis point, one fiercely independent young man was not prepared to ask for professional help until he was “teetering on suicide”. However, during member checking (see Appendix B, Journal Entry 40), he provided a rich and articulate account of his experience of needing to be an “alpha male”:

It’s about strength, not physical strength. I’ve read a few books about the alpha male and it’s saying to be successful and happy in yourself, your whole lifestyle has to be congruent with who you are. Just be yourself and that’ll solidify things and you’ll become alpha in the process. So alpha to me means sort of dominant, not dominant in a bad way, but dominant as in, respected, being a man of your word, approachable, a protector, just being this pinnacle of masculinity, but not in an aggressive sense ... projecting an image of dependability ... and you’ve got a spine.

Often the expression of independence for some of the delayed seekers translated into a discourse of being a burden, or being dependent on another:

If I was asking for help, I’d do it in such a way that it wasn’t imposing on the other person, which is at most, for someone to listen.

The interesting dynamic here was that, despite the clear self-reflection and emotional competency, a contradiction existed. Below the intense self-reliance and fear of dependence was counterpoised a feeling of isolation. Interestingly, one delayed seeker described how societal pressures around acceptable behaviour precluded others’ expression of needing help:
Help-Seeking Behaviours

They must feel isolated if they can’t ask (for help) … I think everyone has got some sort of front, as much as I like to think I don’t, there’d be a mask somewhere, so definitely a loss of alpha-ness, a loss of status when you ask for help … like perceived strength, mental strength, emotional strength.

Similar to Ritchie’s (1999) analysis, the stereotypical view of masculinity was also expressed as emotional restraint. It seemed that the developmental status, of being a young man of 25 to 30 years of age, could be a barrier to help-seeking. Emotional restraint seemed to intensify during this stage, along with the need to intellectualise, articulate and think rationally and logically about an issue, rather than enter into an emotional posture. For the delayed seekers in this position, seeking help was framed logically as an extreme option:

It would have to get to very extreme to ask for professional help, just because I think my support systems and friends, and myself as a whole … I have the ability to weigh up, rationalise, and work through stuff independently … from my experience of personal problems, I’m confident that I can do that.

Interestingly, some of the delayed seekers in this age bracket reported an internal emotional shift from an earlier age (see Appendix B, Journal Entry 10):

It’s largely ego-based … when I was 15 or 20, and asked for help, displays of emotion had less attached to them. In other words, you could recover from them socially. As a teenager, I had outbursts of emotion, whether it be anger or sadness or whatever it would be, and were heartfelt and genuine, but at the same time, they are not things that I would do now, even if I felt the same, I would behave differently.

For the young man who lost a friend through suicide four days before his interview, the insidious silence associated with emotional restraint and the reluctance to ask for help early was tragically acknowledged:
When I heard about his suicide it was a shock. I simply wasn't to know if he was having difficulties, who knows if anyone did ... I felt like a third party ... I got to see the absurd and wasteful nature of the situation and realised how preventable it could have been.

Perhaps counselling could have proved the difference.

During member checking (see Appendix B, Journal Entry 42), this young man, a delayed seeker, conceded the impact of the suicide on his own help-seeking intentions:

*It did make me more likely to encourage any friend who was seeking counselling to continue and to speak about things in an open and supportive way should it arise in a conversation with anyone. That's probably akin to being more likely to seek counselling myself.*

In research by Sayers et al. (2004), young men used a metaphor of help-seeking as “getting a mechanic to fix your car”. Similarly, for the delayed seekers, the position of needing to maintain a fierce independence and sense of self-reliant strength was transformed into a self-imposed expectation of having to “fix things” and figure issues out for themselves. Delayed seekers were less likely to use psychological health services because they believed they could work it out or fix it themselves, and therefore, their issues were not amenable to therapy:

*Another point is effectiveness and I think a lot of guys probably wouldn't think it's (counselling) going to work, especially young practical guys who think they can figure it out themselves and that talking about an issue is not necessarily going to resolve it.*

The complexities of personal issues were also couched in the mechanical metaphor:

*For personal issues, talking to people can be useful and I do that all the time, but relationship issues, it's not like fixing your car, it's not that easy, it's not like “bang, bang” and it's fixed, it's a process that you have to work through yourself all the time.*
One of the most widely identified barriers to help-seeking in the literature is the fear of stigma (Nada-Raja, 2003; Rickwood et al., 2007). However, Pettigrew et al. (2010) and Mojtabai (2007) have suggested that young males today are far more likely to ask for help than previous generations. They found that the perceived stigma had declined. However, for the delayed seekers, stigma was experienced as an overwhelming barrier to help-seeking, due to the socialised ideals of masculinity:

*A bit of a stigma around counselling: you know everyone goes, oh, man up, man up!*

*Everyone thinks a man should be ... a general stereotype of ... you know don’t cry, and don’t ask for help and be strong.*

It is well documented that if a young man’s view of help-seeking is rigidly sex-typed, then his attitudes and behaviour are more likely to reflect poor help-seeking and gendered coping strategies (Gillon, 2007a), as one young man described:

*Other guys? Probably pretty similar to myself, not wanting to show weakness or not wanting to show their emotions, it’s kind of the expectation you can rationalise things and sort things, and that kind of thing (counselling) is more for girls. If one of my mates was seeking counselling, I would think “wow they’re obviously struggling or there’s something really wrong”, yeh ... whereas if it was a girlfriend or one of my girlfriend’s friends, I wouldn’t be as concerned.*

The need of delayed seekers to categorise themselves as non-feminine was clearly evident in their non-help-seeking discourse. Rickwood et al. (2005) argue that young men need to be encouraged to express their internal world to others in a way that is empowering rather than in a way experienced as evidence of weakness. Gillon (2007a) adds that the mental health arena is highly gendered, with terms of perception, diagnosis, and signs and symptoms defined in feminised
terms. Kilmartin (2005) suggests a new “male” language, and that it is crucial that a higher level of gender sensitivity is cultivated by all mental healthcare workers.

Sources of Help: Delayed Seekers

One clear theme permeating the discourse of the delayed seekers was that a situation would have to be an extreme crisis before seeking professional help. That included issues based on a hierarchy of severity, namely suicide-related issues, domestic violence and severe depression (see Appendix B, Journal Entry 12):

_Genuine suicidal thoughts ... some guys would seek (professional) help for that. I think inappropriate violence especially towards your girlfriend or getting really angry and out of control, you might go “O sh*t, I have to get my anger under control, because it’s not called for”. I think a lot of guys if they found they couldn’t get out of bed in the morning and they were having huge mood swings and were in tears, they might think counselling might help them... yeh any sign of what I understand to be a mental issue._

Alarmingly, for delayed seekers, it would take an irresolvable crisis, before asking for professional help:

_It would have to be pretty ... it would have to be a crisis, like on a spectrum of 1 to 10, 1 being an issue with my girlfriend, to 10 wanting to commit suicide which would never happen with me personally ... I would probably never go to anyone._

_I think if you’re in such a desperate state ... well, this is perhaps bad on my part; I’m assuming you have to be desperate to see a counsellor ..._

This construction of reality was disturbing. Despite the emphasis on preventative strategies and early intervention in Australia’s health model (Gillon, 2007b), it was clear that seeking help for a
preventative reason was simply not a logical rhetoric within the masculine ideals of the delayed seekers:

My reluctance to go to those types of things is that I really don't think there's anything wrong with me. You don't go to the doctor if you're not sick, so why go to a counsellor if you don't have problems?

Stereotype of Masculinity: Early Seekers

Despite sharing with the delayed seekers varying degrees of inner tension in order to sustain a masculine identity, there was a clear subgroup of young men in this study, the early seekers, that was willing to engage in early professional intervention. Seven of the participants interviewed had chosen to seek professional help early within the last three years, for emotional issues including mild depression, anxiety, a phobia and a relationship problem. What was different for these early seekers, in contrast to the delayed seekers, was an ability to resolve the perceived dilemma or incongruence between their help-seeking and the socialised stereotypes of masculinity:

Yep, I have seen somebody (professional) before about an issue. It helps to talk about it, but I think it's always going to be the case just because of the bravado of guys our age that they're not going to be open about admitting they have a problem and asking for professional help. It's probably admitting weakness which I guess we're brought up to avoid at all costs.

For the early seekers, the masculine images portrayed in the media and the associated conflict experienced when needing help, meant stepping outside the norms of what is perceived as "manly". Their ability to negotiate a rational position beyond the norm provided a catalyst for seeking professional help:
I think basically, just realising if you have a problem. I don’t feel the pressure to be strong and independent ... I mean if you are going through something, it’s probably better if everyone knew, rather than keep it a big secret.

Emotional restraint was also recognised by early seekers as one aspect of the stereotypical view of masculinity (Ritchie, 1999). The difference for these young men willing to seek professional help early was that they openly acknowledged the common belief of the need for emotional restraint in men, but dismissed it vigorously:

I guess the big stigma that males aren’t supposed to be as emotional as females as human beings, which is rubbish ... I think basically, just realising you have a problem.

The early seekers also acknowledged that the potential for resolution of masculinity pressures was based on their developmental stage:

Now that I’m a bit older and more mature, I realise there are people out there that are trained to help you resolve things and I understand.

The importance of awareness in asking for help was also acknowledged:

I think the hardest thing would be to determine if you needed help as well, and I think now that I’m older, it’s probably changed because I could recognise that I needed help, whereas I wouldn’t have recognised that when I was younger.

Like the delayed seekers, the early seekers in this inquiry also referred to the mechanical model, or the quick fix, in their discourse around help-seeking. However, this metaphor did not interfere with early help-seeking. One young man who reported engaging in professional help for depression described the medication as the easiest option and a quick fix:

Medication certainly feels like the easier option ... like a quick fix ... it’s sort of makes me feel like you know, you’ve got to snap out of it, you’ve got to start growing up now ... you’ve got to deal with your own problems.
This expectation that issues can or need to be fixed quickly also defined their experience of engaging in counselling and psychotherapy:

_I had about four free treatments for a phobia. It helps to talk about it, but I wouldn't say they fixed it._

As for the delayed seekers, the early seekers also experienced stigma as a tension, but not as an overwhelming barrier to engaging in professional help:

_It's easy to feel embarrassed and like there's something wrong with you ... fear of what people will think of you ... stigma I guess ... yeh, that's certainly always in a little bubble up here._

For those who had availed themselves to early professional intervention, stigma was acknowledged, but resolvable:

_There's way more people in society would visit these people (professional counsellors) than you'd expect and I'm aware of that stigma, but personally, I wouldn't feel it._

**Sources of Help: Early Seekers**

An interesting and significant point not well considered in the extant literature to date was the hesitation expressed by the early seekers in telling their fathers if they had to seek professional help:

_I had no problem telling my Mum (about seeing a counsellor). My dad's more of the stereotypical macho type so I'd only tell him if I had to._

For one early seeker, this also extended to hesitation in asking his father for help:

_I guess if I have any problems I just go to my family ... my sister's moved back home, so I can always talk to her or my Mum ... I don't usually go after Dad if I have any issues ... a bit awkward._
The early seekers in this inquiry may be representative of a generational transition, as Pettigrew (2010) and Mojtabai (2007) suggested. Despite the tensions of stigma, contravening masculine norms and the attitudes of fathers, the concern of this young man for his mate contrasted strongly with the father’s reaction:

*If one of my mates was seeing a counsellor I’d be a little bit concerned about why they’re going, not embarrassed. For me it’s not a problem, but if someone’s Dad found out, they’d probably think “what the f**k’s going on?”*

It is possible that this generational shift may be linked to the significant decreased trend in the suicide rate of young men in this age group.

**Discussion**

A prominent and pervasive characteristic of the young men to emerge in this study was their emotional competence, literacy and curiosity which expressed itself as a well-developed capacity for self-reflection, and rich and articulate accounts of their experiences of help-seeking. This included the tensions they experienced between masculine ideology, their life stage, and when and where they might seek help. However, this facility was independent of their willingness to seek professional help. This cohort of young men did not reflect the dichotomy in the literature (DHA, 2005), where emotional competence, or lack of it, was a facilitator or barrier to seeking out professional help. These young men could articulate their experiences well. Being emotionally competent per se was not a determinant of help-seeking. We may therefore need to explore more deeply our understanding and characterisation of the term “emotional competence”.

The stereotypical view of masculinity was a potent driving force in the help-seeking experiences of all these young men from 25 to 30. It was expressed as an image of strong independence, emotional restraint and a “fix it” mentality, which pervaded their descriptions of help-seeking. This was accompanied by strong expectations of global competency for young men
in this specific age bracket, and this issue has been unexplored in the extant literature. It accompanied inner tensions around their identity of masculinity, and impacted their help-seeking activities in a way that was different to when they were younger. They were entering a stage in their lives where they were “bombarded with expectations”. As with other areas permeated with the socialised stereotypes of masculinity, the early seekers were able to bypass the tensions and expectations of this specific age group, and be prepared to seek professional help early. This was commensurate with Australia’s health model of early intervention (Gillon, 2007b). For the delayed seekers, disturbingly, these expectations and inner tensions around images of masculinity and help-seeking interfered with their help-seeking until a situation was critical.

Another significant point raised in the literature and in this study relates to the highly feminised mental health arena, and begs an investigation into the gender sensitivity, not only of the healthcare workers, but the provisions servicing these young men. These are significant points to consider in planning programs and policy, but may involve significant modifications to the paradigms of therapy and training.

A further interesting and significant issue not well considered in the existing literature was the resistance experienced by the early seekers in telling their fathers if they had to engage professional help. It may be that these young men are representative of a generational transition, as Pettigrew (2010) and Mojtabai (2007) proposed, where their attitudes towards professional help-seeking contrasted strongly with their fathers. This shift may be linked to the recent significant decreased trend in suicide rates of young men in this age group.

Developing an enhanced understanding, embedded in the perceptions of those who have experienced the phenomenon of help-seeking, is essential to identify factors that could improve engagement in early professional support. This is critically important especially for those young men who, alarmingly, refuse to seek help until crisis point.
Help-Seeking Behaviours 40

These preliminary insights have great significance for early intervention policy strategies that challenge and interrupt the attitudes and beliefs of these young men. They could further support and inform those responsible for delivery of improved services that benefit them in a way that is faithful to their needs. This should be part of a comprehensive and exhaustive discourse around early intervention strategies for professional help-seeking in young men, from 25 to 30.

Conclusion

The purpose of this study was to explore and understand the phenomenon of help-seeking in young men, in the critical age bracket of 25 to 30 years, and how they experience the factors that influence their help-seeking activities. Such exploratory research is essential for the laying down of a robust base of research evidence which provides a bridge between research and practice. Current literature is lacking in the qualitative exploration of this specific age bracket of young men which embraces a developmental period of substantial change, tension and expectation. Overall, the study findings showed that there were significant, complex and unique factors influencing the help-seeking experiences of these young men. However, because a subgroup of these young men would refuse to seek professional help until crisis point, a comprehensive and preventative discourse on help-seeking needs to be developed.

Strengths, Limitations and Future Directions

This qualitative inquiry has revealed the subtleties, complexities and meanings of the help-seeking behaviours in young men, aged 25 to 30 years, in one Australian context. Key limitations in this inquiry include the discrete division of the cohort of young men into delayed and early seekers which presents a methodological issue, but an issue not raised in the literature. So the cleavage in the sample was unpredictable, but nonetheless produced rich and valuable data. It might also provide future direction for studies of similar context, for example, it may be helpful to limit the sample of young men to either “delayed seekers” or “early seekers”. More
probing needs to be done, in particular, on delayed seekers in an effort to explore and understand reasons for refusing professional help until crisis point.

Transferability (cf. generalisability) refers to the extent to which the research-based understandings can be applied to experiences of individuals in similar contexts (Kitto, 2008; Tuckett, 2005). It is also consistent with the purposes of qualitative research designs. This current inquiry can enhance the transferability of insights and knowledge revealed into future policy and practice, as well as to media sources. For example, this study found, contrary to the literature, that emotional competence did not determine the young men’s willingness to seek help. The subgroup of delayed seekers were articulate and emotionally aware young men, but still refused to seek help until a situation was critical. This may transfer to the health care arena through less emphasis on emotional awareness and more focus on preventative strategies relating to the formidable barriers to help-seeking such as the socialised stereotype of masculinity. Findings could also be transferred to interrupt current media discourse around what defines masculinity. Additionally, it may be helpful in future studies to explore in depth the characterisation and implicit undercurrents of the term “emotional competence” to further tease apart factors influencing help-seeking in these young men.

Another significant area that demands future attention relates to the gender bias and sensitivity of the mental health system. This may present a major challenge in reworking the therapy models and training processes inherent in the current mental health system.

Related to this gender issue is speculation in the journaling (see Appendix B, Journal Entry 17) about the sex of the interviewer. However, the young men interviewed were open and articulate. Way (1997) points out that “matching” gender is a common strategy in many qualitative studies. However, she also believes that this matching belief does not take into account the relational factors that influence the young man’s ability to freely express himself.
This might prove to be interesting future research.

In the light of the findings of this inquiry, another interesting and significant area for future exploration is the possible contrast in attitudes between fathers and sons to professional help-seeking. A dedicated series of questions for fathers may indeed reveal that a generational transition in help-seeking is occurring.

It is hoped that this inquiry has contributed an appreciation and deeper understanding of the experiences of the phenomenon of help-seeking in young men from 25 to 30 years of age. However, awareness and understanding is constantly evolving and must be continually reviewed with fresh eyes.
References


# Appendix A

Comparison of trends in suicide between 1997 (the most recent peak) and 2008

<table>
<thead>
<tr>
<th>Age Groups</th>
<th>Sex</th>
<th>1997 Number of Deaths</th>
<th>Age-Standardised Rates</th>
<th>2008 Number of Deaths</th>
<th>Age-Standardised Rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>15-19</td>
<td>M</td>
<td>122</td>
<td>18.6</td>
<td>71</td>
<td>9.4</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>33</td>
<td>5.3</td>
<td>23</td>
<td>3.2</td>
</tr>
<tr>
<td>20-24</td>
<td>M</td>
<td>295</td>
<td>42.8</td>
<td>149</td>
<td>19.0 (\downarrow 41%)</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>60</td>
<td>9.0</td>
<td>38</td>
<td>5.1</td>
</tr>
<tr>
<td>25-29</td>
<td>M</td>
<td>294</td>
<td>40.5</td>
<td>151</td>
<td>19.7 (\downarrow 47%)</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>59</td>
<td>8.1</td>
<td>37</td>
<td>5.0</td>
</tr>
<tr>
<td>30-34</td>
<td>M</td>
<td>246</td>
<td>34.6</td>
<td>173</td>
<td>23.5</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>56</td>
<td>7.8</td>
<td>48</td>
<td>6.5</td>
</tr>
<tr>
<td>35-39</td>
<td>M</td>
<td>215</td>
<td>29.2</td>
<td>190</td>
<td>23.9</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>64</td>
<td>8.6</td>
<td>58</td>
<td>7.2</td>
</tr>
<tr>
<td>40-44</td>
<td>M</td>
<td>216</td>
<td>31.5</td>
<td>199</td>
<td>26.4</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>58</td>
<td>8.4</td>
<td>47</td>
<td>6.2</td>
</tr>
<tr>
<td>45-49</td>
<td>M</td>
<td>153</td>
<td>23.5</td>
<td>188</td>
<td>24.5</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>45</td>
<td>7.0</td>
<td>49</td>
<td>6.3</td>
</tr>
<tr>
<td>50-54</td>
<td>M</td>
<td>141</td>
<td>25.3</td>
<td>137</td>
<td>19.6</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>51</td>
<td>9.5</td>
<td>61</td>
<td>8.6</td>
</tr>
<tr>
<td>55-59</td>
<td>M</td>
<td>98</td>
<td>22.5</td>
<td>120</td>
<td>18.8</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>32</td>
<td>7.6</td>
<td>37</td>
<td>5.7</td>
</tr>
<tr>
<td>60-64</td>
<td>M</td>
<td>80</td>
<td>22.1</td>
<td>81</td>
<td>14.4</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>24</td>
<td>6.6</td>
<td>19</td>
<td>3.4</td>
</tr>
<tr>
<td>65-69</td>
<td>M</td>
<td>77</td>
<td>22.8</td>
<td>75</td>
<td>18.2</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>25</td>
<td>7.1</td>
<td>15</td>
<td>3.6</td>
</tr>
<tr>
<td>70-74</td>
<td>M</td>
<td>69</td>
<td>24.5</td>
<td>52</td>
<td>16.3</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>22</td>
<td>6.7</td>
<td>20</td>
<td>5.8</td>
</tr>
<tr>
<td>75+</td>
<td>M</td>
<td>131</td>
<td>36.1</td>
<td>118</td>
<td>21.3</td>
</tr>
<tr>
<td></td>
<td>F</td>
<td>41</td>
<td>7.0</td>
<td>26</td>
<td>4.4</td>
</tr>
</tbody>
</table>

| Total\# | M   | 2145                  | 23.3                   | 1710                   | 16.0                   |
|         | F   | 577                   | 6.2                    | 481                    | 4.5                    |


\# Includes deaths by suicide of those aged under 15 years of age not stated.*
### Reflective Journal

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity or Theme</th>
<th>Reflective Journal Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Jan 2010</td>
<td>Reviewing the literature. Reading anything about help-seeking, suicide, masculine identity. Started writing literature review.</td>
<td>No real surprises in the literature: stigma, stereotype of masculinity, suicide ideation, emotional restraint, independence, cost, time, gender issues, etc. However, few qualitative studies found. No tight focus at the moment.</td>
</tr>
<tr>
<td>2. Feb 2010</td>
<td>Continuing with literature review. Reading and trying to understand the phenomenological approach. Concentrating on a focus for the research. Writing proposal.</td>
<td>I can't find any studies conducted on the 25 to 30 year age range of young men: possible gap in the literature. Impetus for study focus: 1). I have three sons between the ages of 25 and 30 years of age. 2). I have completed 2 years of family therapy at the William Street Family Therapy Centre and experienced first hand, male clients of all ages who showed resistance to seeking help for psychological and relationship issues. 3). Two previous science degrees in helping professions, but do I understand the barriers that anyone has to help-seeking?</td>
</tr>
<tr>
<td>3. Feb-Mar 2010</td>
<td>Proposal writing. Reading literature.</td>
<td>I find talking to my three sons is giving me some insights into the issues. This is complementing and adding to my understanding of the literature. I'm getting ideas about questions to ask, but realise how crucial the questions will be to draw out rich and authentic experiences from the participants. I'm finding it hard for me to just listen to my 3 sons and not to advise them as a mother.</td>
</tr>
<tr>
<td>4. 24th March 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
<td>Final review of proposal.</td>
</tr>
<tr>
<td>5. 25th Mar 2010</td>
<td>Proposal handed in.</td>
<td>Waiting for the reviewers’ reports before submitting proposal to ECU Ethics Committee.</td>
</tr>
<tr>
<td>6. 14th April 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
<td>Guidance for potential interviews, and a discussion about phenomenology. Very useful but I feel like the more I read about phenomenology, the more chaotic my understanding gets. Seems to be many, many phenomenologies, which is confusing.</td>
</tr>
<tr>
<td>7. April 2010</td>
<td>Ethics approval received.</td>
<td>There is a moment of &quot;OMG, I can now start the interviews; this is the real deal!&quot;</td>
</tr>
<tr>
<td></td>
<td>Date</td>
<td>Event</td>
</tr>
<tr>
<td>----</td>
<td>------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>8.</td>
<td>May 2010</td>
<td>Reflections during reading, writing and discussions with sons.</td>
</tr>
<tr>
<td>9.</td>
<td>27th May 2010</td>
<td>Pilot interview</td>
</tr>
<tr>
<td>10.</td>
<td>May 29 2010</td>
<td>Interview 1</td>
</tr>
<tr>
<td>11.</td>
<td>5th June 2010</td>
<td>Interview 2</td>
</tr>
</tbody>
</table>
Help-Seeking Behaviours 55

<p>| 12. | 6&lt;sup&gt;th&lt;/sup&gt; June 2010 | Interview 3 | I was feeling a little more relaxed with the questions by this stage and could be more flexible with their delivery. This young man was tormented with a possible separation from his girlfriend of several years, but was not open to getting any professional help even though he was aware of couples counselling. It reminded me of the importance of early intervention, but with some guys not being open to asking for help, because of strong masculine identity issues. He acknowledged however, the value in professional help for issues around suicide, depression and violence. |
| 13. | 8&lt;sup&gt;th&lt;/sup&gt; June 2010 | Interview 4 | I knew I had a lot to learn around interviewing but I sensed that I was very fortunate to have had (so far) young men who provided such rich discourses of their experiences. This young man was very aware of the cultural influences of help-seeking and acknowledged the pressures on young men to conform to the male stereotype. He also gave what I thought was a wonderfully articulate description about how young men use alcohol, fast food, exercise and sex as a means of distraction from emotional issues, which act as a barrier to seeking help. So far I'm pleasantly surprised at the young men's awareness of emotional issues. |
| 14. | 9&lt;sup&gt;th&lt;/sup&gt; June 2010 | Interview 5 | I met this young man in a coffee shop quite late at night and the noise was quite a distraction for me. Not only in the coffee shop but the traffic as well. Surprisingly the tape recording was audible &amp; I am grateful that his comments are intact. What was beginning to emerge was a dichotomy: some of the young men were prepared to engage in early professional intervention, while others were not, even though they all acknowledged that it was appropriate to seek help in extreme situations like suicide ideation, domestic violence and severe depression. The |</p>
<table>
<thead>
<tr>
<th>Date</th>
<th>Event</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>15. 16th June 2010</td>
<td>Interview 6</td>
<td>This young man was driven by self-exploration and self-reflection and I was touched when he offered to lend me a book that he'd read. However, he was strongly imprisoned by stereotypes of masculinity. I was noticing how friends and family were deeply meaningful supports for these young men.</td>
</tr>
<tr>
<td>16. 17th June 2010</td>
<td>Reflections between interviews</td>
<td>The book that the previous young man lent me was incredibly appropriate for young men in this cultural climate and I decided to order a copy for each of my sons. I thought how appropriate it would be for many young men to read this book if only they would be open to its messages.</td>
</tr>
<tr>
<td>17. 20th June 2010</td>
<td>Reflections</td>
<td>I was pleasantly surprised to realise that all the young men I have interviewed so far were not only very open and forthcoming in sharing their opinions and experiences with me, but could articulate them incredibly. I sensed that they were glad they had the opportunity to air their views. I speculated on the difference if I was a male interviewer. I suspect that each one of the young men would have approached the interviews differently, some with greater bravado, some with more caution. However, Way (1997) believes that “the best interviews are often those where the interviewer has little in common with the interviewees, because she holds the fewest assumptions about them. I could not know their experiences in the world”. Perhaps an issue for future research.</td>
</tr>
<tr>
<td>18. 12th July 2010</td>
<td>Interview 7</td>
<td>I travelled to this young man's workplace. He was barely 25 and was assistant manager of a large corporation. I felt pleased for him that he had achieved so much. However, I noticed a small degree of agitation in answering the questions. He was quite fidgety in his chair. I became aware of my drive to let this young man know it was okay to ask for help. His girlfriend had been to counselling and he was okay with that. However, he said it would be unlikely that he or any of his mates would go to counselling unless in extreme crisis. I sensed that it was not part of this young man's reality to admit potential for vulnerability: significant point to consider in planning programs/policy.</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
<td>Details</td>
</tr>
<tr>
<td>----------</td>
<td>---------------------------------</td>
<td>---------</td>
</tr>
<tr>
<td>19. 12&lt;sup&gt;th&lt;/sup&gt; July 2010</td>
<td>Interview 8</td>
<td>It became increasingly clear that the young men I was interviewing valued their mates incredibly. This young man acknowledged he always had someone to ask in his family or friends depending on the issue. This reminded me of the lifecourse issue where at this stage in life, friends and family are the preferred choice for young men, rather than professional help.</td>
</tr>
<tr>
<td>20. 12&lt;sup&gt;th&lt;/sup&gt; July 2010</td>
<td>Reflections after interviews</td>
<td>I was beginning to sense a slight divergence from the literature. For these young men, their emotional awareness and rich discourse was independent of their help-seeking behaviours. The literature revealed it as both a barrier and facilitator.</td>
</tr>
<tr>
<td>21. 22&lt;sup&gt;nd&lt;/sup&gt; July 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
<td>Presented the first draft of my literature review.</td>
</tr>
<tr>
<td>22. 27&lt;sup&gt;th&lt;/sup&gt; July 2010</td>
<td>Reflections during transcriptions and analysis.</td>
<td>I began to realise that greater depth and focus could be achieved by adding another open question relating to the socialisation of young men to be strong and independent. So a further question was appended to the interview schedule for the next 5 interviews.</td>
</tr>
<tr>
<td>23. 3&lt;sup&gt;rd&lt;/sup&gt; August</td>
<td>Interview 9</td>
<td>This young man appeared subtly nervous as I asked questions. It was the first of the interviews where I felt I had to make quite an effort to establish rapport and ease any discomfort he had. I realized how lucky I had been so far to have had young men that were keen and open to sharing their experiences. However, when I touched on issues he was familiar with, he opened up and gave me a wonderful assessment of his perception of the mental health system. He turned out to be was a key informant within the public health system: Everyone is despondent about the treatment and the goals of treatment of many mental health issues, including depression ... like you go in &amp; you go out ... there’s a cyclic thing ... there’s no follow-up when they leave ... by the time someone is diagnosed with a mental health problem, gets back out in the community, there’s the alcohol, the drugs and by that time, they’re sick again &amp; come back in &amp; get treated ... but there’s no treatment plan once they sort of get out there .... because they don’t follow themselves up, they don’t get into</td>
</tr>
<tr>
<td>Date</td>
<td>Event Description</td>
<td>Details</td>
</tr>
<tr>
<td>--------------</td>
<td>--------------------------------------------------------</td>
<td>--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>3rd August 2010</td>
<td>Personal reflection</td>
<td>I felt the challenge of presenting an integration of all the collected data for the peer review tomorrow. I felt “in the thick of it”.</td>
</tr>
<tr>
<td>4th August 2010</td>
<td>Peer review session with supervisor and other students.</td>
<td>This peer review session with my supervisor, Dr Andrew Guilfoyle and other students was incredibly useful. Transcripts, emerging themes and subthemes were shared, discussed and reviewed. What came to mind was the quirky term that van Manen gave to this validation and verification process, that is, “phenomenological nod”. Novel issues were identified which added a fresh perspective to the data. The discussion helped greatly to guide, modify and substantiate my interpretations.</td>
</tr>
<tr>
<td>5th August 2010</td>
<td>Reflections</td>
<td>I had organised to do Interview 10 on Saturday 7th August. On 5th August the young man sent me an SMS message saying that a 26 year old mate of his had committed suicide 2 days before. The tragic news was very sobering as a mother of 3 sons in this age bracket (25, 28, 29). It reminded me of the real life significance and implications. This was not just another uni assignment. It also reminded me of the impossibility of “bracketing”. How could I remove myself from the research process or “bracket out” these experiences which are integral to the process and the big picture. How could I not contribute my own biased understanding of the phenomenon?</td>
</tr>
<tr>
<td>7th August 2010</td>
<td>Interview 10</td>
<td>I was incredibly amazed (again) at the insight and sensitivity of this young man. He described the process and reflections he went through when he recently separated from his girlfriend. He had also lost a mate through suicide four days ago. I felt the need to tread lightly, but also felt the inadequacy of my being there just in the capacity of interviewer.</td>
</tr>
<tr>
<td>7th August (a) 2010</td>
<td>Interview 11</td>
<td>I did this interview and the previous one on the same day and both interviews evoked emotion for me. Not only because of the suicide of a mate but because both young men were sensitive artists who have both suffered...</td>
</tr>
</tbody>
</table>
Help-Seeking Behaviours

<table>
<thead>
<tr>
<th>Date</th>
<th>Time/Event</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>29. 7th August (b) 2010</td>
<td>Reflections between interviews</td>
<td>When I left these 2 young men, I reflected on my experience of the funeral of a friend’s son two years ago who had committed suicide at age 22. I remembered looking around at all the young men. I still feel a deep despair when I think of the excruciating pain and torment a young man must be experiencing in order to choose death over asking for help.</td>
</tr>
<tr>
<td>30. 9th August 2010</td>
<td>Interview 12</td>
<td>I sensed that this young man was the most “macho” of all the young men so far and felt that he reflected the literature around help-seeking and the stereotype of masculinity more closely than for any of the other young men. He identified himself as an “alpha male”. I need to get back to him about this to elaborate on his understanding of alpha male (see Journal Entry 40). I’ve just seen an HJs ad on TV, where gendered toys were given to children: a soft pink donkey for girls and a dark red dragon breathing fire for boys. It made me reflect on the situation, that as a society, we merely pay lip service to gender equality. What I was aware about myself was how much I wanted to convince some of these young men that it was okay to ask for help, to be vulnerable, and that good, effective help was available.</td>
</tr>
<tr>
<td>31. 10th August 2010</td>
<td>Interview 13</td>
<td>I immediately felt the contrast with the last interviewee the day before. This young man had no problems asking for help and had a wonderful insight into his own emotional issues. I was feeling a little relieved at being the last interview, but also realised the enormity of the job ahead of me.</td>
</tr>
<tr>
<td>32.</td>
<td>15th August 2010</td>
<td>Reflections during writing</td>
</tr>
<tr>
<td>33.</td>
<td>20th August 2010</td>
<td>Reflections during writing</td>
</tr>
<tr>
<td>34.</td>
<td>3rd September 2010</td>
<td>Reflections during writing</td>
</tr>
<tr>
<td>35.</td>
<td>5th September 2010</td>
<td>Reflections during writing</td>
</tr>
<tr>
<td>36.</td>
<td>6th September 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
</tr>
<tr>
<td>37.</td>
<td>15th September 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
</tr>
<tr>
<td>38.</td>
<td>20th September 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
</tr>
<tr>
<td>39.</td>
<td>21st September 2010</td>
<td>Member checking: Participant 6.</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td></td>
<td>This young man kindly phoned me to talk. Unfortunately, he was unwell but had this to say: <em>I was brought up with our parents telling us that we can tell them anything; Mum would say: you can always tell us; so we always have.</em></td>
<td></td>
</tr>
<tr>
<td>40.</td>
<td>21st September 2010</td>
<td>Member checking: Participant 12.</td>
</tr>
<tr>
<td></td>
<td>My interpretations of what this young man told me at interview were confirmed by him at a face-to-face meeting. He also gave a wonderfully rich description of his understanding of what an &quot;alpha male&quot; meant to him, part of which is included in the analysis, p29.</td>
<td></td>
</tr>
<tr>
<td>41.</td>
<td>28th September 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
</tr>
<tr>
<td></td>
<td>I’m starting to get a sense of the skill of interpreting, not that I can do it yet, but recognition is a good first step I guess. I feel huge gratitude for such a skilled helper.</td>
<td></td>
</tr>
<tr>
<td>42.</td>
<td>29th September 2010</td>
<td>Member checking: Participant 10.</td>
</tr>
<tr>
<td></td>
<td>This young man had lost a friend through suicide four days before his interview. One of the questions I asked this young man during our second encounter: “Has your mate's suicide influenced your willingness to seek professional help in any way? Or has it affected you in any other way? If you have any other comments about the topic please feel free to elaborate”. This was a sensitive question, but I knew this young man was open and articulate. He conceded the impact of the suicide on his own help-seeking intentions, p34.</td>
<td></td>
</tr>
<tr>
<td>43.</td>
<td>30th September</td>
<td>Member checking: Participant 2.</td>
</tr>
<tr>
<td></td>
<td>I wanted to find out if there were particular mental health issues that the young men thought were more stigmatised than others. He responded by email: <em>Definitely. I think there's no real logic behind these stigmas because at the end of the day the public has very little knowledge of mental health (or any health for that matter). The ones that come to mind that people ridicule/have stigmas about - schizophrenics, bipolars and manic behavioural probs.</em> My interpretations of what this young man told me at interview were also confirmed. Nothing else to add.</td>
<td></td>
</tr>
<tr>
<td>44.</td>
<td>1st October 2010</td>
<td>Member checking: Participant 4.</td>
</tr>
<tr>
<td></td>
<td>Apart from checking my general interpretations, I also asked this young man: <em>Do you think that some mental health issues are more stigmatised than others?</em></td>
<td></td>
</tr>
</tbody>
</table>
He responded: *Probably just depression in general as an "illness"; possibly autism, but not sure of any others.*

<table>
<thead>
<tr>
<th>Date</th>
<th>Event Description</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>5th October 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
<td>More rearranging. Coming from a different angle: trying to streamline the interpretation so that it flows and is more coherent.</td>
</tr>
<tr>
<td>7th October 2010</td>
<td>Member checking: Participant 3.</td>
<td>This young man confirmed my interpretations of his transcripts on my computer.</td>
</tr>
<tr>
<td>12th October 2010</td>
<td>Seminar for PhD student presenting a hermeneutical phenomenology research proposal.</td>
<td>This clarified a few basic classification details, for example, phenomenology and thematic analysis, hermeneutics and interpretation, process and outcome issues.</td>
</tr>
<tr>
<td>12th October 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
<td>More rearranging. Sustained engagement with the transcripts, the back and forth dynamics of continual immersion in the data and literature (hermeneutic circle), exposed a different angle: the separating of the young men into 2 subgroups according to their help-seeking behaviours; have initially categorised them as “early seekers” and “delayed seekers”.</td>
</tr>
<tr>
<td>20th October 2010</td>
<td>Appointment with my supervisor, Dr Andrew Guilfoyle.</td>
<td>The emergence of the two subgroups forced a clarity which I hadn’t felt before. Still needs lots of refining and “tweaking”.</td>
</tr>
<tr>
<td>25th October 2010</td>
<td>Overall appreciation of the research process</td>
<td>I’ve learnt so much from my supervisor, Dr Andrew Guilfoyle, from my three sons and from all thirteen young men and co-researchers. The process has given me an intimate insight into the experiences and understanding of the help-seeking activities of these young men. Each one of these young men had a unique profile that sometimes defied capturing in words that could do them justice. I still feel a sense of inadequacy. Furthermore, I feel that I have had to remove so much really significant information to maintain confidentiality of these young men. Everyone one of their conversations was incredibly meaningful for me. There has been a certain degree of crystallisation around the help-seeking behaviours of these young men and in that respect, I sense I have achieved something important around my understanding of their experience of help-seeking.</td>
</tr>
</tbody>
</table>
Appendix C
Information Letter for Potential Participants

June, 2010

Dear Participant,

Thank you for your interest in this study. My name is Meredith Bolland and I am a student at Edith Cowan University (ECU), Joondalup Campus. This research forms part of the requirements of a Psychology Honours Degree and has been approved by the ECU Human Research Ethics Committee. The aim of this project is to investigate the factors that influence young men, aged 25 to 30 years, seeking help for personal or emotional reasons. Your input would be invaluable. Understanding these issues may help with programs and policies designed to promote psychological health in young men. To take part in the research you must be male and aged between 25 and 30 years.

Participation is voluntary and you may withdraw at any time, during or after the process, without explanation or consequences. You will be asked to sign a consent form and take part in an interview that will discuss your experiences in asking for help, for personal or emotional reasons. The interview will last approximately 1 hour and will be tape-recorded to ensure an accurate record. I do not anticipate that the issues discussed will cause you any distress, but details of free counselling will be made available if required. The interview will be arranged at any time and location that suits you. There will be no payment for participation. There may be a subsequent request to discuss with you my interpretation of your initial interview to ensure its accuracy. However, as before, your participation is totally voluntary.

Any information you provide will be confidential and coded, with only my supervisor and myself having access to what you disclose. All contact you have with me will be confidential. Any identifying information will be omitted from transcripts of the tapes which will be kept in a secure cabinet at ECU. Tapes will be destroyed after transcription and review, and all paper forms will be shredded after five years.

The results of the study may be published in a journal or used at a conference. However, the report will not include your identity or any information which could compromise your privacy. If you are interested, you will have the opportunity to share the results of the report, due for completion in November, 2010.

If you would like to participate (in confidence) or have any questions or concerns about the research project, please contact my supervisor or myself. You may also contact an independent staff member at Edith Cowan University. Our contact details are included below.

Thank you for your interest and time.

Researcher: Meredith Bolland
Ph: [Contact Information]
Email: mbolland@our.ecu.edu.au

Supervisor: Dr Andrew Guilfoyle
Ph: 6304 5192
Email: a.guilfoyle@ecu.edu.au

Independent Staff Contact: Professor Alfred Allan
Ph: 6304 5536
Email: a.allan@ecu.edu.au
Appendix D
Statement of Informed Consent

Exploring the Factors that Influence Help-Seeking Behaviours in Young Men, aged 25 to 30 Years.

Date: April, 2010.

I ______________________ have read and understood the information sheet that was provided by the researcher, Meredith Bolland. I have understood the aim of the research and have freely given my consent for participating in this study. I give authorization for the interview(s) to be tape recorded and understand that the recordings will be erased once the interview is transcribed and reviewed. I have understood that no personal information will be revealed and transcripts will not include any identifying information. I understand that confidentiality will be maintained at all times.

I am aware of my rights as a participant to refuse to answer questions or withdraw at any time without penalty or explanation. I have been given the opportunity to ask questions, and all questions asked have been answered to my satisfaction. I understand that if I have any additional questions that I can contact the research team at any time.

Name (participant): ____________________________
Signed participant: ____________________________
Date: ____________________________
Contact: ____________________________

Name (researcher): Meredith Bolland
Signed researcher: ____________________________
Date: ____________________________
Appendix E
Interview Schedule

Exploring the Factors that Influence Help-Seeking Behaviours in Young Men, aged 25 to 30 yrs.

Thank you for agreeing to participate in my research project. I have several questions I'd like to ask you. If you feel uncomfortable or upset about any question, of course you have the right to refuse without concern. However, I am very interested in your experiences of seeking help for personal or emotional issues. Anything you choose to share with me will be invaluable and greatly appreciated.

1. How does being a young man of your age affect your willingness to ask others for help for personal or emotional issues?
   *Potential probes:* What does this mean for you? Can you tell me more?

2. How is this different now from when you were younger?

3. I am interested to know if you have ever asked, or ever considered asking anyone for help for personal or emotional reasons?
   
<table>
<thead>
<tr>
<th>“YES”</th>
<th>“NO”</th>
</tr>
</thead>
<tbody>
<tr>
<td>a) How was it for you, asking someone for help?</td>
<td>a) What might prompt you to seek help from someone?</td>
</tr>
<tr>
<td>b) Who did you consider approaching?</td>
<td>b) Who might you consider approaching?</td>
</tr>
<tr>
<td><strong>Potential prompts:</strong></td>
<td><strong>Potential prompts:</strong></td>
</tr>
<tr>
<td>Informal: partner, friend, parents, other family member</td>
<td>Informal: partner, friend, parents, other family member</td>
</tr>
<tr>
<td>Formal: counsellor, psychologist, psychiatrist, phone help line, family doctor, web</td>
<td>Formal: counsellor, psychologist, psychiatrist, phone help line, family doctor, web</td>
</tr>
<tr>
<td>c) What could have made things easier for you to ask for help?</td>
<td>c) What could make things easier for you to ask for help?</td>
</tr>
</tbody>
</table>

4. How would it be for you if your friends or family knew you were getting professional help for a personal or emotional problem?
5. In your experience, what do you think are some of the main issues, including practical issues, that other young men of your age face in asking for help? *Prompt:* think about your friends.

6. I'm also interested in any other insights you might have. Is there anything else at all you'd like to share or comment on?

Before we finish, do you have any questions of me?

Thank you very much for your participation and time. I would like to ask for your permission to contact you again if I need clarification or confirmation of my understandings of what you have shared with me. Please feel free to contact me if you have any queries or concerns about the interview or the research project. I'd like to reassure you of the confidentiality of your participation, your responses and any potential future interviews.

**Appended question used for the last five participants:**

7. How do you feel about the pressure or expectation on young men of your age to be strong, independent and in control?
Appendix F

Contact Details for Free Counselling Services

ECU Psychological Services Centre
Joondalup House
8 Davidson Terrace
Joondalup WA 6027

Telephone: 9301 0011
Facsimile: 9301 0014
E-mail: s.morris@ecu.edu.au

Operating Hours

The clinic is attended from 8.40am to 4.45pm (last appointment 3.30pm) weekdays and appointments are available Monday to Thursday.

For further information or to make an appointment:

Appendix G

Themes and Sub-Themes of Experiences of Help-Seeking for Young Men aged 25 to 30 years

<table>
<thead>
<tr>
<th>Main Themes</th>
<th>Sub-Themes</th>
<th>Points of Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emotional competence</td>
<td>Emotional awareness</td>
<td>Healthy vocabulary</td>
</tr>
<tr>
<td></td>
<td>Emotional literacy</td>
<td>Understanding</td>
</tr>
<tr>
<td></td>
<td>Emotional curiosity</td>
<td>Self-reflection</td>
</tr>
<tr>
<td>2. Enculturation of the stereotype</td>
<td>Strong and independent,</td>
<td>Masculinity</td>
</tr>
<tr>
<td>of masculinity</td>
<td>Emotional restraint</td>
<td>Societal expectations</td>
</tr>
<tr>
<td></td>
<td>Mechanical model</td>
<td>Developmental stage</td>
</tr>
<tr>
<td></td>
<td>Stigma</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Gender</td>
<td></td>
</tr>
<tr>
<td>3. Sources of help</td>
<td>Available sources of help</td>
<td>Professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Non-professional</td>
</tr>
<tr>
<td></td>
<td></td>
<td>On-line resources</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fathers</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Domestic violence</td>
</tr>
<tr>
<td></td>
<td>Problem type</td>
<td>Depression, Anxiety</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Relational</td>
</tr>
</tbody>
</table>
A

Addiction
Addiction refers to a state of dependence produced by habitual practice, and characterised by compulsion, loss of control and continued patterns of use despite negative consequences.

Adolescence
Adolescence refers to a period of growth and development from puberty to maturity.

Adulthood
Adulthood refers to a stage of growth and development that follows adolescence.

Aggression
Aggression refers to physical or verbal behaviour that is forceful or hostile and enacted to intimidate others.

Anxiety
Anxiety is a psychological and physiological state characterized by cognitive, somatic, emotional, and behavioral components. These components combine to create an unpleasant feeling that is typically associated with uneasiness, apprehension, fear, or worry. Anxiety is a generalized mood condition that can often occur without an identifiable triggering stimulus.

Anxiety disorder
Anxiety disorder is a form of neurosis in which anxiety dominates the person's life. Examples are Acute Stress Disorder, Agoraphobia, Generalised Anxiety Disorder, Obsessive Compulsive Disorder, Panic Attack, Panic Disorder, Post Traumatic Stress Disorder, Separation Anxiety Disorder, Social Phobia, Specific Phobia, Substance-induced Anxiety Disorder.

Approach factor or Facilitator
An approach factor or facilitator is a factor that enables progress or action.

Attitude
Attitude is a hypothetical construct that represents an individual's degree of like or dislike for an item. Attitudes are generally positive or negative views of a person, place, thing, or event.
Audit trail
An audit trail refers to the transparent, systematic and explicit documentation of the theoretical, methodological and analytical decisions made throughout the process of data collection and analysis.

Being
Being is the most universal concept of Heidegger's hermeneutic phenomenology, and refers to the nature or meaning of the phenomenon.

Bipolar affective disorder
Bipolar affective disorder is a severe mental illness with repeated episodes of mania and depression. The person is usually well in the intervals between episodes.

Bracketing
Bracketing describes the act of suspending one's beliefs in the reality of the natural world in order to study the essential structures of the world. The term was borrowed from mathematics by Husserl, the father of phenomenology, who himself was a mathematician.

Conscious
Conscious refers to being aware of the existence of one's own mental state.

Coping
Coping refers to efforts directed towards how to manage stress, conflict and change.

Counsellor
A counsellor is a health professional that helps clients and families evaluate their patterns of problem solving and develop more effective ones.

Crisis
A crisis is a turning point that results from a stressful event or a perceived threat to one's well-being that cannot be readily solved by methods that have been successful in the past.

Dependence
Dependence refers to the physical and/or psychological effects produced by habitual practice, and characterised by compulsion, loss of control and continued patterns of use.
Depression
Depression is a mental state characterised by excessive sadness. Activity may be agitated and restless or slow and retarded. The person may experience feelings of worthlessness, despair and extreme pessimism. There are usually disruptions to sleep, appetite and concentration.

Distraction
Distraction refers to a diversion of attention of an individual or group from the chosen object of attention onto the source of distraction. Distraction can be a coping mechanism.

Diversity
Diversity refers to the quality of being different or varied, or encompassing a wide range of groups, individuals and phenomena.

E
Early intervention
Early intervention refers to the planned action of a health worker, targeting people displaying the early signs and symptoms of a health problem. This may include counselling, intensive support, referral, or prescribing medication.

Effectiveness
Effectiveness tests the 'real world' impact of interventions that have been shown to be efficacious under controlled conditions.

Ego
Ego refers to the part of the mind that develops from a person’s experience of the outside world and is most in touch with external realities.

E-mental health
E-mental health refers to mental health services or information delivered or enhanced through the Internet and related technologies. It can include mental health promotion, prevention, early intervention, treatment, relapse maintenance and emergency services.

Emotion
Emotion refers to strong instinctive feelings or sensations.

Emotional and social wellbeing
Emotional and social wellbeing refers to a holistic concept of health that includes mental health, emotional, social, psychological and spiritual wellbeing, and issues impacting specifically on wellbeing of an individual and community.
Emotional competence
Emotional competence refers to the ability to identify and describe emotions, the ability to understand emotions, and the ability to manage emotions in an effective and non-defensive manner.

Emotional curiosity
Emotional curiosity refers to a deep and passionate desire for self-knowledge, and for insight into how others navigate through their emotional currents as well.

Emotional literacy
Emotional literacy refers to an ability to use and understand the vocabulary of emotional expression.

Emotional restraint
Emotional restraint refers to an ability to contain one's emotions, or self-control.

Enculturation
Enculturation is the process by which a person adapts to and assimilates the culture in which he lives and learns the accepted norms and values of that culture or society. As part of this process, the influences which limit, direct, or shape the individual include parents, other adults and peers.

Essence
Essence refers to the inner essential nature of a thing, the true being of a thing.

Evaluation
Evaluation is the process used to measure the value or worth of a program or service.

Evaluative rigour
Evaluative rigour is the transparent description of ethical and political aspects of the conduct of research.

F

Facilitator or Approach factor
A facilitator or approach factor is a factor that enables progress or action.

Family therapy
Family therapy refers to the psychotherapeutic treatment of the family as a unit to clarify and modify the ways they relate together and communicate.
H

Hermeneutic phenomenology
Hermeneutic phenomenology tries to be attentive to both terms of its methodology. It is a descriptive (phenomenological) methodology because it wants to be attentive to how things appear; it wants to let things speak for themselves. It is an interpretive (hermeneutic) methodology because it claims that there are no such things as uninterpreted phenomena.

I

Identity
Identity refers to an awareness of being a person separate and distinct from all others.

Incidence
Incidence refers to the rate at which new cases of a particular condition occur in a given place at a given time.

Informed consent
Informed consent is consent obtained freely, without coercion, threats or improper inducements, after questions asked by the consumer have been answered. This includes appropriate disclosure to the consumer, and adequate and understandable information understood by the consumer. It enables the consumer to make a fully informed decision based on all relevant factors.

Insight
Insight refers to a person's capacity for understanding hidden truths.

Intervention
Intervention refers to the planned action taken by a health worker in the context of treatment, for example, counselling, intensive support, referral, or prescribing medication.

L

Lifeworld
Lifeworld refers to the world of lived experience. Husserl described the lifeworld as the "world of immediate experience".

Lived experience
Lived experience refers to the learning about the experiences of people in an honest, committed effort to understand their experience.

Lived meaning
Lived meaning refers to the way that a person experiences and understands his or her world as
real and meaningful. Lived meanings describe those aspects of a situation as experienced by the person in it.

**Manic episode**
Manic episode refers to a distinct period during which there is an abnormally and persistently elevated, expansive or irritable mood.

**Mental health**
Mental health describes a dynamic process in which a person’s physical, cognitive, affective, behavioural and social dimensions interact functionally with one another and with the environment, in ways that promote their sense of wellbeing, enhance their personal development, and allow them to achieve their life goals.

**Mental health literacy**
Mental health literacy refers to the ability to recognise specific disorders; knowing how to seek mental health information; knowledge of risk factors and causes, of self-treatments and of professional help available, and attitudes that promote recognition and appropriate help-seeking.

**Mental health problem**
A mental health problem refers to diminished cognitive, emotional or social abilities but not to the extent that the criteria for a mental illness are met.

**Mental health professional**
A mental health professional is a professionally trained person working specifically in mental health, such as social workers, occupational therapists, psychiatrists, psychologists and psychiatric nurses.

**Mental health promotion**
Mental health promotion refers to those actions that maximise mental health and wellbeing among populations and individuals.

**Mental illness**
Mental illness refers to a clinically diagnosable disorder that significantly interferes with an individual’s cognitive, emotional, behavioural or social abilities. The diagnosis of mental illness is generally made according to the classification systems of the *Diagnostic and statistical manual of mental disorders* (DSM) or the *International classification of diseases* (ICD).
Norms
Norms refer to the standard or average. They can also refer to unspoken rules of conduct or standards of acceptable behaviour in a culture.

Obsession
An obsession is a recurrent thought, feeling or action which the person cannot prevent, that is unpleasant and provokes anxiety.

Panic Attack
A panic attack refers to a sudden, unpredictable, intense episode of anxiety characterised by personality disorganisation, a fear of losing one’s mind, going crazy, being unable to control one’s behaviour, a sense of impending doom, helplessness and being trapped.

Phenomenology
Phenomenology is the study of phenomena, the way things appear to us in experience or consciousness. For Husserl, phenomenology is a discipline that endeavors to describe how the world is constituted and experienced through conscious acts.

Phobia
A phobia refers to an unrealistic fear or aversion to a situation or thing. Avoiding the feared situation may severely restrict one’s life and cause much suffering.

Prevalence
Prevalence refers to the percentage of the population with a particular condition at a given point of time (point prevalence) or during a given period (period prevalence).

Prevention
Prevention refers to interventions occurring before the initial onset of a disorder.

Procedural rigour
Procedural rigour refers to the transparent description of the conduct of research.

Psychiatrist
A psychiatrist is a medical practitioner who has completed formal specialist training in the study of abnormal behaviour from a medical perspective. Psychiatrists are able to prescribe medication and authorise medical treatment to people suffering from psychiatric conditions. Psychiatrists
provide diagnoses and can provide psychotherapy.

**Psychoanalysis**
Psychoanalysis is a treatment modality based on Freudian constructs, the analysis of the relationship that the client develops with the psychoanalyst.

**Psychologist**
A psychologist is a person trained in the science and assessment of human behaviour. There are a number of types of psychologists involved in mental health.

**Psychotherapy**
Psychotherapy refers to psychological methods for the treatment of mental disorders and psychological problems, for example, psychoanalysis, family therapy, group therapy.

**Qualitative research**
Qualitative research refers to a method of inquiry used in many different academic disciplines, and involves the collection and analysis of qualitative (non-numerical) data to search for patterns, themes, and holistic features.

**Reflexivity**
Reflexivity refers to the open acknowledgement of the complex influences among the researchers, the research topic and subjects on the research results.

**Relationship problems**
Relationship problems include patterns of interaction between or among members of a unit that are associated with significant impairment in functioning, or symptoms among one or more members of the unit, or impairment in the functioning of the unit itself.

**Self-concept**
Self-concept refers to the sum total of perceptions, feelings and beliefs about oneself.

**Skill**
Skill refers to an understanding of how to implement knowledge of or about a particular practice or action.

**Stigma**
A stigma is a label of disgrace or shame associated with a state or practice.
Stress
Stress refers to any factor that threatens the health of the body or has an adverse effect on its functioning such as injury, disease or worry.

Support
Support refers to direct services and interventions provided for a person with a (health) problem.

Symptoms
Symptoms refer to the characteristics by which diseases are recognised; they are the complaints or changes in a person’s mind or body that indicate they may be suffering from a particular illness.

Trauma
Trauma refers to any injury, either physical or emotional.

Treatment
Treatment refers to specific physical, psychological and social interventions provided by health professionals aimed at the reduction of impairment and disability and/or the maintenance of current level of functioning.

Triangulation
Triangulation is a comprehensive approach to the conduct of research using multiple theories, data and methods.

Understanding
Understanding is a dialectical process between the reader and writer.

Values
Values refer to the individualised rules by which people live. It can include the worth or significance attached to various objects, events, people or processes.