

“I think self-harm to self-kindness is how it’s sort of developed over time”

The experiences of young men who engaged in self-harm during adolescence and help-seeking behaviours: An Interpretative Phenomenological Analysis (IPA)

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Thesis submitted in partial fulfilment of the requirements of Staffordshire University as part of the Professional Doctorate in Clinical Psychology.

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THESIS PORTFOLIO: CANDIDATE DECLARATION

Title of degree programme	Professional Doctorate in Clinical Psychology
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Declaration and signature of candidate

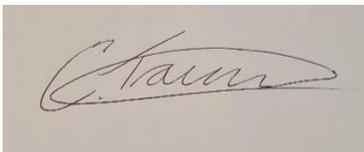
I confirm that the thesis submitted is the outcome of work that I have undertaken during my programme of study, and except where explicitly stated, it is all my own work.

I confirm that the decision to submit this thesis is my own.

I confirm that except where explicitly stated, the work has not been submitted for another academic award.

I confirm that the work has been conducted ethically and that I have maintained the anonymity of research participants at all times within the thesis.

Signed:



Date: 28/04/2024

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Thesis Abstract

As part of the Professional Doctorate in Clinical Psychology, the author of this thesis was particularly interested in exploring men's mental health, barriers to help-seeking and young males' experiences of self-harm.

Paper 1 is a comprehensive literature review of 16 published studies that explore the barriers to mental health help-seeking in working age males. Findings indicated that men who adhered more strongly to gender role constructs such as 'traditional masculinity', were less likely to seek help for their mental health. They were more likely to minimise mental health symptoms and self-medicate using illicit substances. Younger, lower-educated and rurally based men were more likely to adhere to these gender constructs and therefore less likely to seek help for their mental health.

Paper 2 is an empirical study which used Interpretative Phenomenological Analysis (IPA) to explore how young males made sense of their self-harm during their adolescence, and their experiences of help-seeking. Findings suggest that overwhelming emotions, a sense of relief, a need to punish themselves, and self-loathing were driving factors for these young men's self-harm. Unhelpful experiences of help-seeking led these young people to feel misunderstood and judged for their self-harm by those around them, including services. However, participants shared that experiences which allowed them to feel heard and understood, opened the door for future help-seeking and allowed them to treat themselves with more self-compassion and kindness.

Paper 3 is an executive summary which is an accessible version of the empirical study that was written for the participants of this study. Within this summary the aims, methods, findings, and implications are discussed. Two participants gave feedback on the accessibility and accuracy of their experiences within the executive summary. This summary can also be disseminated to professionals in Child and Adolescent Mental Health Services as well as the general public.

Paper 1: Literature Review

What are the barriers to adult males' mental health help-seeking? A review.

Callum Trainor

This review has been written in accordance with author guidelines from *The Journal of Men's Studies* with the intention of publication. A summary of submission guidelines for this journal can be found in Appendix 4.

Word Count: 7,899

Abstract

Background & Aims: Current research has outlined the unmet mental health needs of men in recent years and the disparity of mental health service utilisation between genders.

Recent reviews have attempted to understand this by looking at help-seeking as a whole (including physical health) or one facet of barriers to help-seeking (masculinity). This review aims to build on previous research by examining and exploring all perceived barriers to mental health help-seeking in men.

Methods: Five electronic databases were systematically searched using terms related to males, help-seeking, barriers, and mental health. Titles and abstracts were screened for suitability before critical appraisal of the resulting studies was completed. The Crowe Critical Appraisal Tool (CCAT) was used to appraise the strength of the studies. A thematic and narrative synthesis was completed on the qualitative and quantitative data respectively.

Results: Of 1169 citations identified, 16 met the inclusion criteria. 8 of these studies were quantitative and 8 were qualitative research. Findings suggest that attitudinal barriers such as masculinity, gender role conflict, self-stigma, and self-reliance were commonly expressed by men as reasons for not seeking help.

Conclusion: Results showed that men who were more likely to adhere to gender role constructs such as traditional masculinity, were less likely to seek help for their mental health difficulties. Men also reported more attitudinal barriers than structural barriers as the reason for not seeking help. Future research examining aspects of positive masculinity and how this can be incorporated for younger men (or boys) would be useful for encouraging men to utilise and engage in services.

Introduction

Differences in help-seeking behaviours between genders have been observed and studied for many years across Western society (Kung et al., 2003; Mackenzie et al., 2006; Pattyn et al., 2015; Wendt & Shafer, 2015). Research has shown that males are less likely than females to access formal and informal support networks for their mental health difficulties. Recent NHS England statistics have shown this as double the number of females accessed NHS talking therapies than males in the year 2021-22 (NHS, 2022a). Furthermore, females are more likely to receive certain mental health diagnoses compared to males. For example, a diagnosis of a depression is twice as common in working-age females than it is in males (Harkness et al., 2010; Kuehner, 2017), and prevalence rates for generalised anxiety is 1.5 times higher (McLean et al., 2011). When it comes to comparing self-harm rates between genders, much of the research has shown that females are more likely than males to self-injure and to access emergency/crisis services in the UK due to their injuries (Marchant et al., 2019). Half of the people in England who have died by suicide have previously disclosed self-harm behaviours. (Kapur et al., 2013). It might be assumed that women would be most at risk of death by suicide. However, it is in fact men who are more likely to die by suicide. Suicide is the biggest cause of death for males under 35 in the UK (ONS, 2021). Males are almost four times more likely than females to die by suicide in the UK (Samaritans, 2021), even though females make more attempts to end their life. Three out of four people who died by suicide in the UK in the last ten years were never seen by mental health services previous to their attempts on their lives (NCISH, 2018; Hawton & Pirkis, 2017). This is not a phenomenon isolated to the UK, with most “westernised” countries (USA, Canada, and Australia) also having similar gender suicide rates (Dattani et al., 2023). Men who experience suicidal ideation are again, less likely to use mental health services (Hom et al., 2015), which therefore reduces opportunities for assessment, prevention, and intervention. Recent figures show males were more likely than females to be detained under the Mental Health Act in the UK (NHS, 2022b). This again infers that males are possibly delaying help-

seeking until they reach crisis or exhibit behaviours which deem them to be a danger to themselves or others. Understanding why men are delaying or avoiding help-seeking is vitally important for early intervention and to possibly reduce rates of deaths by suicide. There are perhaps unmet mental health needs of males as they do not seem to be accessing services in the same way as females. A large study in Belgium showed that men were over one and half times more likely to have an unmet mental health need than women (Rens et al., 2020).

Men are more likely to present to services with externalising mental health needs such as ADHD, substance misuse, and aggressive behaviour (Kessler & Wang, 2008). Aggression is often encouraged in men by traditional masculine norms (Eagly & Steffen, 1986; Malonda-Vidal et al., 2021). It is hypothesised that substance misuse and aggression are likely masking men's depression and anxiety. This is possibly contributing to why men are less likely to be diagnosed with these conditions but are seen more in the criminal justice system with unmet mental health needs. In fact, studies have shown that men who are perpetrators of violent crimes are likely to have unmet mental health needs and substance misuse difficulties (Lipsky et al., 2010).

Galdas et al. (2005) reviewed the help-seeking behaviours in men, in both mental health and physical health services. They found that men were less likely to seek help for a range of health problems due to masculine beliefs being a hinderance to help-seeking. However, the processes and specific barriers were left unexplained. Seidler et al. (2016) reviewed the role of masculinity on men's help-seeking for depression. They concluded that conformity to traditional masculine norms of men had a negative impact on the way men experience and seek help for depression. However, this review only focused on the role of help-seeking in depression and as masculinity as a potential barrier. The current review will attempt to look at a range of potential barriers to help-seeking for mental health difficulties.

Sex and gender have been discussed as two different constructs by feminist theorists in the late 1970's, with sex relating to the biological aspect, and gender relating roles and norms

(Unger, 1979). However, social constructionist theories develop this understanding, stating that sex and gender are not separate but intertwined. (Maracek et al., 2004; Lorber, 2018). This view asserts gender as a prescription to normative beliefs about sex categories (based on culture and situational factors). Gender beliefs make up sets of behaviours like 'masculine' or 'feminine' behaviours and roles. Society defines these roles by biological features which make up concepts such as "man" and "woman". However, the gendered perception of being masculine or feminine is not always so neatly defined by sex or reproductive organs. Therefore, gender can be understood as external to the individual, consisting of ongoing judgements and evaluations by others and of others (Brown & Bigler, 2016; Meissner, 2005). This review will focus on analysing the construct of western masculinity, within the male gender role and male sex, and their perceived barriers to help-seeking. This, therefore, encompasses all those who identify themselves as "male".

Rationale and Aims

There are clear unmet needs of men by delaying or avoiding help-seeking for their mental health needs. It would be useful to understand different barriers to help-seeking for mental health difficulties that men face. Barriers associated with help-seeking often extend into therapy (therapy interfering behaviours); such as, difficulties with attendance, engagement, and a precarious therapeutic relationship (Seidler et al., 2021).

The first aim of this review was to synthesise the literature in this area to provide insight into what the barriers are that prevent men seeking help for their unmet mental health needs. The second aim of this review was to suggest particular targeted interventions that could promote service utilisation and engagement in men, based on the findings of the review.

Method

The review was conducted in three stages: a systematic searching of the literature

regarding barriers to men's mental health help-seeking, a critical appraisal of the selected studies, and thematic and narrative syntheses of the studies. The review protocol was not pre-registered. Prisma guidelines were followed for this review (Moher et al., 1996).

Search Strategy

Scoping searches of the International Prospective Register of Systematic Reviews (PROSPERO), Cochrane Library, and Google Scholar were completed to determine whether any similar reviews had already been published in this area as well as to ensure the review was viable (i.e. of sufficient scope to contribute to evidence in this area). This search produced no exact matches. Similar reviews were found for help-seeking in males in general (Galdas et al., 2005) and one specifically looking at masculinity as a barrier (Seidler et al., 2016). As the current review aims to focus on mental health help-seeking and a range of potential barriers (not just masculinity), it was concluded that this was a niche focus that had not been previously examined. Title and abstract searches were completed using five databases: PsycINFO, Web of Science, Cumulative Index to Nursing and Allied Health Literature (CINAHL), ScienceDirect and PubMed between 1st April and 19th May 2023. Search terms are defined in Figure 1 and were determined through discussion with the academic supervisor and understanding of the existing literature in the area. There were no year limiters used for searches. The PRISMA diagram (Figure 3) outlines the search strategy and Figure 2 sets out the eligibility criteria for inclusion. Hand searches of reference lists were also completed to find relevant studies not found in database searches. Grey literature was not included in this review as to not include literature that has not been peer-reviewed.

Figure 1*Database search terms*

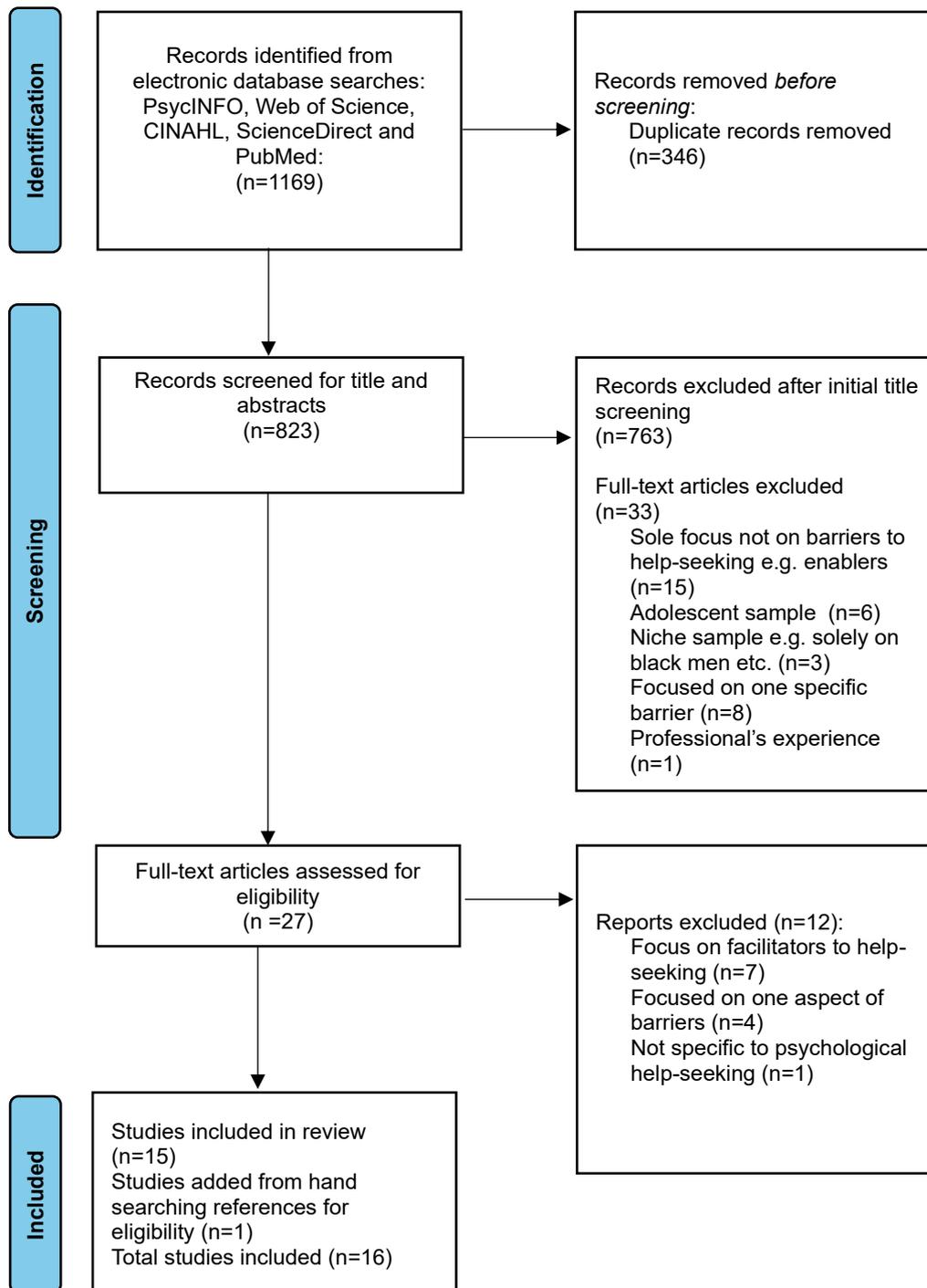
“Help-seeking”	“Men”	“Mental-Health”	“Barriers”
Help-seeking	Men	Mental-Health	Barriers
	AND	OR male*	AND
		OR Wellbeing	AND
		OR Psycholog*	OR Attitudes
		OR Psychiatr*	

Figure 2*Eligibility criteria for inclusion in review*

Criteria	Inclusion	Exclusion
Population	Adult males (age 18+).	Sole focus on adolescents or older adults.
Target issue	Barriers to help-seeking behaviours in males, specific to mental health help-seeking.	Sole focus on facilitators to help-seeking.
Aim or Objective	Examination/understanding experiences or facets of barriers to mental health help-seeking in males.	Examination of facilitators to help-seeking in males or focus is not solely mental health help-seeking.
Publication Type	Peer reviewed research studies.	Theoretical papers, books chapters, dissertations.
Language	English	

Figure 3

PRISMA flow chart showing search process (Moher et al., 2009)



Database searches yielded 1169 papers initially and 823 after duplicates were removed.

Seven hundred and sixty-three articles were excluded at title screening level with a further

33 articles excluded at the abstract screening level. Twenty-seven papers were screened at

full text level. Hand searching of reference lists of eligible papers, identified one further eligible paper. Twelve papers were excluded at full text screen, which left 16 articles eligible for inclusion for this review.

Quality Assessment

The Crowe Critical Appraisal Tool (CCAT) was used to critically appraise both qualitative and quantitative papers in this review (Crowe & Shepherd, 2011a). Each paper was scored out of 40 and a percentage score was determined. The tool is divided into 8 categories and 22 items. Each item has multiple item descriptors that make it easier to appraise and score a category. Each category receives a score on a 6-point scale from 0–5. The lowest score a category can achieve is 0, and 5 is the highest score. The CCAT is shown to have good inter-rater reliability and to be more reliable than informal appraisal approaches (Crowe et al., 2011). Please see Appendices for copy of CCAT form and table of appraisal.

Synthesis

A thematic synthesis was completed for the qualitative papers. Identifying what data to synthesise in qualitative papers can be difficult and subjective. This synthesis will follow the guidelines set out in Thomas and Harden (2008) on completing a thematic synthesis.

Therefore, all text under “results” will be analysed and key findings were coded and sorted into similar overarching themes and subthemes.

A narrative synthesis of the findings was completed for the quantitative papers. It was decided due to the lack of effect sizes disclosed in the chosen papers, that a meta-analysis could not be completed or would under-represent the body of evidence (Higgins et al., 2019).

The first author used a reflective diary to consider how their views and experiences may be influencing the analysis.

Results

Overview of Included Studies

This review included sixteen peer-review articles. No date parameters were applied as part of the search; most of the studies were recent, published between 2012 and 2023 with one study being published in 1989. The articles consisted of eight qualitative studies and eight quantitative studies. The studies were predominantly solely focused on male participants except one quantitative study which included female participants (Yousaf et al., 2014). - the male data was extrapolated and included as part of the review. All studies reviewed came from “Western” countries; 6 from the US, 4 from Canada, 3 from the UK, 2 from Ireland, and 1 from Germany.

Aims and Objectives

The main aim of the studies was to explore or understand the barriers to help-seeking to mental health in men. The qualitative studies were focused on exploring males’ experiences of help-seeking in mental health services, of their experiences of mental health difficulties in general and what prevented them from seeking help for their difficulties.

The majority of the quantitative studies explored which barriers to help-seeking and other determining factors were more predictive of men’s reluctance to seek help. For example, Berke et al. (2020), Good et al. (1989), Hammer et al. (2013), Sullivan et al. (2015), Yousaf et al. (2014), and Rice et al. (2020) looked at attitudes to help-seeking and their relationship to other barriers to help-seeking such as masculinity, self-stigma and, gender role conflict.

Participants in Cole & Ingram (2020) were asked to complete a role-play task, then rate their likelihood to seek help and what may prevent them from doing so. Finally, Seidler et al. (2020) asked participants to complete online measures regarding common barriers/attitudes to help-seeking and which correlated higher with those who did or did not want to seek treatment.

Sample Characteristics and Recruitment

Most of the quantitative studies recruited participants through convenience sampling via online recruitment (e-mails, forums, crowdsourcing sites, social media etc.) or through online survey sampling. 2 studies (Cole & Ingram 2020; & Good et al., 1989) recruited participants via the local psychology undergraduate class.

Most of the qualitative studies were recruited via online recruitment or local recruitment (posters, youth centres etc.). Lynch et al. (2018) used snowball sampling until data saturation was met, whilst the rest used purposive sampling. Cleary (2017) conducted interviews from men who had recently made an attempt to end their life and then completed follow up interviews up to seven years later. Kwon et al. (2023), used secondary data from a national survey in Australia to draw out themes to help-seeking.

Sample sizes from the quantitative studies ranged from 73 (Yousaf et al., 2014) to 4748 participants (Hammer et al., 2013). Sample sizes for the qualitative studies ranged from 12 (Staiger et al., 2020) to 73 participants (Kwon et al., 2023). Not all of the studies were able to produce data regarding demographics of the participants (Kwon et al., 2023; Yousaf et al., 2014), whilst others provided partial data for some demographics. Of the studies that were able to provide data, 67.1% of participants were Caucasian, 86.5% identified as heterosexual, and the mean age of participants was 27.9 years old.

Study Design

All of the quantitative studies were cross-sectional designs and relied on use of self-report measures. Two of the studies were completed face-to-face (Cole & Ingram, 2020; Good et al., 1989), at University campuses, and the rest were completed online. All of the studies used a self-report measure to understand perceived barriers or attitudes to help-seeking. For example, one study used the Barriers to Help-Seeking Scale (BHSS) (Berke et al., 2020), another (Yousaf et al., 2014) used the Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS), another study used the Self-Stigma of Help-Seeking Scale (SSOSH),

two studies (Rice et al., 2020; Seidler et al., 2020) used the Barriers to Mental Health Services Scale (BMHSS), and three studies (Good et al., 1989; Hammer et al., 2013; Sullivan et al., 2015) used the Attitudes Toward Seeking Professional Psychological Help Scale (ATSPPH). All studies cited the psychometric robustness of these measures and their reliability. These were then used to find the best predictor of barriers to help-seeking by comparing their relationship against other measures of personality, masculinity, or mental health difficulty.

Four of the qualitative studies conducted semi-structured interviews to explore males' experiences of the barriers to help-seeking. Two studies used focus groups and semi-structured interviews, (Lynch et al., 2018; Rice et al., 2018) whereas only one study (Sagar-Ouriaghli et al., 2020) used solely focus groups. The final study analysed qualitative data from a national survey (Kwon et al., 2023). One study (Johnson et al., 2012) used discourse analysis, one study used narrative analysis (Staiger et al., 2020), one study used grounded theory (Tang et al., 2014). The rest of the qualitative studies used thematic analysis to analyse the data.

Quality Appraisal

The following data was extracted from each study: author, year, study design, aims, recruitment and sampling, methodology, main findings, implications, and limitations (Please see table below). Quality appraisal of the studies rated 14 of the studies as high quality (>75%) and 2 as moderate quality (>55%<75%), as suggested by Crowe & Shepherd (2011b). These scores help in assessing the strength of inferences these studies make and to highlight any considerable methodological problems that may compromise the validity of results and therefore the suitability of including them in the review (Khan et al., 2003).

Two papers (Good et al., 1989; Yousaf et al., 2014) did not mention consent or ethical approval at all within the papers. Since one paper is over 30 years old, it could be

understood that may not have been a requirement, however, the other is less than ten years old, so it is a concern that ethical approval was not mentioned.

Within the qualitative studies, only one study discussed relevance of the number of participants used (Sagar-Ouriaghli et al., 2020), which stated they recruited until data saturation was reached. All quantitative studies described the self-report measures used and stated the psychometric properties of each measure, which added to the validity and rigour of the papers.

Two of the qualitative studies (Lynch et al., 2018; Sagar-Ouriaghli et al., 2020) demonstrated reflexivity in their development of themes which is important when considering any bias which may occur by the researchers. Most studies did not give power calculations so it was difficult to determine the strength of the relationships they were claiming in their studies.

Table 1

Overview of studies included in review

Authors and Year	Country	Study Design	Aims	Methodology	Main Findings/Barriers
Berke et al., (2020)	US	Quantitative	To understand the impact of gender role and masculinity on psychiatric distress and barriers to help-seeking in men.	N=558, cross-sectional, online self-report measures: <ul style="list-style-type: none"> Brief Symptom Inventory (BSI) Masculine Discrepancy Stress Scale (MDSS) Barriers to Help-Seeking Scale (BHSS). 	<ul style="list-style-type: none"> Higher levels of masculine discrepancy stress predicted greater reported barriers to help-seeking; in turn, greater endorsement of barriers to help-seeking predicted greater levels of psychiatric distress ($ab = 0.052$, 95% CI [0.028, 0.080]).
Cleary, A. (2017)	Ireland	Qualitative	To examine attitudes to treatment among a sample of men who made a suicide attempt.	N=52, semi-structured interviews, thematic analysis.	<ul style="list-style-type: none"> Non-disclosure of distress due to being seen as "weak". Lack of psychological knowledge/mindedness. Negative attitude about treatment ("doesn't get me anywhere"). Self-medicating as "treatment" or avoidance.
Cole & Ingram (2020)	US	Quantitative	To understand the impact of self-stigma and gender role conflict on help-seeking in men.	N=313, cross-sectional, role-play task. <ul style="list-style-type: none"> Self-Stigma of Help-Seeking Scale (SSOSH) Gender Role Conflict Scale (GRCS). 28 item list of how they might respond to the role-play. 	<ul style="list-style-type: none"> Self-stigma negatively predicted professional help-seeking ($\beta = -.35$, $p < .001$) and informal support ($\beta = -.26$, $p < .001$) while positively predicting avoidance behaviours ($\beta = .34$, $p < .001$). GRC was negatively associated with informal support use ($\beta = -.14$, $p < .001$) and positively associated with avoidant behaviours ($\beta = .25$, $p < .001$). Self-stigma was also positively associated with GRC ($\beta = .37$, $p < .001$).
Good et al., (1989)	US	Quantitative	To examine both attitudes toward male roles and factors associated with gender role conflict and	N=401, cross-sectional, self-report measures:	<ul style="list-style-type: none"> Regression analysis using male role variables to predict attitudes to help-seeking was significant ($F(4, 392) = 20.89$,

			how they impact help-seeking attitudes and behaviour.	<ul style="list-style-type: none"> Attitudes Toward Men Scale (AMS) Gender Role Conflict Scale-I (GRCS-I) Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale Help-Seeking Attitude and Behaviour Scale (HABS) 	<ul style="list-style-type: none"> $p < .001$), 17.6% of the variance in attitudes to help-seeking scores was explained by male role variables. Restrictive emotionality men was a significant predictor of attitudes to help-seeking.
Hammer et al., (2013)	US	Quantitative	To examine the relationship between traditional masculine norms, self-stigma, and attitudes towards counselling.	<p>N=4748, cross-sectional, online self-report measures:</p> <ul style="list-style-type: none"> Conformity to Masculinity Norms Inventory (CMNI-22). SSOSH ATSPPHS-(Short Form). The Center for Epidemiological Studies Depression scale (CES-D). 	<ul style="list-style-type: none"> Self-stigma and traditional masculine norms play a role in formation of barriers to help-seeking in men. Results showed significant differences in the relationships of conformity to masculine norms and self-stigma for men living in rural areas compared with men living in both suburban areas ($\chi^2=12.74$, $p<.001$), and urban areas, ($\chi^2=14.00$, $p<.001$). There were also significant differences for men with a postgraduate degree ($b=.41$) and men with both a high school diploma or less ($b=.55$), $\chi^2=6.90$, $p<.009$), and a 4-year college degree ($b=.54$), $\chi^2=7.02$, $p<.008$). Men with a postgraduate degree exhibited a weaker connection between conformity to masculine norms and self-stigma.
Johnson et al., (2012)	Canada	Qualitative	To explore men's discourses for seeking help for depression.	N=38, semi-structured interviews, discourse analysis.	<ul style="list-style-type: none"> Manly self-reliance (believing they can deal with problems themselves). Guarded vulnerability. Role of desperation.
Kwon et al., (2023)	Australia	Qualitative	To gain better insight into the reasons men give for	N=73, online survey, thematic analysis of qualitative data.	<ul style="list-style-type: none"> <i>Autonomy</i> - strong desire for control in decision making with health professionals. <i>Professionalism</i> - the lack of professionalism among staff.

			their disengagement from mental health services.		<ul style="list-style-type: none"> • <i>Authenticity</i> – perceived health-care providers were not genuinely interested in them and not genuinely empathic. • <i>Systemic Barriers</i> - Three issues with the health care system identified as barriers: consistency, aftercare, and accessibility.
Lynch et al., (2018)	Ireland	Qualitative	To explore barriers to professional help-seeking for mental health problems among young men.	N=17, focus groups (2 groups, 6 participants each) and semi-structured interviews (5 participants), thematic analysis.	<ul style="list-style-type: none"> • <i>Acceptance From Peers</i> – perceived help-seeking can cause negative social ramifications. • <i>Personal Challenges</i> - issues with communication, symptom recognition, and ineffective coping mechanisms. • <i>Cultural and Environmental Influences</i> - religious influences, generational divides, and rural life. • <i>Self-Medicating With Alcohol</i> - accepted way of coping with and escaping difficult feelings. • <i>Fear of Homophobic Responses</i> - impact of the stigma of being gay in a traditionally Catholic country. • <i>Traditional Masculine Ideals</i> - majority reported that professional help-seeking compromised their masculinity.
Rice et al., (2020)	Canada	Quantitative	To understand what barriers to help-seeking are more predictive of men's reluctance to seek help.	N=530, cross-sectional, online self-report measures: <ul style="list-style-type: none"> • Barriers to Mental Health Services Scale–Revised (BMHSS-R). • Patient Health Questionnaire (PHQ-9). • Suicidal Behaviours Questionnaire-Revised (SBQ-R). 	Attitudinal barriers were more predictive than structural barriers in differentiating men's mental health help-seeking: <ul style="list-style-type: none"> • <i>I do not know the reasons people go to psychotherapy (p=.008)</i> • <i>I need to solve my own problems (p=.012)</i> – • <i>I would not tell my physician if I was feeling down or depressed (p=.016)</i> • <i>It would be normal for me to be sad or down given the circumstances of my life (p=.033)</i>

Rice et al., (2017)	Australia	Qualitative	To identify barriers to mental health care, in young help-seeking men and staff involved in mental health service provision.	N=25, semi-structured interviews (5 participants), and 4 focus groups, Thematic analysis.	<ul style="list-style-type: none"> • <i>Personal barriers</i> - help-seeking appeared in conflict with internalised male role expectations. This occurred through stigma, shame, and needing to avoid being perceived as weak/vulnerable. Some reported discussing uncomfortable emotions was unfamiliar. • <i>Structural Barriers</i> - Lack of knowledge regarding available services, perceived lack of accessibility of services, and difficulty navigating the system.
Sagar-Ouriaghli et al., (2020)	UK	Qualitative	To identify potential approaches that would be relevant to improving mental health help-seeking in male students.	N=24, 3 focus groups, thematic analysis.	<ul style="list-style-type: none"> • Protecting male vulnerability – men did not want to engage as it was not “manly”. • Differences over intervention format – not knowing what the most suitable intervention would be. • Difficulty knowing when and how to seek help.
Seidler et al., (2020).	Canada	Quantitative	To understand which perceived barriers to help-seeking in men correlated highly with each other and were the best predictors of barriers.	N=778, cross-sectional, online self-report measures: <ul style="list-style-type: none"> • BMHSS-R • Kessler Psychological Distress Scale (K6). 	Men who did not want treatment were more likely to endorse the following barriers: <ul style="list-style-type: none"> • <i>A psychotherapist would not understand me or my problems</i> ($p=.002$, $V=.11$) • <i>I would not tell my physician if I was feeling down or depressed</i> ($p<.001$, $V=.15$) • <i>I am not sure if psychotherapy really works or is effective</i> ($p<.001$, $V=.15$) • <i>I need to solve my own problems</i> ($p<.001$, $V=.18$) • <i>I would not know how to find a psychotherapist</i>, was more often endorsed as a barrier by those men wanting treatment ($p=.001$, $V=.12$).

Staiger et al., (2020).	Germany	Qualitative	To explore men's experiences and attitudes toward depression, help-seeking, and service use in order to develop gender-sensitive services.	N=12, semi-structured interviews, narrative analysis.	<ul style="list-style-type: none"> Men's attitudes toward coping with depression: critical stance toward masculine norms e.g. trivialising symptoms, hiding depression. Men's perception of societal views on depression: the stigma of being depressed as "unmanly". Experiences within the family context – loss of empathy, paternal role expectations.
Sullivan et al., (2015)	UK	Quantitative	To determine, whether adherence to masculine norms, emotional expressiveness, and intimacy in close relationships were associated with UK men's attitudes towards seeking professional psychological help.	N=536, cross-sectional, online self-report measures: <ul style="list-style-type: none"> Fear of Intimacy Scale (FIS). Normative Male Alexithymia Scale (NMAS). Male Role Attitudes Scale (MRAS). ATSPPHS-SF 	<ul style="list-style-type: none"> Traditional masculine ideology was negatively correlated with help-seeking ($r = -.191, p < .01$ [two-tailed]) Normative alexithymia was found to be negatively correlated with help-seeking ($r = -.327, p < .01$ [two-tailed]) Bivariate Pearson's correlation was carried out between fear of intimacy and help-seeking attitudes ($r = -.245, p < .01$ [two-tailed]). Fear of intimacy accounted for 6% of the variance observed in help-seeking. Masculinity, normative alexithymia, and fear of intimacy accounted for 12% of the variance observed in psychological help-seeking.
Tang et al., (2014)	Canada	Qualitative	To describe the connections between masculinities and college men's depression-related help-seeking.	N=21, semi-structured interviews, grounded theory.	<ul style="list-style-type: none"> Denying weakness – seeking help was seen as being "weak" by most participants. Limiting self-disclosure and mustering autonomy – a need to hide vulnerabilities and manage problems on their own.

Yousaf et al., (2014)	UK	Quantitative	To investigate whether there is a relationship between masculine attitudes and attitudes toward psychological help-seeking.	<p>N=124 (51 females; 73 males), cross-sectional, online and face-to-face measures:</p> <ul style="list-style-type: none"> • The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS). • Male Role Norms Inventory-Revised (MRNI-R). 	<ul style="list-style-type: none"> • Men's gender role norms significantly predicted their attitudes to help-seeking ($F(1, 71) = 74.00, p < .001, \beta = -.23$) and there was a strong negative correlation ($r = -.71$). • Younger men (18-40) had more negative attitudes to help-seeking than older men. • Men scored higher on gender norms scales than women.
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Outcomes

Thematic Synthesis of Findings (Qualitative)

The thematic synthesis of the qualitative studies identified two main overarching themes or in relation to barriers to help-seeking with multiple subthemes in each. The first overarching theme was Attitudinal Barriers to help-seeking which included subthemes of; self-reliance and autonomy, psychological mindedness, and challenges to masculinity. The second overarching theme was Systemic Barriers.

Overarching Theme 1: Attitudinal Barriers

This theme related to the participants attitudes and beliefs in regard to the perceived barriers to help-seeking for mental health difficulties. The subthemes within, relate to the participants intrinsic beliefs, cognitions, and/or feelings of what prevented them from help-seeking for their difficulties. This was by the far the most common barriers males came across when thinking about help-seeking.

Self-Reliance and Autonomy

This subtheme was supported by five studies (Cleary, 2017; Johnson et al., 2012; Kwon et al., 2023; Lynch et al., 2018; Tang et al., 2014) and reflected on ways in which men avoid help-seeking by asserting the need to rely on their own “strength” and be autonomous. This usually meant, men engaged in unhealthy coping strategies as a way to manage instead. Participants in Cleary’s (2017) study specifically spoke about using alcohol and other substances to self-medicate when they were having struggles with their mental health instead of reaching out to their family, friends, or services.

“...I was using all sorts of drugs to, just kind of, to go out and enjoy myself basically, you know that kind of way. To forget about everything, to forget about it, you know that was what I was doing, to basically forget about it . . . I didn’t look for help or anything but just thought ‘right, I’ll stop’. It was only when I stopped that the depression starting kicking in... Things were just deteriorating but I was afraid to tell...” (Cleary, 2017, p.222)

Men in other studies spoke about how they wanted control over decisions regarding accessing mental health services (or not), but this would mean suppressing their emotions or inhibiting them in other ways (alcohol, drugs etc.). Though, this was tied to beliefs (or perceptions) that they needed to be “strong” for others and this is how “men” should act in society. Help-seeking would be damaging to their self-image and worth.

“I should be able to take care of myself . . . if you’ve to go see a mental health service . . . then you can’t” (Lynch et al., 2018, p.142).

“You’re not supposed to open up to other guys about that. You’re supposed to seem confident and strong and you can accomplish things on your own and stuff like that. . . That’s what proves your value to other people I think and so, by discussing it with other people. . . it just lowers your value. . . so you just shouldn’t talk about it.” (Tang et al., 2014, p. 221).

Psychological Mindedness

This subtheme was supported by five studies (Cleary, 2017; Lynch et al., 2018; Rice et al., 2017; Sagar-Ouriaghli et al., 2020; Staiger et al., 2020) and pertains to the lack of psychological mindedness disclosed by men. Some men spoke about not understanding mental health issues as a whole and therefore not being able to acknowledge or be aware of their distress.

“I didn’t pay attention to them (symptoms). I didn’t notice them, and didn’t do anything about it . . . I didn’t think they were serious.” (Cleary, 2017, p. 222)

Furthermore, some stated they did not understand the processes involved in receiving help, therefore they did not feel comfortable engaging in something they did not understand or see the benefits of.

“we don’t actually talk about the process itself [i.e. therapy], how long does it take, what it looks like, when we should expect the first effect, why it’s not straight away, people don’t know this” (Rice et al., 2017, p. 8)

Participants in Staiger et al., (2020) also disclosed that a lack of understanding from families also created barriers to help-seeking.

“My family couldn’t understand that I, a father, didn’t go to the hardware store today, because I didn’t feel good. It was never really recognized” (Staiger et al., 2020, p. 6).

Challenges to Masculinity

This subtheme was discussed in four studies (Lynch et al., 2018; Rice et al., 2017; Sagar-Ouriaghli et al., 2020; Staiger et al., 2020). This aspect of masculinity discussed by men in these studies, holds many parallels to traditional/toxic masculinity i.e. the need to be strong, deny weakness and suppress emotion (Courtenay, 2000; Hill et al., 2020). Many men discussed that asking for help was not seen as “manly” or even having/acknowledging a mental health difficulty in the first place was a threat to their masculinity. Being “mentally unwell” meant that they were not living up to their (and society’s) ideal of what a man should be.

“If you go and ask for professional help, you are not really a man” (Lynch et al., 2018, p.143)

Men expressed that they would not seek help as if they did, it would mean they are acknowledging there is something “wrong” with them. They felt that help-seeking was a sign of weakness, and therefore a threat to their masculinity.

“you would definitely be seen as a weak member of the group if you were [seeking counselling]” (Lynch et al., 2018, p. 142).

Fears of homophobic responses was seen as a threat to their masculinity and a barrier to help-seeking. Not acknowledging difficulties then, could be seen as a protective behaviour from this perceived threat from peers or other men.

“Yep, I think it is the stigma that society puts on guys to not cry and not show emotions; and that if you talk about your problems or acknowledge that you have problems in the

first place, you are automatically gay or feminine or less of a man; and that's intimidating to - like, it just proves how insecure boys are to even acknowledging the fact that they are insecure in the first place.” (Rice et al., 2017, p. 63)

Overarching Theme 2: Systemic Barriers

The second overarching theme related to systemic barriers that might have deterred men from reaching out to or continuing to access services. The subthemes identified within mainly relate to the running of mental services and how that contributed to the lack of uptake of services in males.

System Processes

This subtheme was explored in two studies (Rice et al., 2017; Sagar-Ouriaghli et al., 2020) and relates to the difficulties men faced trying to navigate services when help-seeking. These systemic difficulties unintentionally hindered and created barriers for men rather than encouraging or promoting the benefits of help-seeking. Men discussed that they were completely unaware of the services being offered to those in need of mental health support or mental health crises.

“I was in hospital, in the mental ward a couple of years ago, and they didn't even tell me this place existed.” (Rice et al, 2017, p. 62).

Others were discouraged by the current state of waiting lists and assessment processes when they do muster up the courage to seek help. Those who did manage to stay on the waiting list and wait for psychological support described the intervention on offer as something that they could not relate to at first and therefore withdrew from treatment or support. Participants in the Sagar-Ouriaghli et al. (2020) study disagreed with the support they were offered and did not find it helpful. Some stated that they could not give more than an hour or more than a couple of sessions, whilst others saw the benefits of attending multiple sessions over many months.

Perception of Support

This subtheme was only mentioned in one study (Lynch et al., 2018) but it seemed a pertinent theme in that study and could be useful for service providers to address in the future. Men in this study felt that service providers and staff were not listening to their needs which meant they did not want to be part of a system which was not person-centred. Interestingly, this might link to an earlier theme in which men stated that a barrier to seeking help was needing to feel autonomous. It could be argued that men still need some autonomy and control over their care even when they have made the step to seek support.

“I ended it because people were no longer responding to my needs or listening to me, rather they had their own idea of what was best for me. This did not align with what I actually needed and felt that I was wasting their time and they were wasting mine.” (Lynch et al., 2018, p. 5).

Narrative Synthesis of Findings (Quantitative)

Summarising of the quantitative studies was performed by one author in a narrative synthesis. Most of the studies included in this review were concerned with comparing attitudes towards help-seeking with an aspect of masculinity, personality, psychological flexibility etc. to attempt to understand men’s perceived barriers to help-seeking

Gender Role Conflict

The most commonly measured barrier to help-seeking was the concept of male Gender Role Conflict (GRC). O’Neil (2008) defines GRC as “a psychological state in which socialized gender roles have negative consequences for the person or others. GRC occurs when rigid, sexist, or restrictive gender roles result in restriction, devaluation, or violation of others or self”. In regard to males, this relates to the intrinsic beliefs, that men need to conform to societal expectations of traditional masculine norms or “what it is to be a man”. Namely, to be emotionally restrictive, fear of femininity, and to compete for power (O’Neil, 2013). This is similar to “toxic” or “traditional” masculinity (Courtenay, 2000; Hill et al., 2020) .

Six studies (Berke et al., 2020; Cole & Ingram, 2020; Good et al., 1989; Hammer et al., 2013; Sullivan et al., 2015; Yousaf et al., 2014) directly measured GRC as a barrier to help-seeking in men. Berke et al. (2020) found that men who were the most concerned about deviating from prescribed masculine ideals/roles, reported more attitudinal barriers to help-seeking, whilst also reporting high levels of psychological distress. Cole and Ingram (2020) showed that GRC was negatively associated with informal support use ($\beta = -.14, p < .001$) and positively associated with avoidant behaviours ($\beta = .25, p < .001$). This meant, men who were conflicted by gender/masculine roles were much less willing to engage in help-seeking for psychological difficulties and had higher levels of avoidant behaviours such as self-medicating, minimising problems, and stoicism. Furthermore, Good et al. (1989) also reported that violating traditional masculine norms was predictive of negative attitudes to help-seeking in the men studied ($F(4, 392) = 20.89, p < .001$). This included being less emotional and expressing less affection to other men – which were both predictive of past and future help-seeking behaviours.

Self-Stigma

Another barrier to help-seeking that was measured was men's self-stigma. Hammer & Vogel (2010) define self-stigma in help-seeking as "the belief that one is inadequate or weak if he wants to seek professional help". This particular barrier was reported in two studies (Cole & Ingram, 2020; Hammer et al., 2013). Self-stigma was negatively associated with attitudes towards help-seeking (Cole & Ingram, 2020; Hammer et al., 2013) ($\beta = -.35, p < .001$) and positively associated with avoidance behaviours ($\beta = .34, p < .001$). Men who had higher self-stigma were also less likely to view psychological support as helpful or admitted that they did not understand the benefits of it. Self-stigma was also positively associated with GRC ($\beta = .37, p < .001$), meaning that men who viewed themselves as being inadequate, also had conflict with their perceived gender roles (Cole & Ingram, 2020).

Education, Class, and Age

Some of the studies showed the differences between demographics as barriers to help-seeking. Working-age men had poorer attitudes to help-seeking (Yousef et al., 2014) as they scored lower on attitudes to help-seeking scales ($M=53.80$, $SD=15.44$) compared to older men ($M = 63.39$, $SD=16.06$). This was also shown in Rice et al. (2020) as age was a significant predictor of help-seeking attitudes ($p= .041$), with younger men being less likely to engage.

Hammer et al. (2013) found that “less” educated men were more likely to conform to societal masculine norms and self-stigma (which leads to less favourable attitudes to help-seeking) than men with a postgraduate degree ($p=.009$). Sullivan et al. (2015) corroborated these findings; men who went on to further education reported more favourable opinions to help-seeking. There were also differences found between men from different community sizes (rural vs urban), suggesting that men from rural areas were less likely to seek help than men in urban areas ($p<.001$).

Discussion

The aims of this review were to synthesise literature in this area to provide insight into what the barriers are that prevent help-seeking in men for mental health needs, and to suggest targeted interventions that could promote more service utilisation and engagement in men.

Attitudinal barriers were more commonly measured, expressed, and identified as barriers to help-seeking in men for their mental health difficulties, than structural barriers. Most common attitudinal barriers were related to men’s masculinity and gender role conflict. These were common themes throughout both the thematic and narrative syntheses. Men who were more likely to conform to traditional masculinity and unhelpful gender roles, were more likely to delay help-seeking, be less positive about help-seeking in the first place, minimise their symptoms, and use unhelpful coping strategies to manage distress (alcohol/drugs). Much research has shown that men are greatly influenced by these traditional masculine gender

roles of not showing emotion, not expressing weakness, not being feminine (Hill et al., 2020), leading to unmet health needs as they delay help-seeking.

Self-stigma was also a barrier to help-seeking. This was defined as “the belief that one is inadequate or weak if he wants to seek professional help” (Hammer & Vogel, 2010). Men conveyed not wanting to appear vulnerable or weak by seeking help for their difficulties, instead wanting to have autonomy over their health – again this usually led to unhelpful coping strategies. Some of the quantitative studies were also able to show significant negative correlations between self-stigma and help-seeking (Cole & Ingram, 2020; Hammer et al., 2013). Again, this idea of not wanting to appear weak or vulnerable has significant parallels to prescribed gender roles of men in society, and traditional masculinity.

Younger men, those with lower education, and men from rural areas were found to have more negative attitudes to help-seeking, though it was not explored as to why this was. Using the findings from this review it could be hypothesised that these demographics of men adhere to unhelpful gender roles more so than others. It could also be due to a lack of psychological mindedness and knowledge about mental health difficulties that prevent them from even being aware about their own distress or where to seek help i.e. lack of information in their communities, peer groups or schools.

Structural barriers were explored by men in qualitative studies but did not have strong correlational relationships to help-seeking in the quantitative studies but were also less rigorously measured compared to other factors. Common structural barriers highlighted were not knowing these services existed, waiting times, and not feeling that the care they were receiving was person-centred. It is promising that men did not express that services were causing barriers to help-seeking, but it does beg the question of what services can do to encourage men to access support if their lack of access is strongly linked to their attitudes and beliefs about their roles in society.

Sagar- Ouriaghli et al. (2019) reviewed strategies that services can implement to encourage men to access services. This could include targeting behaviour change techniques that build on positive masculine traits such as resilience and strength (Sagar-Ouriaghli et al., 2019). Carlson & Kiselica (2013) also outlined many ways in which services can encourage men to access services, and how services can adapt to meet the needs of men. This includes (but is not limited to) understanding male ways of relating, promoting male ways of caring, incorporating male role models, and fostering healthy male self-reliance. This is based on the Positive Psychology/Positive Masculinity (PPPM) Framework outlined in Kiselica & Engar-Carlson (2010). The PPPM is a very encouraging framework that could be used to adapt services to meet the unmet needs of men in health services. They also state that when men do come to services, they should not only be praised, but reinforce that they are not an outlier. In line with social norms theory, this can help to affirm to men that they are not alone with their difficulties, and that other men struggles with similar difficulties (Mackie et al., 1990).

Limitations

This review has several methodological limitations. Only peer-reviewed studies were searched for, and grey literature was not included in this search. This meant the review is subject to publication bias as positive findings are more likely to be published than non-significant results. The choice of search databases may have been limited, though hand searching of reference lists of the studies aimed to increase the scope of the review.

Through inclusion of mixed gender samples, the scope and breadth of the review was widened. Finally, as only one author conducted the critical appraisal, it could be subject to personal biases.

A further limitation to this review, which could also influence further research, is that the gender identity of being non-binary, or identifying with a different gender than birth sex, was not commented on. The studies reviewed did not give space for other genders, other than the two binary genders, nor did they ask about gender transitioning. This could have an

impact on how people adhere to specific gender roles and identities and would be an interesting potential research area to understand any barriers to help-seeking, especially as LGBTQ+ groups experience more unmet mental health problems and have more unmet mental health needs than heteronormative populations (Steele et al., 2017; Silveri et al., 2022)

Further Research

Research could focus on how males can be supported from a young age by challenging traditional views of masculinity. For example, emotional regulation interventions such as mindfulness or cognitive-behavioural based approaches (Pickerell et al., 2023), or promoting the PPM framework in schools, as gender norms are embedded at a young age and reinforced by society, peers, and their community.

As there are large unmet mental health needs of men who enter the criminal justice system, research could try to understand the barriers to help-seeking in this cohort. Currently, 95% of the prison population is male (MoJ, 2023), and toxic masculinity is a considerable barrier to “treatment” and recidivism (Kupers, 2005). This cohort may be able to shed more light on further barriers to help-seeking in men, as these men are likely to be further embedded into traditional masculine traits (Hill et al., 2020; Lipsky et al., 2010).

Conclusion

Overall, results showed that men experience more attitudinal barriers to help-seeking. This was linked to themes of challenges to masculinity, self-stigma, and gender role conflict. These themes were also backed up in the quantitative literature as they were negatively correlated with help-seeking. Younger men, men from rural locations and men who were less educated were also more likely to have negative opinions on help-seeking, suggesting that these cohorts may possibly prescribe to these attitudinal barriers more than other cohorts. Future research should research why these cohorts are more likely to be reluctant to seek help and what can be done to encourage service utilisation. It may be beneficial to explore

how the PPPM framework can be used with young males to challenge traditional forms of masculinity in order to overcome the attitudinal barriers found in this review.

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Appendices

Appendix 1 – Crowe Critical Appraisal Tool

Crowe Critical Appraisal Tool (CCAT) Form (v1.4)

Reference Reviewer

This form must be used in conjunction with the CCAT User Guide (v1.4); otherwise validity and reliability may be severely compromised.

Citation	
<input type="text"/>	Year <input type="text"/>

Research design (add if not listed)	
<input type="checkbox"/> Not research	Article Editorial Report Opinion Guideline Pamphlet ...
<input type="checkbox"/> Historical	--
<input type="checkbox"/> Qualitative	Narrative Phenomenology Ethnography Grounded theory Narrative case study ...
<input type="checkbox"/> Descriptive, Exploratory, Observational	A. Cross-sectional Longitudinal Retrospective Prospective Correlational Predictive ...
	B. Cohort Case-control Survey Developmental Normative Case study ...
<input type="checkbox"/> Experimental	<input type="checkbox"/> True experiment Pre-test/post-test control group Solomon four-group Post-test only control group Randomised two-factor Placebo controlled trial ...
	<input type="checkbox"/> Quasi-experiment Post-test only Non-equivalent control group Counter balanced (cross-over) Multiple time series Separate sample pre-test post-test [no Control] [Control] ...
	<input type="checkbox"/> Single system One-shot experimental (case study) Simple time series One group pre-test/post-test Interactive Multiple baseline Within subjects (Equivalent time, repeated measures, multiple treatment) ...
<input type="checkbox"/> Mixed Methods	Action research Sequential Concurrent Transformative ...
<input type="checkbox"/> Synthesis	Systematic review Critical review Thematic synthesis Meta-ethnography Narrative synthesis ...
<input type="checkbox"/> Other	--

Variables and analysis		
Intervention(s), Treatment(s), Exposure(s)	Outcome(s), Output(s), Predictor(s), Measure(s)	Data analysis method(s)
<input type="text"/>	<input type="text"/>	<input type="text"/>

Sampling					
Total size	Group 1	Group 2	Group 3	Group 4	Control
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Population, sample, setting <input type="text"/>					

Data collection (add if not listed)	
<input type="checkbox"/> Audit/Review a) Primary Secondary ... b) Authoritative Partisan Antagonist ... c) Literature Systematic ...	<input type="checkbox"/> Interview a) Formal Informal ... b) Structured Semi-structured Unstructured ... c) One-on-one Group Multiple Self-administered ...
<input type="checkbox"/> Observation a) Participant Non-participant ... b) Structured Semi-structured Unstructured ... c) Covert Candid ...	<input type="checkbox"/> Testing a) Standardised Norm-ref Criterion-ref Ipsative ... b) Objective Subjective ... c) One-on-one Group Self-administered ...

Scores					
Preliminaries	Design	Data Collection	Results	Total [/40]	
Introduction	Sampling	Ethical Matters	Discussion	Total [%]	

General notes
<input type="text"/>

Category Item	Item descriptors <input type="checkbox"/> Present; <input type="checkbox"/> Absent; <input type="checkbox"/> Not applicable	Description [Important information for each item]	Score [0-5]
1. Preliminaries			
Title	1. Includes study aims <input type="checkbox"/> and design <input type="checkbox"/>		
Abstract (assess last)	1. Key information <input type="checkbox"/> 2. Balanced <input type="checkbox"/> and informative <input type="checkbox"/>		
Text (assess last)	1. Sufficient detail others could reproduce <input type="checkbox"/> 2. Clear/concise writing <input type="checkbox"/> , table(s) <input type="checkbox"/> , diagram(s) <input type="checkbox"/> , figure(s) <input type="checkbox"/>		
			Preliminaries [/5]
2. Introduction			
Background	1. Summary of current knowledge <input type="checkbox"/> 2. Specific problem(s) addressed <input type="checkbox"/> and reason(s) for addressing <input type="checkbox"/>		
Objective	1. Primary objective(s), hypothesis(es), or aim(s) <input type="checkbox"/> 2. Secondary question(s) <input type="checkbox"/>		
Is it worth continuing?			Introduction [/5]
3. Design			
Research design	1. Research design(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Suitability of research design(s) <input type="checkbox"/>		
Intervention, Treatment, Exposure	1. Intervention(s)/treatment(s)/exposure(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Precise details of the intervention(s)/treatment(s)/exposure(s) <input type="checkbox"/> for each group <input type="checkbox"/> 3. Intervention(s)/treatment(s)/exposure(s) valid <input type="checkbox"/> and reliable <input type="checkbox"/>		
Outcome, Output, Predictor, Measure	1. Outcome(s)/output(s)/predictor(s)/measure(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Clearly define outcome(s)/output(s)/predictor(s)/measure(s) <input type="checkbox"/> 3. Outcome(s)/output(s)/predictor(s)/measure(s) valid <input type="checkbox"/> and reliable <input type="checkbox"/>		
Bias, etc	1. Potential bias <input type="checkbox"/> , confounding variables <input type="checkbox"/> , effect modifiers <input type="checkbox"/> , interactions <input type="checkbox"/> 2. Sequence generation <input type="checkbox"/> , group allocation <input type="checkbox"/> , group balance <input type="checkbox"/> , and by whom <input type="checkbox"/> 3. Equivalent treatment of participants/cases/groups <input type="checkbox"/>		
Is it worth continuing?			Design [/5]
4. Sampling			
Sampling method	1. Sampling method(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Suitability of sampling method <input type="checkbox"/>		
Sample size	1. Sample size <input type="checkbox"/> , how chosen <input type="checkbox"/> , and why <input type="checkbox"/> 2. Suitability of sample size <input type="checkbox"/>		
Sampling protocol	1. Target/actual/sample population(s): description <input type="checkbox"/> and suitability <input type="checkbox"/> 2. Participants/cases/groups: inclusion <input type="checkbox"/> and exclusion <input type="checkbox"/> criteria 3. Recruitment of participants/cases/groups <input type="checkbox"/>		
Is it worth continuing?			Sampling [/5]
5. Data collection			
Collection method	1. Collection method(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Suitability of collection method(s) <input type="checkbox"/>		
Collection protocol	1. Include date(s) <input type="checkbox"/> , location(s) <input type="checkbox"/> , setting(s) <input type="checkbox"/> , personnel <input type="checkbox"/> , materials <input type="checkbox"/> , processes <input type="checkbox"/> 2. Method(s) to ensure/enhance quality of measurement/instrumentation <input type="checkbox"/> 3. Manage non-participation <input type="checkbox"/> , withdrawal <input type="checkbox"/> , incomplete/lost data <input type="checkbox"/>		
Is it worth continuing?			Data collection [/5]
6. Ethical matters			
Participant ethics	1. Informed consent <input type="checkbox"/> , equity <input type="checkbox"/> 2. Privacy <input type="checkbox"/> , confidentiality/anonymity <input type="checkbox"/>		
Researcher ethics	1. Ethical approval <input type="checkbox"/> , funding <input type="checkbox"/> , conflict(s) of interest <input type="checkbox"/> 2. Subjectivities <input type="checkbox"/> , relationship(s) with participants/cases <input type="checkbox"/>		
Is it worth continuing?			Ethical matters [/5]
7. Results			
Analysis, Integration, Interpretation method	1. A.I.I. method(s) for primary outcome(s)/output(s)/predictor(s) chosen <input type="checkbox"/> and why <input type="checkbox"/> 2. Additional A.I.I. methods (e.g. subgroup analysis) chosen <input type="checkbox"/> and why <input type="checkbox"/> 3. Suitability of analysis/integration/interpretation method(s) <input type="checkbox"/>		
Essential analysis	1. Flow of participants/cases/groups through each stage of research <input type="checkbox"/> 2. Demographic and other characteristics of participants/cases/groups <input type="checkbox"/> 3. Analyse raw data <input type="checkbox"/> , response rate <input type="checkbox"/> , non-participation/withdrawal/incomplete/lost data <input type="checkbox"/>		
Outcome, Output, Predictor analysis	1. Summary of results <input type="checkbox"/> and precision <input type="checkbox"/> for each outcome/output/predictor/measure 2. Consideration of benefits/harms <input type="checkbox"/> , unexpected results <input type="checkbox"/> , problems/failures <input type="checkbox"/> 3. Description of outlying data (e.g. diverse cases, adverse effects, minor themes) <input type="checkbox"/>		
			Results [/5]
8. Discussion			
Interpretation	1. Interpretation of results in the context of current evidence <input type="checkbox"/> and objectives <input type="checkbox"/> 2. Draw inferences consistent with the strength of the data <input type="checkbox"/> 3. Consideration of alternative explanations for observed results <input type="checkbox"/> 4. Account for bias <input type="checkbox"/> , confounding/effect modifiers/interactions/imprecision <input type="checkbox"/>		
Generalisation	1. Consideration of overall practical usefulness of the study <input type="checkbox"/> 2. Description of generalisability (external validity) of the study <input type="checkbox"/>		
Concluding remarks	1. Highlight study's particular strengths <input type="checkbox"/> 2. Suggest steps that may improve future results (e.g. limitations) <input type="checkbox"/> 3. Suggest further studies <input type="checkbox"/>		
			Discussion [/5]
9. Total			
Total score	1. Add all scores for categories 1-8		
			Total [/40]

Appendix 2

Full table of critical appraisal studies

Authors and Year	Country	Study Design	Aims	Methodology	Main Findings/Barriers	Implications	Limitations
Berke et al., (2020)	US	Quantitative	To understand the impact of gender role and masculinity on psychiatric distress and barriers to help-seeking in men.	N=558, cross-sectional, online self-report measures: <ul style="list-style-type: none"> Brief Symptom Inventory (BSI) Masculine Discrepancy Stress Scale (MDSS) Barriers to Help-Seeking Scale (BHSS). 	<ul style="list-style-type: none"> Higher levels of masculine discrepancy stress predicted greater reported barriers to help-seeking; in turn, greater endorsement of barriers to help-seeking predicted greater levels of psychiatric distress ($ab = 0.052$, 95% CI [0.028, 0.080]). 	The social pressures on men to "be a man" contributes greatly to their psychiatric distress. Addressing and accounting for this stress in services could enhance mental health promotion in young men.	Quantitative measures do not capture full diversity of men's experiences. Unable to determine causal relationships from this study design.
Cleary, A. (2017)	Ireland	Qualitative	To examine attitudes to treatment among a sample of men who made a suicide attempt.	N=52, semi-structured interviews, thematic analysis.	<ul style="list-style-type: none"> Non-disclosure of distress due to being seen as "weak". Lack of psychological knowledge/mindedness. Negative attitude of treatment ("doesn't get me anywhere"). Self-medicating as "treatment" or avoidance. 	More nuanced training for frontline, especially A&E, staff in suicidal behaviour would both improve attitudes and increase detection rates for those with serious suicidal intent. A considerable level of unmet need is implied here, and young males may need more assertive outreach.	Only focused on men who did receive help, even after a serious suicide attempt, not on men who continue to disengage.

Cole & Ingram (2020)	US	Quantitative	To understand the impact of self-stigma and gender role conflict on help-seeking in men.	<p>N=313, cross-sectional, role-play task.</p> <ul style="list-style-type: none"> • Self-Stigma of Help-Seeking Scale (SSOSH) • Gender Role Conflict Scale (GRCS). • 28 item list of how they might respond to the role-play. 	<ul style="list-style-type: none"> • Self-stigma negatively predicted professional help-seeking ($\beta = -.35, p < .001$) and informal support ($\beta = -.26, p < .001$) while positively predicting avoidance behaviours ($\beta = .34, p < .001$). • GRC was negatively associated with informal support use ($\beta = -.14, p < .001$) and positively associated with avoidant behaviours ($\beta = .25, p < .001$). • Self-stigma was also positively associated with GRC ($\beta = .37, p < .001$). 	High gender role conflict and self-stigma are significant barriers to help-seeking in men which encourages avoidance of tendency to seek help.	Lack of diversity among participants - mainly white and heterosexual. Only researched college males, so cannot be generalised to other education levels.
Good et al., (1989)	US	Quantitative	To examine both attitudes toward male roles and factors associated with men's gender role conflict and how they impact men's help-seeking attitudes and behaviour.	<p>N=401, cross-sectional, self-report measures:</p> <ul style="list-style-type: none"> • Attitudes Toward Men Scale (AMS) • Gender Role Conflict Scale-I (GRCS-I) • Attitudes Toward Seeking Professional Psychological Help (ATSPPH) scale • Help-Seeking Attitude and Behaviour Scale (HABS) 	<ul style="list-style-type: none"> • Regression analysis using male role variables to predict attitudes to help-seeking was significant ($F(4, 392) = 20.89, p < .001$), 17.6% of the variance in attitudes to help-seeking scores was explained by male role variables. • Restrictive emotionality, and restrictive affectionate behaviour between men were all significant predictors of attitude to help-seeking. 	The findings support the role of men's restrictive emotionality in decreasing both men's indicated likelihood of future help seeking and past help-seeking behaviour. Men may be more likely to terminate therapy early, therefore, more research is needed on how to keep men engaged in therapy.	Lack of diversity among participants - mainly white and heterosexual. Only researched college males, so cannot be generalised to other education levels.

Hammer et al., (2013)	US	Quantitative	To examine the relationship between traditional masculine norms, self-stigma, and attitudes towards counselling.	<p>N=4748, cross-sectional, online self-report measures:</p> <ul style="list-style-type: none"> • Conformity to Masculinity Norms Inventory (CMNI-22). • SSOSH • ATSPPHS-(Short Form). • The Center for Epidemiological Studies Depression scale (CES-D). 	<ul style="list-style-type: none"> • Self-stigma and traditional masculine norms play a role in formation of barriers to help-seeking in men. • Results showed significant differences in the relationships of conformity to masculine norms and self-stigma for men living in rural areas compared with men living in both suburban areas ($\chi^2=12.74$, $p<.001$), and urban areas, ($\chi^2=14.00$, $p<.001$). • There were also significant differences for men with a postgraduate degree ($b=.41$) and men with both a high school diploma or less ($b=.55$, $\chi^2=6.90$, $p<.009$), and a 4-year college degree ($b=.54$, $\chi^2=7.02$, $p<.008$). Men with a postgraduate degree exhibited a weaker connection between conformity to masculine norms and self-stigma. 	The central clinical implication is that self-stigma is an important barrier to seeking professional mental health services for men across community size, education, and income.	Most participants were self-reported depressed, and this may have impacted on their help-seeking barriers compared to those who are not depressed or deny being depressed.
Johnson et al., (2012)	Canada	Qualitative	To explore men's discourses for seeking help for depression.	N=38, semi-structured interviews, discourse analysis.	<ul style="list-style-type: none"> • Manly self-reliance (believing they can deal with problems themselves). • Guarded vulnerability. • Role of desperation. 	These barriers could be reframed as men attempting to seek out (or protect against rejection from) a desire to reach out, be heard, and discover genuine connection. It would be useful for Health	Study only explored health services as the only source of help instead of other systemic facilitators or barriers.

						service providers and policymakers to take men's attitudes to help-seeking into account as they attempt to engage men with the health system.	
Kwon et al., (2023)	Australia	Qualitative	To gain better insight into the reasons men give for their disengagement from mental health services and what men say will reengage them.	N=73, online survey, thematic analysis of qualitative data.	<ul style="list-style-type: none"> • <i>Autonomy</i> - strong desire for control in decision making with health professionals. • <i>Professionalism</i> - complained about the lack of professionalism among staff. • <i>Authenticity</i> – perceived health-care providers were not genuinely interested in them and not genuinely empathic. • <i>Systemic Barriers</i> - Three issues with the health care system identified as barriers: consistency, aftercare, and accessibility. 	It is recommended that mental health services set out specific goals when working with men, to maintain transparency, and offer men a range of services as these were specific barriers mentioned. Psycho-education could also be helpful for men to understand their mental health needs.	Specific ethnic, cultural, and sexual minority populations were underrepresented, and their reasons for engagement and disengagement may vary. The type of mental health conditions or diagnosis of individual participants was not asked which could have an impact on barriers to help-seeking.

Lynch et al., (2018)	Ireland	Qualitative	To explore barriers to professional help-seeking for mental health problems among young men.	N=17, focus groups (2 groups, 6 participants each) and semi-structured interviews (5 participants), thematic analysis.	<ul style="list-style-type: none"> • <i>Acceptance From Peers</i> – perceived help-seeking can cause negative social ramifications. • <i>Personal Challenges</i> - issues with communication, symptom recognition, and ineffective coping mechanisms. • <i>Cultural and Environmental Influences</i> - religious influences, generational divides, and rural life. • <i>Self-Medicating With Alcohol</i> - accepted way of coping with and escaping difficult feelings. • <i>Fear of Homophobic Responses</i> - impact of the stigma of being gay in a traditionally Catholic country. • <i>Traditional Masculine Ideals</i> - majority reported that professional help-seeking compromised their masculinity. 	Services and professionals should endeavour to show men genuine care and respect to create an engaging environment for men. Formal education could do more to implement mental health education in schools. Solutions need to be considered from an integrative approach to reduce barriers	Unable to generalise to other populations outside of Northern Ireland and were only able to recruit men from youth centres who may be more readily available to seek help than other men.
Rice et al., (2020)	Canada	Quantitative	To understand what barriers to help-seeking are more predictive of men's reluctance to seek help.	N=530, cross-sectional, online self-report measures: <ul style="list-style-type: none"> • Barriers to Mental Health Services Scale-Revised (BMHSS-R). • Patient Health Questionnaire (PHQ-9). 	Attitudinal barriers were more predictive than structural barriers in differentiating men's mental health help-seeking: <ul style="list-style-type: none"> • <i>I do not know the reasons people go to psychotherapy</i> ($p=.008$) – lack of awareness of MH issues. 	Suggests the use of researched strategies to engage men in services and to be employed for health care providers and educations.	Was unable to identify a distinct relationship between help-seeking and level of depression.

				<ul style="list-style-type: none"> • Suicidal Behaviours Questionnaire-Revised (SBQ-R). 	<ul style="list-style-type: none"> • <i>I need to solve my own problems (p=.012) – possible lack of vulnerability and self-autonomy.</i> • <i>I would not tell my physician if I was feeling down or depressed (p=.016)</i> • <i>It would be normal for me to be sad or down given the circumstances of my life (p=.033) – possible lack of awareness of minimisation.</i> 		
Rice et al., (2017)	Australia	Qualitative	To identify barriers to mental health care, in young help-seeking men and staff involved in mental health service provision.	N=25, semi-structured interviews (5 participants), and 4 focus groups, Thematic analysis.	<ul style="list-style-type: none"> • <i>Personal barriers</i> - the process of help-seeking appeared in conflict with internalised male role expectations. This occurred through stigma, shame, and a need to avoid being perceived as weak/vulnerable. Some reported discussing uncomfortable emotions was unfamiliar. • <i>Structural Barriers</i> - Lack of knowledge regarding available services, perceived lack of accessibility of services, and difficulty navigating the system. 	Gender role expectations greatly impacted ,men's help seeking behaviour and promoted health-risk behaviours such as minimising or ignoring symptoms. Added to weight of research promoting gender-based approaches in services.	Participants were already engaging in mental health services, therefore may not represent all barriers, especially for men who cannot or won't seek help.

Sagar-Ouriaghli et al., (2020)	UK	Qualitative	To identify potential approaches that would be relevant to improving mental health help-seeking in male students.	N=24, 3 focus groups, thematic analysis.	<ul style="list-style-type: none"> • Protecting male vulnerability – men did not want to engage as it was not “manly”. • Differences over intervention format – not knowing what the most suitable intervention would be. • Difficulty knowing when and how to seek help. 	These themes can be used to develop more male friendly interventions that are suitable for male students. This could help improve help-seeking attitudes and the uptake of mental health interventions for male students experiencing emotional distress.	Not generalisable for other education levels and outside of this age cohort of male students.
Seidler et al., (2020).	Canada	Quantitative	To understand which perceived barriers to help-seeking in men correlated highly with each other and were the best predictors of barriers.	N=778, cross-sectional, online self-report measures: <ul style="list-style-type: none"> • BMHSS-R • Kessler Psychological Distress Scale (K6). 	Men who did not want treatment were more likely to endorse the following barriers: <ul style="list-style-type: none"> • <i>A psychotherapist would not understand me or my problems (p=.002, V=.11)</i> • <i>I would not tell my physician if I was feeling down or depressed (p<.001, V=.15)</i> • <i>I am not sure if psychotherapy really works or is effective (p<.001, V=.15)</i> • <i>I need to solve my own problems (p<.001, V=.18)</i> • <i>I would not know how to find a psychotherapist, was more often endorsed as a barrier by those men wanting treatment (p=.001, V=.12).</i> 	The high endorsement of both structural (e.g., cost) and attitudinal (e.g., beliefs) barriers by respondents suggests that service delivery must adapt to better respond to dominant masculine ideals while also improving men’s ease of access into a transparent treatment process.	Barriers were pre-determined in a survey, not exhaustive, so more nuanced barriers may have been missed. Again, surveyed men who were already seeking help or in the process so may be missing a population of men who are not at that stage yet.

Staiger et al., (2020).	Germany	Qualitative	To explore men's experiences and attitudes toward depression, help-seeking, and service use in order to develop gender-sensitive services.	N=12, semi-structured interviews, narrative analysis.	<ul style="list-style-type: none"> • Men's attitudes toward coping with depression: critical stance toward masculine norms e.g. trivialising symptoms, hiding depression. • Men's perception of societal views on depression: the stigma of being depressed as "unmanly". • Experiences within the family context – loss of empathy, paternal role expectations. 	Peer-led men-only groups may increase participants' self-esteem and assist in disclosing weaknesses. In the context of GPs' mediating role, training for health professionals concerning the impact of masculine norms on mental health is recommended.	An older aged cohort may only capture this generation of men's attitudes and beliefs about help-seeking. Again, explored these with men who were accessing services, so may miss other barriers.
Sullivan et al., (2015)	UK	Quantitative	To determine, whether adherence to masculine norms, emotional expressiveness, and intimacy in close relationships were associated with UK men's attitudes towards seeking professional psychological help.	<p>N=536, cross-sectional, online self-report measures:</p> <ul style="list-style-type: none"> • Fear of Intimacy Scale (FIS). • Normative Male Alexithymia Scale (NMAS). • Male Role Attitudes Scale (MRAS). • ATSPPHS-SF 	<ul style="list-style-type: none"> • Traditional masculine ideology was negatively correlated with help-seeking ($r = -.191, p < .01$ [two-tailed]) • Normative alexithymia was found to be negatively correlated with help-seeking ($r = -.327, p < .01$ [two-tailed]) • Bivariate Pearson's correlation was carried out between fear of intimacy and help-seeking attitudes ($r = -.245, p < .01$ [two-tailed]). Fear of intimacy accounted for 6% of the variance observed in help-seeking. • Masculinity, normative alexithymia, and fear of intimacy accounted for 	Hypothesized consequences of male emotional and interpersonal development and male gender role socialization were associated with men's attitudes towards seeking psychological help.	As it was an online survey, it targeted a younger, white demographic that may not be generalisable to the rest of the UK. As this was an online survey, men may not have also felt the societal pressures as they were completing it alone.

					12% of the variance observed in psychological help-seeking.		
Tang et al., (2014)	Canada	Qualitative	To describe the connections between masculinities and college men's depression-related help-seeking.	N=21, semi-structured interviews, grounded theory.	<ul style="list-style-type: none"> Denying weakness – seeking help was seen as being “weak” by most participants. Limiting self-disclosure and mustering autonomy – a need to hide vulnerabilities and manage problems in their own way. 	The findings demonstrate connections between masculinities and help-seeking that can assist health care providers to understand the practices of college men who experience depression.	Did not note social classes of participants which may have been interesting to be aware of. No mention of researcher reflexivity during interview process to maintain integrity of research and bias.
Yousaf et al., (2014)	UK	Quantitative	To investigate whether there is a relationship between masculine attitudes and attitudes toward seeking psychological help.	<p>N=124 (51 females; 73 males), cross-sectional, online, and face-to-face measures:</p> <ul style="list-style-type: none"> The Inventory of Attitudes Toward Seeking Mental Health Services (IASMHS). Male Role Norms Inventory-Revised (MRNI-R). 	<ul style="list-style-type: none"> Men's gender role norms significantly predicted their attitudes to help-seeking ($F(1, 71) = 74.00, p < .001, \beta = -.23$) and there was a strong negative correlation ($r = -.71$). Younger men (18-40) also had more negative attitudes to help-seeking than older men. Men scored higher on gender norms scales than women. 	The finding that masculinity attitudes accounted for gender differences in attitudes to psychological help-seeking, suggests that the reason men hold more negative attitudes toward psychological help-seeking is their attitudes about how men should think and behave. This could be targeted by health care professionals by addressing men's masculinity attitudes.	Study was not open about its strengths nor limitations or the impact of the study on future research. Lack of demographic information given, nor reporting of results in tables.

Appendix 3

Critical Appraisal scores of studies

Authors and year	Study Design	Preliminaries	Intro	Design	Sampling	Data Collection	Ethical Matters	Results	Discussion	Total score/ percentage	Quality Rating
Berke et al., (2020)	Quantitative	5	5	5	4	4	3	4	4	34/85%	High
Cleary, A. (2017)	Qualitative	5	3	4	4	4	3	3	2	28/70%	Moderate
Cole & Ingram (2020)	Quantitative	5	5	4	4	4	3	5	5	35/88%	High
Good et al., (1989)	Quantitative	5	3	4	3	3	2	4	4	30/ 75%	High
Hammer et al., (2013)	Quantitative	5	5	4	4	4	3	4	5	34/85%	High
Johnson et al., (2012)	Qualitative	5	5	5	4	4	5	4	3	35/88%	High
Kwon et al., (2023)	Qualitative	5	5	5	5	5	5	4	5	39/98%	High
Lynch et al., (2018)	Qualitative	5	5	5	4	5	5	5	5	39/98%	High
Rice et al., (2020)	Quantitative	5	5	3	4	5	4	4	4	34/85%	High
Rice et al., (2017)	Qualitative	5	4	4	4	4	5	4	5	35/88%	High
Sagar-Ouriaghli et al., (2020)	Qualitative	5	4	4	5	5	5	5	4	37/93%	High
Seidler et al., (2020)	Quantitative	5	4	4	4	4	3	3	4	30/75%	High
Staiger et al., (2020)	Qualitative	5	5	5	5	4	4	4	5	36/90%	High
Sullivan et al., (2015)	Quantitative	5	5	5	4	5	5	4	5	38/95%	High
Tang et al., (2014)	Qualitative	5	4	3	3	4	3	4	4	30/75%	High
Yousaf et al., (2014)	Quantitative	5	4	3	3	3	1	2	3	24/60%	Moderate

Appendix 4

Author Guidance

The Journal of Men's Studies

Full author guidance can be found here: <https://journals.sagepub.com/author-instructions/MEN>

Manuscript preparation.

The Journal of Men's Studies publishes regular articles (7,500 to 8,500 words) and brief reports (2,500 to 3,000 words). Authors should prepare manuscripts according to the Publication Manual of the American Psychological Association (7th ed., 2019). Formatting instructions and instructions on the preparation of abstracts, text with designated headers (A-level through C-level), references, tables, and figures appear in the Manual. All copy must be double-spaced.

Abstract and keywords.

All manuscripts must include an abstract containing a maximum of 120 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References.

References should be listed in alphabetic order (also double-spaced). Each listed reference should be cited in the text, and each text citation should be listed in the References.

Paper 2: Empirical Paper

“I think self-harm to self-kindness is how it’s sort of developed over time”

The experiences of young men who engaged in self-harm during adolescence and help-seeking behaviours: An Interpretative Phenomenological Analysis (IPA)

Callum Trainor

This research has been written in accordance with author guidelines from *The Journal of Men’s Studies* with the intention of publication. A summary of submission guidelines for this journal can be found in Appendix A.

Word Count: 7,792

Abstract

Background & Aims: Prevalence rates of self-harm in young males has been increasing in recent years. Recent research regarding young people's experiences of self-harm has been largely focused on females. Research focused on male experiences is needed due links between prolonged self-harm use and death by suicide in males. This research aims to explore the experiences of young males' self-harm during their adolescence and any help-seeking behaviours used. This adds to the somewhat limited but expanding research area of young males' self-harm

Methods: Semi-structured interviews were carried out with seven young men (aged 18-24) who had previously self-harmed during their adolescence. Interpretative Phenomenological Analysis (IPA) was used to understand the participants' experiences of self-harm and help-seeking behaviours during adolescence.

Results: Five Group Experiential Themes were identified: You feel like your pain stopped; I deserve this; Misunderstood, judged and dismissed; A sense of connectedness: towards recovery; and Self-kindness rather than self-harm. These themes describe the experiences of why these young men felt they needed to self-harm and the unhelpful rhetoric some found when initially seeking help as well as the experiences that facilitated help-seeking behaviours and recovery from self-harm.

Conclusion: The findings show the experiences of these young males, with drivers for self-harming being experienced as a need for relief and to punish oneself. There was also a felt sense of being misunderstood by their social networks and the systems around them before experiences of recovery from self-harm were explored. Clinical implications for practice include support for teachers to explore these issues with male students and introducing compassion and acceptance skills for emotion regulation. Future research should explore utility of self-harm treatments and school support for adolescent males.

Introduction

Male self-harm prevalence is rising in the UK (Carr et al., 2016; Geulayov et al., 2016; Clements et al., 2019) with rates almost tripling since the turn of the millennium (McManus et al., 2019). Self-harming behaviour tends to begin during early adolescence (Hawton et al., 2012) with research suggesting that females are more likely than males to self-harm at this age (Arkins et al., 2013). Prevalence of self-harm is lower in males during early adolescence (males 8.5%, females 22.8%) but becomes much closer in late adolescence (males 20.1%, females 28.2%) (Patalay & Fitzsimons, 2021). This suggests that between early and late adolescence, there is rapid increase in young male self-harm. Adolescent self-harmers are 17 times more likely to die by suicide than their peers (Morgan et al., 2017) whereas adolescent and young adult males are more than twice as likely than their female peers to die by suicide (Miranda-Mendizabal et al., 2019; Royal College of Psychiatrists, 2020). With further research showing links between recurrent self-harm and risk of death by suicide in adults (Joiner, 2007; Kapur et al. 2013) and adolescents (Rodway et al., 2016; Olfson et al., 2018), it is becoming increasingly important to understand the experiences of men's self-harm from a young age, and their subsequent help-seeking behaviours.

Self-harm is defined as "an intentional act of self-poisoning or self-injury, irrespective of the motivation or apparent purpose of the act and is an expression of emotional distress" (NICE, 2022). The most common method of self-harm, without the intent to end one's life, is self-cutting in both adult and adolescent populations (Hawton et al., 2012; Cully et al., 2019). However, in males other methods are also common, such as burning and self-hitting (Victor et al., 2018). Much of the earlier research defines self-harm as self-cutting or self-scratching behaviours, failing to include the different self-harming behaviours that may be present in younger boys (Wilkinson, 2022). There is some discrepancy in the research regarding prevalence rates between cis-genders. Some research has shown that females are much more likely to self-harm (Arkins et al., 2013; Madge et al., 2008; Straiton et al., 2013), whereas other research presents very little or no difference (Klonsky, 2011; Victor et al.,

2018) especially in older adolescence. Though prevalence of self-harm tends to peak around mid-adolescence, around ages 15-16 (Plener et al., 2015), late adolescence is when there is a decreased gender disparity (Patalay & Fitzsimons, 2021). Prevalence rates are also increasing generally in this age group (Public Health England, 2014). This is of a particular public health concern due to the potential increased risks of developing mental health issues and higher prevalence rates of health risk behaviours in those who self-harm during mid-late adolescence (Kidger, 2012). This is especially significant in males as research has shown there to be links between repeated self-harm and death by suicide in males (McMahon et al., 2014). Therefore, it is imperative to understand the experiences underpinning young men's self-harm.

There is a wealth of research regarding common reasons for self-harm. Lloyd-Richardson et al. (2007) found common functions of self-harm were "to try to get a reaction from someone", "to get control of a situation" or "to stop bad feelings". Whilst these reasons apply to both cis-genders, male self-harm can have more nuanced reasons underpinning it. For example, Green and Jakupcak (2016) concluded that men's self-harm can be informed by traditional male gender norms such as not to express emotions openly, to show aggression and dominance, and to 'not appear like a woman'. Greene (2018) also suggested that self-harm in males may be used as a means to autonomously manage their own emotions and therefore be perceived to not need help/support from others. As a result, males may not present to services at the same levels as females or may use their support networks differently than females. This is in line with recent research that males are less likely to seek help for self-harm than females (Steinhoff et al. 2020). This reflects a wider trend relating to male help-seeking for mental health problems and talking therapies (Galdas et al., 2005; NHS, 2021). Men who self-harm may be overlooked by professionals and consequently are under-represented in current research regarding self-harm which shows a need to better understand this area and what support or adaptations might be utilised when working with men.

The above research largely focuses on adult males' experiences of self-harm but there is little research on the motivations and experiences of adolescent males' experiences of self-harm and help-seeking during that developmental stage. Birtwistle et al. (2018) state that early identification and intervention with self-harm can help to minimise distress and prevent unhealthy coping strategies from becoming entrenched patterns of behaviours, hence why understanding the experiences of young and adolescent boys is so important.

Rationale

Research exploring early adolescent experiences in young men would be useful in understanding risk factors, barriers to help-seeking, and what support may have been helpful to potentially reduce repeated self-harm incidents. Much of the recent research in this area focuses on the experiences of females engaging in self-harm, and subsequent help-seeking behaviours (Wadman et al., 2018; Hall & Melia, 2021; Miller et al., 2021; Bilello et al., 2024). Some research has focused solely on males, though this has typically been focused on adult males (Russell et al., 2010; Adamson & Braham, 2011), those who are currently receiving 'treatment' for self-harm (Hassett & Isbister, 2017) or is focused solely on recovery (Gabrielsson et al., 2024). The present research uses retrospective interviewing to explore the experience of young men's self-harm during their adolescence. This research will aim to explore all experiences of self-harm, not just recovery and open to young men who may never have sought formal help for their self-harming behaviours which offers a unique perspective into help-seeking and experiences of self-harm in general. Retrospective interviewing was also used due to the ethical dilemmas that would have arisen when exploring self-harm with children and adolescents. Younger men are also more likely to have insight that would be relevant to services more currently, rather than middle aged men, where services may have changed drastically since their youth.

Research Questions

What are the experiences of young males who previously self-harmed during adolescence?

What help-seeking behaviours (if any), both formal and informal, did they engage in to support them manage their distress and their self-harming behaviours?

Aims

The present research aims to explore the experiences of young males who self-harmed during adolescence.

The present research also aims to understand how young males managed their self-harm, how they explored seeking help for this, and any help-seeking behaviours they used, if at all.

Methods

Ethics

Ethical approval for this research project was granted by Staffordshire University Research Ethics Committee (Appendix B). Informed consent to participate in this research was given by all participants and pseudonyms were given for anonymity. Participants were also informed of their right to withdraw within the Participant Information Sheet (Appendix D). Due to the potentially emotive topic at hand, participants were debriefed once the interview had ceased and were given information regarding services which could offer further support. No participants appeared distressed during the interview but all were given the opportunity to take a break should they need to.

Research Design

A qualitative, retrospective study was undertaken using semi-structured interviews. Qualitative methodology was used as the research was interested in exploring the experiences of young males. This methodology allows for a “deeper understanding of experiences, phenomena and context” (Cleland, 2017). Semi-structured interviews were utilised as it allows participants to express their experiences and tell their stories in their own terms, compared with structured interviews which may be more prescriptive (DeJonckheere & Vaughn, 2019). Interview questions were determined by drawing upon existing research in

the area (Miller et al., 2021; Vafaei et al., 2023), through discussion with an academic supervisor and ethical considerations from the Ethics Panel.

Interpretative Phenomenological Analysis (IPA) was perceived to be the most suitable qualitative approach as it is concerned with sense making of individual experiences of the world. It allows for multiple individuals who may have experiences of similar events to tell their stories. IPA aims to generate experiential themes at the individual level compared with other qualitative methodologies which may have a varied focus (Smith et al., 2022). IPA is favoured over other qualitative approaches when dealing with subject matters that are complex, ambiguous, and emotionally laden (Smith & Osborn, 2014); such as self-harm. Due to the emotive nature of the research question, IPA is deemed to be an appropriate research methodology as it “shows sensitivity and respect to the lived experiences of the research participants” (Alase, 2017). It also engages the researcher in the ‘double hermeneutic’; the researcher is making sense of the participants’ sense making. The researcher assumes a central role in analysis and interpretation of the participants’ experiences (Harper & Thompson, 2012). Therefore, the researcher intends to probe the surface-level meanings by reading in between the lines for deeper interpretation (Montague et al., 2020).

Epistemology and Reflexivity

The lead researcher held a social constructionist stance when conducting this research and analysis. The lead researcher held the view that knowledge is socially constructed via interaction with the world around us as opposed to created or discovered (Bryman, 2004). This is particularly salient to this research as gender can be considered a socially constructed concept and so ideas about what it means to be a “man” who self-harms and seeks help, are likely to be influenced by this.

Reflexivity in qualitative research is the practice of focusing the lens back on the researcher in order to recognise and take account of biases and accounts that may have impacted the

research (Berger, 2013). Reflexivity has been established as a way of ensuring rigor and quality in qualitative research and a means for determining trustworthiness (Teh & Lek, 2018). Bracketing was utilised during the analysis by analysing one interview at a time to decrease the likelihood that previous interviews influenced the next. However, this is not always possible and there are likely some influences on the data from the previous interviews. To account for this, the lead researcher kept a reflexive journal in order to identify any personal biases or influences during the research process that may incidentally affect the research analysis.

As the researcher jointly constructs meaning and sense-making with the participants it was important to consider the potential influences or biases the lead researcher brought to this research. The lead researcher identifies as a young adult male with both professional and personal experiences of self-harm and help-seeking. Therefore there may have been preconceived assumptions regarding self-harm in males, such as that there is a considerable influence by 'toxic' masculinity or that men may minimise the severity of their self-harm.

Recruitment

Purposive sampling was used for this study. This is particularly useful in IPA as there is a need to generate a fairly homogeneous sample to capture the experiences of a specific group who have experienced a particular, similar phenomenon (Gerald Gauci, 2019).

Twelve colleges and universities within Staffordshire and Shropshire were contacted to disseminate recruitment posters to students; three agreed to promote it. Recruitment posters were also displayed at Staffordshire University campuses. A recruitment poster was also advertised on men's mental health groups on social media sites such as Facebook and Reddit. Recruitment posters were also shared by peers and promoted on Instagram and LinkedIn (Appendix C). Potential participants were directed to a registration form on MS Forms to declare their interest in participating in the research project and that they met the

inclusion criteria. They were then subsequently contacted via email to arrange an interview (Consent Form and Participants Information Sheet were attached, Appendices D & E); if there was no reply, potential participants were contacted once more before ceasing contact. There was a space for participants to ask questions about the research prior to being contacted.

To be eligible, participants needed to be male, between the ages of 18 and 24 and had previously self-harmed on at least one occasion during adolescence. The World Health Organization (2023) defines adolescence as being between 10-19 years of age. However, as shown earlier, research has found that onset of self-harm behaviours usually begins at ages 12-13 and peaks in mid-late adolescence; 15-16. Since these seem to be key ages 12-16 is the age range referred to when speaking about experiences during adolescence. Different methods of self-harm, such as hitting, burning, and jumping from a height, were outlined on the recruitment poster to encourage participants who used other methods of self-harm to take part. Again, younger adolescent boys may self-harm using different methods (Barrocas et al., 2012), therefore it was important this was made explicit on the recruitment poster. Recruitment took place between September 2023 and March 2024.

Participants

Seven males aged between 19 and 22 years (mean 20.7 years) took part in this study; within the range of 6-10 interviews suggested by Smith et al. (2022) when conducting doctoral research. A small sample is preferred in IPA research as depth and richness of the data is most important and is more easily achieved with a smaller sample (Smith et al., 2022). Thirty-one people expressed interest in participating in the research. Only nine replied and agreed to take part. Two participants did not attend their scheduled interview. One stated that family difficulties prevented him from being able to participate whilst the other did not state a reason. Participant demographic information is shown in Table 1. Participants were from across the UK.

Table 1

Participant Demographic information

No.	Pseudonym	Age	Sexuality	Ethnicity	Age at first self-harm	Method of Self-harm	Child services accessed?	Education Level
1	Oliver	20	Homosexual	White British	12/13	Hitting	None	Undergraduate (studying)
2	Troy	21	Bisexual	Mixed Race	12/13	Cutting	CAMHS	Undergraduate (studying)
3	Thomas	20	-	White British	11	Cutting	CAMHS/School counselling	BTEC
4	Freddie	22	Heterosexual	White British	13	Cutting	School counselling	Undergraduate (studying)
5	Adam	22	Bisexual	White British	12/13	Restricting food intake & Strangulation	None	Masters (studying)
6	Matthew	19	Bisexual	White British	8/9	Strangulation & Cutting	CAMHS	Level 3 Diploma
7	Luke	21	Heterosexual	White British	15	Cutting	None	Masters (studying)

Procedure

After individuals expressed an interest in taking part in the study, consent forms were sent with a participant information sheet explaining the purpose and aims of the research (Appendices D & E). Once participants had consented to the research, by returning signed consents forms, a mutually agreed time was arranged for the interviews to take place.

Semi-structured interviews were conducted via Microsoft Teams video call. An interview schedule consisting of twelve questions was used (Appendix F). Examples of questions were “What was happening in your life at that time that you believe prompted you to self-harm?”, “Did you seek any professional support?”, and “What (other) support do you think would have been helpful/supportive at the time?”. A debrief was given after the interview to check-in emotionally with the participants due to the topic area. A debrief information form (Appendix G) was also sent via email that outlined the study details and contained self-help numbers should participants have been affected by the interview. Interviews were video recorded and transcribed using the built-in transcription tool within Microsoft Teams. This was then corrected by the researcher. Interviews lasted between 28 and 63 minutes (mean 39 minutes).

Analysis

Analysis was conducted following guidelines outlined by Smith et al. (2022). The researcher immersed themselves in the data by reading the transcripts and listening to recordings of the interview, several times. Once the researcher was familiar with the interview, they began to make initial descriptive and exploratory notes on Word, next to the transcript. Following this, personal experiential statements were made using the initial notes. Transcripts were then re-read to ensure the identified themes reflected the participant's words and maintain the hermeneutic circle. These experiential statements were then examined in chronological order to make sense of the interview as a whole. These were printed and cut out to make it easier to form patterns and connections. Each interview's Personal Experiential Themes (PETs), and subthemes within these were made based on these connections and patterns. When certain clusters of themes appeared, these were colour coded across the interviews. For example, PETs and subthemes that seemed to be related to 'reasons for self-harm' were coded in red. To stay with the idiographic focus of IPA, each interview was analysed separately. Again, transcripts and experiential statements were re-read to ensure they capture the 'whole' text accurately without losing meaning. Once this had been completed, further links and connections were made across the interviews to develop Group Experiential Themes (GETs).

Personal and group themes were brought to a peer group to account for any further biases and to review the relevance of the themes to the data. Trustworthiness, rigor, and transparency was established by having a documented analysis process to provide a clear audit trail and using direct participants' quotes. Finally, participants were given a draft of the executive summary and provided feedback regarding whether it represented their experiences accurately.

Results

Through a process of analysis, five Group Experiential Themes (GETs) and four subthemes emerged from the data. These themes were included due to being well supported within the

data by being present in at least half of the participants which is supported by Smith et al. (2022) for theme plausibility. These themes are described below with quotations direct from the transcripts.

Table 2

Table of Themes

Group Experiential Theme	Subthemes	Present in Participant(s)
You feel like your pain stopped	Overwhelming and intense emotions	1, 2, 3, 4, 5, 7
	Relief. Every time.	1, 2, 3, 4, 6
I deserve this	It was like a punishment	1, 3, 5, 6
	I just hated myself	2, 3, 6, 7
Misunderstood, judged, and dismissed		2, 3, 4, 6, 7
A sense of connectedness: towards recovery		1, 2, 4, 5, 7
Self-kindness rather than self-harm (accepting emotion)		2, 4, 5, 7

Theme 1: You feel like your pain stopped

This first theme describes the sense that participants used self-harm as a means to manage their emotional pain. Self-harm was seen as a strategy to bring relief to distressing and overwhelming emotions.

Overwhelming and intense emotion

The majority of participants described struggling with overwhelming emotions that directly precipitated their self-harm as adolescents and feeling unsure how to regulate this. The emotion varied between participants but all noted that the intensity of emotion or the feeling of being overwhelmed with emotion led directly to them self-harming as a way to manage these emotions.

“So like I said, it used to be something would happen when I was feeling just, I guess, like intensely just shameful or upset with myself . I think I still have strong feelings like that sometimes” (Adam)

Adam describes feeling intense and strong emotions that would precipitate his self-harming. The word “intensely” shameful or upset suggests that his self-harm did not occur whenever unpleasant emotions showed up but actually when it became too much; overwhelming.

“So sometimes it’s out of anger. I remember often doing it, feeling so angry that I didn’t know what to do with myself, so I took it out myself and sometimes just out of feeling upset. Feeling worthless?” (Freddie)

Freddie described a number of different emotions he felt around the time of self-harming. It suggests that the overwhelming emotion alongside not having the knowledge as a young teenager to either self-soothe or reach out for support, led to Freddie taking his emotion out on himself.

“I was very much “a bottle it up and deal with it later” kind and I think that’s what caused it to spill over.” (Luke)

Luke’s use of a metaphor here to explain his emotion regulation also further demonstrates the feeling of being overwhelmed with emotions before self-harm. He would “bottle it up” but did not necessarily have the strategies as an adolescent and therefore his emotions would “spill over” – tip him over the edge with his emotional capacity and therefore lead him to self-harm as a way to manage this.

Relief. Every Time.

There was a sense that a perpetuating factor for the participants’ self-harm was that they obtained a sense of relief from their emotions by self-harming, if only temporarily.

Participants wanted relief from their overwhelming emotions and achieving this by self-harm only seemed to reinforce the behaviour for them.

“Relief. Every time.” (Matthew)

When asked about how self-harm made him feel immediately after, Matthew had a direct, concrete answer. His response suggests a reinforcing consequence for self-harm and likely how many people get stuck in cycles of self-harm; it is not just a one-time occurrence.

“...you know, almost being exciting and sort of like to feel something, almost like a relief or release in some senses.” (Troy)

Again, Troy describes a sense of needing to feel some sort of relief or release from his emotional pain and self-harm being the answer. He also describes the cycle as being “exciting”, again further suggesting that the relief felt by some after self-harm is reinforcing.

“...I guess also the feeling of pain as well kind of gives you something else to focus on rather than what's going on in your head and it almost externalizes what you're feeling. You know, you're feeling mental pain and you know, [this] kind of stuff and it turns into physical pain. And then once the physical pain stops, you know, you see the blood coming out once you stop it. Then I guess you kind of feel better. You feel like your pain stopped.” (Freddie)

Freddie likens his emotional pain to the physical sensation of pain and the sight of his blood. When the pain and the blood stops, he not only feels relief from physical pain but he also synonymously feels relief from emotional pain.

Theme 2: I deserve this

There was a sense from participants that their self-harm and the pain they inflicted on themselves was somewhat deserved. This was due to feeling like they needed to be punished, because they had such low self-esteem, or were experiencing feelings of shame and worthlessness.

It was like a punishment

The majority of the participants described a need to punish themselves as a driver for self-harm. At times this was experienced as a consequence for past wrongdoings or specific characteristics about themselves. For example, being/feeling different to others or because of a general lack of self-worth and self-hatred.

“Sometimes it was just to cause an element of damage and [to] cause pain to oneself, but yeah, that was the main thing to [it] kind of. It was like a punishment, almost.”

(Thomas)

Thomas describes a drive or need to inflict damage and pain on himself, perhaps to punish himself. Reading into his transcript, he felt the need to punish himself for feeling so low in mood but also due to his difficulties in social relationships due to his neurodiversity. Self-harm was possibly a punishment to himself for feeling ‘different’ or struggling to make friends which Thomas refers to in his interview.

Oliver also stated a desire to punish himself because of differences he felt with his sexuality.

“And the only way I could kind of justify it is hit myself as like oh, you deserve this.

You're not right.” (Oliver)

By telling himself that he is “not right”, he is further justifying the need to punish and self-harm, as if it is a societal norm to punish things that are ‘not right’ or difficult to accept.

Adam attempts to compare his self-harm to a religious metaphor, again on the basis that he feels like he is “not right” or different somehow and therefore this deserves punishment.

“I guess it was just like a sort of self-flagellating sort of thing, that's not quite the right term, but just like I don't know, like I've done something wrong or I'm not right. So I should do this because it'll I don't know just make it feel like I'm doing something to - I guess like get what I deserve with it.” (Adam)

Self-flagellation refers to the practice of flogging oneself either for religious purposes or for discipline. Though ‘flagellation’ in its own right refers to any form of punishment.

I just hated myself

This subtheme captured the experiences that some participants had prior to self-harming. There was a sense that most of the participants experienced a feeling of self-hatred and self-loathing which precipitated a self-harming incident or continued to perpetuate this behaviour.

"I know I hurt myself a good few times because I was just quite low, I just hated myself." (Matthew)

Matthew states that he remembers self-harming as a direct result of his self-hatred and low self-esteem throughout his adolescence. Whereas Thomas shared that his self-hatred of himself perpetuated his self-harm, pulling him into a vicious cycle.

"...but then also sort of a feeling of hatred, thinking: Was this enough? Did I harm myself enough?" (Thomas)

The way in which Thomas questions his self-harm suggests that he also feels he deserved this pain he dealt upon himself. There was a need to make sure that he felt enough pain to satisfy what he thought he deserved.

Others conveyed their self-hatred by referring to lots of shame they felt about who they were or their feelings of worthlessness, conveying that they held no value or regard to themselves.

"Focused around like feeling worthless or that people didn't actually like me. That was the key threads that I'd pull up." (Luke)

Theme 3: Misunderstood, judged, and dismissed

This theme refers to barriers to help-seeking that the participants faced when making attempts to reach out for support. Participants described experiences where they felt misunderstood, dismissed, and unheard by the people around them. Most either described unhelpful experiences with friends and families but others also described poor experiences with health services that also left them feeling dismissed. Due to these experiences, they

described a lack of willingness to seek support due to fears about what people might think about their self-harm or that people would not understand.

Thomas and Troy recount their perceptions of how people reacted with shock to their self-harm which possibly confirmed their beliefs regarding the stigma around self-harm:

“I think [there is] a sort of the reaction of saying ‘I’ve self-harmed’ - I feel like the reaction people have isn’t very helpful. It’s a bit of like a shock. ‘Why you doing this?’ sort of thing and it’s not particularly helpful.” (Thomas)

“Yeah, and there’s definitely a sort of, if you were to show [self-harm] there’s definitely a sort of a stigma of attention seeking. ... sort of ‘Oh my God’ or judgment or that background level of that underlying tone of ‘are you just doing this for attention?’” (Troy)

Freddie had many different layers to his experiences and beliefs around other’s perception of his self-harm. Initially he feared the repercussions of acknowledging his self-harm to professionals and the potential consequences for his future career prospects.

“I hid my self-harm for quite a while because I was worried about how it impact[ed] on my career and about hav[ing] a record would impact on [me] being able to study medicine...” (Freddie)

Freddie also demonstrated how people dismissed his mental health and self-harm struggles to unrelated, external factors:

“This death stick here is apparently also the source of all my problems. (shows vape stick to the camera)” (Freddie)

The tone in which Freddie implies that vaping is the “source to all his problems” implies that his self-harm is something that could be ‘fixed’ by something as straightforward as stopping vaping, not considering, or understanding the complexities behind why many people start and continue to self-harm.

Though he hadn't reached out to many people for support, hearing the way in which others talk about self-harm in a stereotypical way, has had long term consequences for Luke's beliefs around help-seeking:

"...never with someone that I've actually told, but I have had discussions with people around [me] viewing self-harm as attention seeking or, yeah, mainly like crying for attention which makes it feel uncomfortable for me to then bring up the topic...." (Luke)

Finally, Thomas shares an unhelpful account of when he presented to A&E for medical assistance regarding his self-harm injuries:

"...and I think a couple times I'd self-harmed and ended up having to go to A&E [and] the reaction I'd got from the staff of A&E massively affected me... There was a sort of shaming and saying things like, 'what are you doing this for? Attention? Is this really what we want to do? It's your life' sort of thing. I think that was not particularly helpful." (Thomas)

Four of the participants who did reach out to mental health services for support, found that services were hard to reach or could not meet their needs. Two participants described being told they were not "risky enough" to be seen by CAMHS which ultimately led them to feeling let down and dismissed by services.

"That was the problem. Yeah, they never considered me risky enough" (Matthew)

"CAMHS didn't take my case serious enough to provide a (service). But I mean, oh, there was a brief span, but I wasn't on the suicidal side enough that they could afford to work with me." (Troy)

Theme 4: A sense of connectedness: towards recovery

Though participants struggled with experiences of being dismissed, unheard and feeling misunderstood throughout their adolescence, it was a sense of connectedness to others and themselves (internal sense of self) that led them to develop healthier ways of coping. This

did not come across as a sudden change but a gradual approach as they had positive experiences with those around them regarding talking about their self-harm.

Troy spoke about his first experience with a private counsellor and how her way of approaching and reacting to his self-harm was so different to what he had previously experienced.

“I went back to the private counsellor that I [had] gone to when I was about 11 whilst I was on this waiting list and [told] her about self-harm...

She was so incredibly nonchalant about it in a caring but nonjudgmental way, a sort of, ‘yeah, I get it’.” (Troy)

The non-judgemental way in which Troy describes his counsellor reacting to his disclosure made him feel like she understood him, especially in the way he assumed that she ‘gets it’. It is likely that Troy felt understood and connected to his counsellor.

All but one participant spoke about the importance of those around them in their path to recovery from self-harm and a sense of being listened to and heard by others. Most spoke about how talking to friends or partners who were understanding and non-judgemental was important in helping them with their self-harm behaviours and thoughts:

“And then I told a few of my friends as well. I was like, ‘I’m doing this’. I realised it’s not right and they’re like ‘Yeah, OK. If you ever need us, we’ll be here’.” (Oliver)

“Yeah, I guess talking to people, talking to people and I’m really lucky with the people I’m living with.” (Freddie)

One participant spoke about the importance of having a support network as he got older which was something that he was lacking in his earlier teenage years:

“I think the main thing was really just connecting with other people and like, gain[ing] a bit more like self-respect really.” (Adam)

Having people around him who he could connect to, helped him with his self-respect and image of himself. When he found this new sense of self-respect, it played a large role in managing his emotions and self-harm.

Theme 5: Self-kindness rather than self-harm

This theme describes the experiences that participants felt supported their self-harm recovery. They reflected that treating themselves with compassion or kindness often helped with their ability to manage distressing emotions when they arise and possibly counteracted this need for punishment too.

“You know, I think self-kindness rather than self-harm is how it's sort of developed over time.” (Troy)

Self-kindness was also demonstrated as activities or skills they practiced and not just a change in their thinking. For example, something as simple as taking time out of their day, for themselves, something they know will help their overall wellbeing:

“...being kind to yourself, leaving the work at home, going for a coffee, just sit and have an afternoon of you know relaxation outside of being in a library.” (Troy)

“Going out for coffee for myself, I think is one of the best things I can do for my mental health. Because I like a good coffee me. And yeah, just for like myself. Just say whether I'm studying, reading a book or just doing nothing - I find that really makes me feel better, and I think that's one of my main coping mechanisms. Or going to the beach. Going to beach works great as well.” (Freddie)

Whereas other times, adopting a more accepting stance towards emotions, and allowing them space, benefitted them:

“But I think knowing that's one way to treat myself has taught me to just step back every time I do feel shame and think, OK, this is something that I'm feeling, it's OK to

be feeling this, but it's not OK to treat yourself badly because of this, you know.”

(Adam)

Adam discusses how he now has developed the skill to be able to acknowledge and accept any emotion that comes up for him, even if they are distressing emotions. He is able to take a ‘step back’ and do something different, instead of self-harming.

“I thought it was silly to originally start, but I've been journaling and meditating and that seems to be helping in that it gives me like space to process what I'm actually feeling rather than bottling everything up and then exploding.” (Luke)

Luke also describes how certain mindfulness practices give him space to be able to process and understand his emotions. Instead of bottling up his emotions until they become overwhelming, he is able to allow the unpleasant emotion to come and go.

Discussion

Key Findings

The aims of the study were to explore the experiences of young men who had previously self-harmed during adolescence and also to attempt to understand how they explored seeking help for their self-harm, if at all. Five GETs emerged from the data: (1) You feel like your pain stopped; (2) I deserve this; (3) Misunderstood, judged, and dismissed; (4) A sense of connectedness: towards recovery; and (5) Self-kindness rather than self-harm. Much of the current literature regarding experiences of adolescent self-harm focus on female experiences. The present research therefore demonstrates the experiences of a community sample of males, across the UK, both who have and have never accessed services during adolescence, and a younger sample to provide more recent insights into the experiences of male self-harm.

Emotional pain and relief

Participants shared that not being able to manage overwhelming emotional pain was a main precipitating factor for self-harm. This is in line with previous wider research into functions of self-harm “to stop bad feelings” or regulate their emotions (Klonsky, 2007; Lloyd-Richardson et al., 2007; Miller et al., 2021) and in line with research specific to males (Power et al., 2015; Gardner et al., 2016). There was also a sense of relief that came from self-harming which then reinforced the self-harm and perpetuated the self-harming cycle. Again, something that has been well established in the wider research regarding functions of adolescent self-harm (Rodham et al., 2004; Scoliers et al., 2008; Rasmussen et al., 2016) and adult male motivations to self-harm (Adamson & Brahman, 2011; Power et al., 2015). This present research offers a unique perspective in that some of these participants have never accessed formal services previously and utilised informal support networks. This research also shows that these are still the main motivators and reasons for self-harm earlier in the lifespan for males and within a community setting.

Self-punishment and self-hatred

Some of the participants shared that their experience of self-harm served as a punishment to themselves and they felt they “deserved it”. Recent research (Edmondson et al., 2016; Stänicke, 2021;) supports this as a prominent reason for self-harm, typically among young females, so it is interesting that this was also a notable theme amongst these young male participants.

There was also a strong feeling of self-hatred or worthlessness that led to or perpetuated some of the participants self-harming behaviours. This is reported in the wider research also but appears mainly in female focused studies (Hooley & St Germain, 2013; Powell et al., 2013).

Misunderstood, judged, and dismissed

Most participants found that other’s beliefs and attitudes towards self-harm impacted on their willingness to reach out for support. Some shared unhelpful experiences where the belief

and stigma that self-harm is 'attention seeking' was held. Research has shown that fear of being stigmatised, especially as 'attention-seeking' has long been a barrier to help-seeking (Biddle et al., 2007; Rowe et al., 2014). This would explain why the young men in this study were reluctant, at first, to share their self-harm with others when there is a socially constructed belief and stigma that their self-harm is 'just for attention', when in fact the functions of self-harm in men are incredibly more nuanced and complex (Toftthagen et al., 2021). One participant shared an example of how he felt judged and dismissed when presenting to A&E after a self-harm incident. This response is often unhelpful to patients, prolonging their distress (O'Keeffe et al., 2021). Research has highlighted that more support and education is needed to A&E staff to effectively support people who present with self-harming behaviour and injuries (Friedman et al., 2006; McCann et al., 2006).

A sense of connectedness: towards recovery

Participants shared that when they experienced people or professionals who were compassionate and understanding, it helped them to feel like they could make changes to their behaviour and talk about their experiences more. This is understandable considering when they felt misunderstood and judged, they would continue their silence and suffering. Previous research has shown that a sense of connectedness and social support outside of the family was a protective factor to help-seeking (Boydell et al., 2023). Though there is some research regarding help-seeking facilitators in young people (Rowe et al., 2014), there is a paucity of research regarding help-seeking facilitators and self-harm.

Self-kindness rather than self-harm

Being able to 'take a step back' and accept unpleasant emotion was a strategy that participants discussed helped with managing their self-harm urges. This is in line with previous research regarding the use of acceptance-based emotion regulation in people who self-harm (Gratz et al., 2012). Furthermore, acceptance of emotion are core concepts used within Acceptance and Commitment Therapy (ACT) and Dialectical Behaviour Therapy (DBT

– radical acceptance) which have both been shown to be effective when working with people who self-harm (Tighe et al., 2018; Kothgassner et al., 2021).

Participants also shared that being kinder and compassionate to themselves helped with their self-harm. They spoke about taking time for themselves, practicing mindfulness approaches, and putting their own needs first. Previous research has shown that being self-compassionate and self-forgiving are important protective factors regarding urges to self-harm (Cleare et al., 2019). Meditation and mindfulness are also key strategies to cultivate not only self-compassion but also acceptance of emotion (Baer et al., 2006) which highlights why this may be an important skill for young men to adopt.

Only one participant spoke about their experiences of self-harm being related to their sexuality, despite most of the participants identifying as non-heterosexual. Those who identify as LGBTQ+ are more likely than heterosexual people to struggle with mental health difficulties, more likely to attempt suicide, and deliberately self-harm (King et al., 2008); especially bisexual people (Dunlop et al., 2020) and gay men (Skegg et al., 2003). Other participants did not disclose their sexuality as a factor in their self-harm possibly due to the present study not being specifically about sexuality. However, it is likely that this did play an important role in their self-harming motivations.

Clinical Implications

The findings in this research highlight a need for more support in schools for young boys regarding expressing and feeling their emotions, rather than bottling emotions up or ignoring them, as seen in traditional masculine methods of dealing with emotion (Hill et al., 2020). Emotion dysregulation plays a key role in elevating risks of self-harm regardless of gender or age (Wolff et al., 2019) and something the young men in this study experienced as a precipitating factor for their self-harm. Boys also have a lower tendency to seek social support for emotional difficulties than girls (Schlesier et al., 2019), therefore the responsibility may fall on the teacher-child relationship or on teaching the child self-soothing and

regulating skills. There is also a role for clinical psychology within this. As there is more emphasis on links between CAMHS and schools (Department for Education, 2017), Clinical Psychology could offer support to the school and teachers. This could be determined by the use of reflective spaces for teachers to explore students' issues. Clinical Psychologists could also offer training support to teachers and other staff on how to support young people with self-soothing and other therapeutic techniques that have been shown to be effective when working with self-harm in young people.

Utilising therapeutic approaches with young males on how to manage their emotions and self-harm behaviours could also be thought about within services. There is an emerging evidence base to support the efficacy of using ACT with self-harm (Tighe et al., 2018; Jalali Azar et al., 2023), though more research is needed for adolescents and its use in schools. Radical acceptance is also used within DBT and is often used with adolescents to manage self-harm urges and behaviours effectively (Mehlum et al., 2019). The use of self-kindness referenced within the themes also points to a Compassion-Focused Therapy approach (Gilbert, 2014). Again, treating oneself with compassion and kindness in the face of difficult emotions and adversity lead these participants to being able to manage their emotions and self-harm with more socially acceptable methods.

There also needs to be a wider understanding on how to support young males when they disclose their self-harm through more psychoeducation for young males' support network. This could be in collaboration with schools and mental health services, but also from a community psychology approach to reach wider support circles and networks. This is especially important as shown in the data and recent research, that unhelpful responses can have further consequences on people's willingness to seek help (Tan et al., 2024).

The role of friends and family was vital to support them through their self-harm, despite early incidents of feeling unheard and misunderstood. Five of the participants spoke about the role in which friends, families or partners played in breaking down the stigma of self-harm in males and facilitating help-seeking behaviours. Supporting families on managing disclosure

is most important as familial disclosure by adolescents has shown to facilitate informal help-seeking, improve coping and reduce suicidality (Hasking et al., 2015). Whereas disclosure to peers may encourage self-harming in the friendship group (You et al., 2013). Again there is a lack of research in this area regarding males.

Limitations

The small sample size is a necessary feature of IPA as it allows for in-depth exploration of participants experiences. The results are not intended to be generalisable but can give insight into a similar group. However, it should be noted that this sample was predominantly White British. Research shows that self-harm in non-white men is even more nuanced and might have other socially constructed implications that underpin non-white men's motivations to self-harm (Rojas-Velasquez et al., 2020). For example, what it means to be a black man and seek support and wider systemic issues such as racial discrimination (Coimbra et al., 2020).

Using a retrospect study design also presents some limitations. For example, asking young men to recall experiences that may have occurred around ten years ago presents potential issues with recall. Therefore, experiences may have been missed and prone to recall bias.

Most of the sample were also highly educated which suggests that the experiences of young men from other socio-economic backgrounds was not heard. Research again has shown that most highly educated men (men with graduate education) are more likely to seek support for their self-harm than men from lower class backgrounds and are less influenced by constructs such as masculinity that may impede help-seeking (Hammer et al., 2013). Due to the method of data collection, the experience of those without internet access, limited digital literacy or those who do not use social media may have been missed.

Future Research

Future research should consider investigating the facilitators to help-seeking in young males and the ways in which self-harm can be 'treated' effectively in males. There are already DBT

protocols for adolescents that can be utilised (Kothgassner et al., 2021) to understand any gender differences when 'treating' self-harm with this approach.

There is also a need for research to understand school support for young males regarding self-harm and mental wellbeing in general compared to females due to potential differing needs and beliefs about self-harm in males. School staff are often the front line for self-harm support so it would be interesting to understand young boys' experiences of help-seeking at school but also school staff's experiences of self-harm disclosure from boys.

Finally, as informal support systems were often used by this young male sample, it would be useful to build on recent research about female friend's experiences of self-harm disclosure by their peers (Hall & Melia, 2021). Disclosure by male peers may have different implications on how peers manage this disclosure due to gender constructs and masculinity.

Conclusion

The present study explored the sense young males made of their self-harm and help-seeking throughout adolescence. Functions of self-harm were similar to what is known about adolescent females' functions of self-harm in the wider literature but this research adds the experiences of young males to this literature. These young men also spoke about what inhibited and facilitated their help-seeking as they moved into late adolescence and adulthood. There is a need for more support in schools regarding emotion regulation for young boys using strategies from established therapeutic approaches such as ACT, CFT and DBT. Future research could look into the effectiveness of these approaches with an adolescent male population and self-harm.

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Appendices

Appendix A

Author Guidance

The Journal of Men's Studies

Full author guidance can be found here: <https://journals.sagepub.com/author-instructions/MEN>

Manuscript preparation.

The Journal of Men's Studies publishes regular articles (7,500 to 8,500 words) and brief reports (2,500 to 3,000 words). Authors should prepare manuscripts according to the Publication Manual of the American Psychological Association (7th ed., 2019). Formatting instructions and instructions on the preparation of abstracts, text with designated headers (A-level through C-level), references, tables, and figures appear in the Manual. All copy must be double-spaced.

Abstract and keywords.

All manuscripts must include an abstract containing a maximum of 120 words typed on a separate page. After the abstract, please supply up to five keywords or brief phrases.

References.

References should be listed in alphabetic order (also double-spaced). Each listed reference should be cited in the text, and each text citation should be listed in the References.

Appendix B

Ethical Approval



School of Health, Science and Wellbeing

ETHICAL APPROVAL FEEDBACK

Researcher name:	Calum Trainor
Title of Study:	SU_22_253: Exploring the experiences of young men who engaged in self-harm during adolescence and help-seeking behaviours following self-harm
Status of approval:	Approved

Thank you for addressing the committee's comments. Your research proposal has now been approved by the Ethics Panel and you may commence the implementation phase of your study.

Please note the Chair of UREC is Nachi Chockalingam: N.Chockalingam@staffs.ac.uk
You should note that any divergence from the approved procedures and research method will invalidate any insurance and liability cover from the University. You should, therefore, notify the Panel of any significant divergence from this approved proposal. This approval is only valid for as long as you are registered as a student at the University.

You should arrange to meet with your supervisor for support during the process of completing your study and writing your dissertation.

When your study is complete, please send the ethics committee an end of study report. A template can be found on the ethics [BlackBoard](#) site.

Signed: 

Date: 19/05/2023

Dr Jade Elliott

Ethics Co-ordinator
Psychology
School of Health, Science and Wellbeing

Appendix C

Recruitment poster

RESEARCH OPPORTUNITY

Exploring the experiences of young men who engaged in self-harm during adolescence

WHY IS THIS IMPORTANT?

- There has been lots of research attempting to understand the experiences of young people who self-harm.
- However, very little of this research focuses on young men's experiences and what can be done to support them.
- This could be a great opportunity to share your own experiences with the hope that it could contribute to the wider research in the area and impact how services can support men's mental health in the future.

CAN I TAKE PART?

- ✓ Male aged between 18-24 years old
- ✓ Have self-harmed* on at least one occasion during adolescence (between the ages of 12 and 16)
- ✓ Are able and comfortable to talk about their past experiences of self-harm
- ✓ Live in the UK and have access to the internet (for interview purposes)

* Self-harm can be defined as (but not limited to) cutting, scratching, pinching, burning, hitting self (punching, slapping etc) or hitting inanimate objects - all with the function to harm self

WHAT IS INVOLVED?

If you are eligible to take part in this research, you will be asked to complete a short interview regarding your experiences of self-harm during adolescence.

This will be a confidential one-to-one interview via Microsoft Teams.

Please contact me or scan the QR code to register your interest

CONTACT

 callum.trainor@student.staffs.ac.uk



This research project is under the supervision of Dr Yvonne Melia, Academic Director on the Professional Doctorate in Clinical Psychology course at Staffordshire University.

This research is being conducted as part of the Professional Doctorate in Clinical Psychology course at Staffordshire University. This project has received favourable ethical opinion from Staffordshire University (Ref: SU_22_253)



Appendix D

Participant information Sheet



INFORMATION SHEET FOR PARTICIPANTS

Project Reference Number: SU_22_253

Title of Project: Exploring the experiences of young men who engaged in self-harm during adolescence and help-seeking behaviours following self-harm.

Researcher: Callum Trainor

I would like to invite you to participate in this research project which forms part of my Clinical Psychology doctoral research. Before you decide whether you want to take part, it is important for you to understand why the research is being done and what your participation will involve.

Please take time to read the following information carefully and discuss it with others if you wish. Ask me if there is anything that is not clear or if you would like more information.

What is the purpose of the study?

The purpose of the study is to explore the experiences of young men who have previously self-harmed, during adolescence and what support (if any) you accessed (both formal and informal) to help manage your distress and self-harming behaviours. If you did not reach out to any support, then any barriers that prevented you from reaching out would also be interesting to explore.

There are many different ways in which someone may harm themselves and it would be interesting to explore and listen to the reasons that led to you commencing harming yourself. This can involve, but is not limited to, cutting, scratching, burning, hitting self or objects.

Am I eligible to take part?

In order to be eligible to volunteer to participate in this study you will need to be:

- Male between the ages of 18-24 years old.
- Have self-harmed* on at least one occasion during adolescence (between the ages of 12 and 16).
- Are able and comfortable to talk about their past experiences of self-harm.
- Live in the UK and have access to the internet (for interview purposes).
- Not currently experiencing serious mental health difficulties which may negatively impact your wellbeing.
- Not acutely mentally unwell e.g. diagnosed with a psychotic disorder or eating disorder.

* Self-harm can be defined as (but not limited to) cutting, scratching, pinching, burning, hitting self (punching, slapping etc) or hitting inanimate objects - all with the function to harm self

What will happen if I take part?

If you agree to take part, you will be asked to take part in an interview in which your experiences of self-harm in your youth will be explored. You will be asked a series of questions. Examples include: "What do you remember about the circumstances surrounding the times your self-harmed?" and "What support did you have around you to support you?" (Among other questions).

The interviews will be conducted via Microsoft Teams, so it is important that you are able to have access to the internet to be able to participate. The interview should last roughly 30-60 minutes, giving plenty of opportunity to talk about your experiences. You will be able to pause or stop the interview at any point and can withdraw your data should you wish to (within two weeks of the interview being completed)

The interview will be recorded for the sole purpose of supporting the analysis of the experiences you share. You will be asked if you consent to this prior to the recording being commenced. You do not have to have your camera on for the interview if you do not wish to.

Reflecting on your experiences of your own self-harm during your adolescence may be emotive in some cases. You will be signposted to support services that you can utilise or reach out to, should you feel you want to.

Do I have to take part?

Participation is completely voluntary. You should only take part if you want to and choosing not to take part will not disadvantage you in anyway. Once you have read the information sheet, please contact us if you have any questions that will help you [make a decision](#) about taking part. If you decide to take part, we will ask you to sign a consent form and you will be given a copy of this consent form to keep.

You may also cease the interview at any point if you change your mind or do not feel like continuing. The interview can be recommenced at a later date or ceased completely and your data will not be used.

Once the interview is complete, you are also able to withdraw your data within 2 weeks of the interview date. Withdrawal of your data will not be possible after this time due to analysis of the data having commenced.

What are the possible risks of taking part?

It is possible that talking about experiences of self-harm in adolescence may be emotive for you. Although research suggests that talking about self-harm should not increase risk of self-harm there may be difficult feelings and memories that arise discussing these issues again. That is ok and completely normal. If this does occur, you are able to pause or cease the interview should you wish to. As mentioned above, this can be recommenced at a later date or ceased completely.

If any difficulties do arise, the researcher will not be able to offer psychological support, however, can signpost for support. Information regarding further support

will be given to you such as self-help lines, signposting to NHS services etc. and this is available to all participants whether you have completed the interview or decided to withdraw.

Participants should consider whether volunteering for this study this may negatively affect their mental wellbeing by answering questions regarding the subject matter.

What are the possible benefits of taking part?

There are no intended benefits of taking part in the study other than being part of research to understand experiences of self-harm in young men which you yourself have experienced.

However, it is not uncommon for participants to benefit from having a protected space to talk about and share their experiences and contributing to research in an area they have lived experience of. The research may also help improve our knowledge and understanding of self-harm in young men, a neglected area of research and support, currently and what support may be beneficial to young men.

Data handling and confidentiality

Your data will be processed in accordance with the data protection law and will comply with the General Data Protection Regulation 2016 (GDPR).

The information you provide will be confidential and kept secure on Staffordshire University's online cloud network storage. Only the researcher and supervisor will have access to this data for analysis purposes. During transcription of your interview, a pseudonym will be used in place of your name to ensure anonymity. However, in the dissemination, direct quotations may be used and there is a chance that you may recognise your quotes within the data. This will not be identifiable to anyone else.

Your data will be stored and retained by Staffordshire University for 10 years in accordance with the University's policies and procedures.

If you disclose information which may put yourself or others in immediate danger/risk, then this will need to be discussed with relevant services (Crisis, 999, Police etc.) in order to keep yourself and others safe. This will always be explained to you if confidentiality needs to be broken to keep you and others safe from harm.

Data Protection Statement

The data controller for this project will be Staffordshire University. The University will process your personal data for the purpose of the research outlined above. The legal basis for processing your personal data for research purposes under the data protection law is a 'task in the public interest' You can provide your consent for the use of your personal data in this study by completing the consent form that has been provided to you.

You have the right to access information held about you. Your right of access can be exercised in accordance with the General Data Protection Regulation. You also have

other rights including rights of correction, erasure, objection, and data portability. Questions, ~~comments~~ and requests about your personal data can also be sent to the Staffordshire University Data Protection Officer. If you wish to lodge a complaint with the Information Commissioner's Office, please visit www.ico.org.uk.

What if I change my mind about taking part?

You are free to withdraw at any point of the study, without having to give a reason. Withdrawing from the study will not affect you in any way. You are able to withdraw your data from the study up until two weeks after completion of the interview (without having to give any reason after which withdrawal of your data will no longer be possible as data analysis will have started).

If you choose to withdraw from the study, we will not retain any information that you have provided us as a part of this study.

What will happen to the results of the study?

The results of the study will be used as part of a Clinical Psychology Doctorate thesis. This research will also be written up and submitted for publication in a peer reviewed journal which could be made publicly available. These findings may also be used for other purposes such as training for mental health services, schools etc. or as part of conferences. Again, assurance is given that your data will be kept anonymous.

Who should I contact for further information?

If you have any questions or require more information about this study, please contact me using the following contact details:

Researcher

Callum Trainor

Trainee Clinical Psychologist

Email: callum.trainor@student.staffs.ac.uk

Supervisor

Dr Yvonne Melia

Principal Lecturer in Clinical Psychology

Academic Director, Professional Doctorate in Clinical Psychology

Email: yvonne.melia@staffs.ac.uk

What if I have further questions, or if something goes wrong?

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Dr Tim Horne

Director of Research

tim.horne@staffs.ac.uk

Thank you for reading this information sheet and for considering taking part in this research.

Appendix E
Consent Form



RESEARCH PROJECT CONSENT FORM

Exploring the experiences of young men who engaged in self-harm during adolescence and help-seeking behaviours following self-harm.

Researcher: Callum Trainor

(Please initial in the boxes to confirm your consent)

- | | | |
|--|-----|--------------------------|
| I have read and understood the information sheet. | Yes | <input type="checkbox"/> |
| I have been given the opportunity to ask questions, and I have had any questions answered satisfactorily. | Yes | <input type="checkbox"/> |
| I understand that my participation in this study is entirely voluntary and that I can withdraw at any time without having to give an explanation. | Yes | <input type="checkbox"/> |
| I understand that the interview will be video/audio recorded for the sole purpose of analysis. I am also able to turn my camera off should I wish to. | Yes | <input type="checkbox"/> |
| I consent that data collected could be used for publication in a scientific journal or could be presented in scientific forums (conferences, seminars, workshops) or can be used for teaching purposes and understand that all data will be presented anonymously. | Yes | <input type="checkbox"/> |
| I agree that data will only be used for this project (as stated above), although the data may also be audited for quality control purposes. | Yes | <input type="checkbox"/> |
| All data will be sorted securely on a password protected computer (electronic data), or locked away securely on University property (hard copies of data) for 10 years before being destroyed | Yes | <input type="checkbox"/> |
| I understand that I can withdraw my data from the project up to two weeks after completion of the interview without having to give an explanation | Yes | <input type="checkbox"/> |
| I understand that if I disclose an immediate risk to myself or others, then this will be discussed with relevant services (Crisis, Police etc.) in order to keep myself and others safe | Yes | <input type="checkbox"/> |
| I hereby give consent to take part in this study. | Yes | <input type="checkbox"/> |

Name Participant (print) Date Signature

Name Researcher (print) Date Signature

Appendix F

Interview Schedule

Semi-Structured Interview Schedule

Start by rechecking consent to study and brief overview of research project again.

Complete demographic questionnaire:

- What is your age?
- What part of the UK are you from?
- What is your Ethnicity?
 - Asian or Asian British
 - Black, Black British, Caribbean or African
 - Mixed or multiple ethnic groups
 - White
 - Other ethnic background
 - Prefer Not to Say
- What is your Sexual Orientation
 - Heterosexual
 - Homosexual
 - Bisexual
 - Pansexual
 - Other
 - Prefer Not to Say
- What gender do you identify as?
- What is your highest level of education?
- Have you accessed mental health services in the past or currently?
 - If yes, what for?
- Have you been diagnosed with a mental health condition?

Q1: Are you okay for me to begin asking you about your experience of self-harm?

Q2: How old were you the first time your self-harmed?

- What did you do?
- Did you self-harm once or did this happen again?
- Did the type of self-harm you relied on change, or did it stay the same?

Q3: What was happening in your life at that time that you believe led you to self-harm? (What were the reasons behind your self-harm?)

- If you had to describe the dominant feelings you were experiencing before you self-harmed, what were they?
- Why did you use self-harm as a way to respond to these feelings or experiences?
- What made you believe this could be helpful?

Q4: How did you feel at the time of self-harming?

Q5: How did you feel after?

- Was there relief, shame, guilt?

Q6: Did you tell anyone or ask for help?

- If yes, how would you describe people's reactions when you told them?
- If no, what prevented you from reaching out for help? (Go to Q7 then Q9)
- Did anyone find out about your self-harm in another way? (Go to Q8)

Q7: What were your reasons for not seeking support or telling anyone?

- Were there any feelings of Shame/Stigma?
- Wanting to manage your self-harm by yourself?
- Did you think that you didn't need any help?
- Did the thought of seeking help impact on who you were as a person or your beliefs about what it means to ask for help?

Q8: Did you seek any professional support? E.g. GP, A&E, CAMHS, Private counselling services.

- How helpful was this support?

Q9: What (other) support do you think would have been helpful/supportive at the time? Who/what would have been important in this support?

- What do you think could have helped you get the support you needed?

Q10: Did your self-harming resolve itself or stop? What helped?

Q11: Thinking about more currently, has this experience impacted your later life?

- What are your current coping strategies?
- Are you still self-harming?
- Would you seek help now if you were going through a mental health difficulty or started self-harming again?

Q12: Is there anything we have missed or I haven't asked about that you think is important to mention about your experiences of self-harm during your adolescence?

Appendix G

Debrief Sheet



RESEARCH PROJECT DEBRIEF FORM

Title of Project: Exploring the experiences of young men who engaged in self-harm during adolescence and help-seeking behaviours following self-harm.

Researcher: Callum Trainor

Thank you for taking part in the above study.

The study aims to explore the experiences of young men who had previously self-harmed during adolescence and subsequently what support they sought (if any). Males are much less likely than females to seek support for the mental health – though this is changing in recent years. Although, young girls are more likely to self-harm than boys, there is still a significant number of boys who self-harm which has not been clearly researched and understood how boys can reach out for support for this. Trying to understand these experiences by looking back at what help-seeking behaviours young boys engaged in, would give valuable insight into what services/communities could do to support young boys who self-harm.

The responses you have provided will be confidential and kept secure on Staffordshire University's online cloud network storage. Only the researcher and supervisor will have access to this data for analysis purposes. During transcription of your interview, a pseudonym will be used in place of your name to ensure anonymity. However, in the dissemination, direct quotations may be used and there is a chance that you may recognise your quotes within the data. This will not be identifiable to anyone else.

You still have the right to withdraw your information from this study, within the next two weeks. If you would like to do so, then please contact myself via the contact details below.

Should you wish to see the findings of the study, an executive summary (short summary) can be sent to you at your request.

Researcher
Callum Trainor
Trainee Clinical Psychologist
Email: callum.trainor@student.staffs.ac.uk

If you were affected by the content discussed during the interview and would like further support then please reach out to the services below who can offer support:

- If you live in Staffordshire you can call the **NHS Urgent Mental Health Helpline** on 0808 196 3002 or if you live in Stoke-on-Trent call 0800 032 8728.

- You can call the **NHS** on **111** to speak to a mental health specialist on how to get further support.
- If you feel you need **urgent** support than please call **999** or go to **A&E**.
- **Campaign Against Living Miserably (CALM)** - You can call the CALM on **0800 58 58 58** (5pm–midnight every day) if you are struggling and need to talk. Or if you prefer not to speak on the phone, you could try the CALM webchat service on their website: www.thecalmzone.net
- To talk about anything that is upsetting you, you can contact **Samaritans**, 24 hours a day, 365 days a year on **116 123**.

If this study has harmed you in any way or if you wish to make a complaint about the conduct of the study you can contact the study supervisor or the Chair of the Staffordshire University Ethics Committee for further advice and information:

Dr Tim Horne
Director of Research
tim.horne@staffs.ac.uk

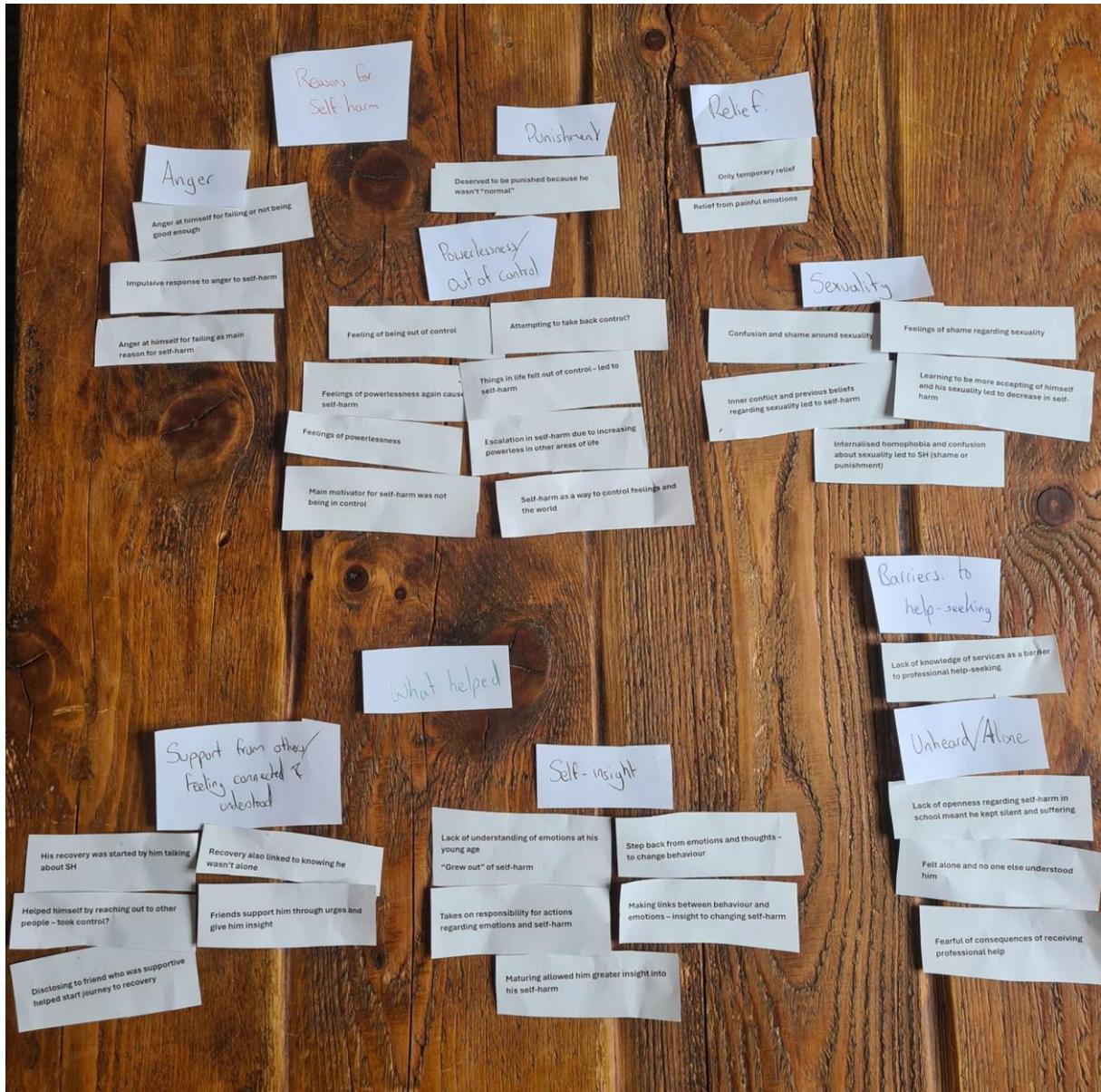
Appendix H

Example Transcript with Line-By-Line Coding and Development of Experiential Statements - Thomas

Experiential statements		Initial notes and comments
<p>Stress as a trigger for self-harm</p> <p>Transitional stress as a trigger for self-harm</p> <p>Difficulties with sense of self due to ASC</p> <p>Low self-esteem and hatred precipitator to self-harm</p> <p>Unmanageable stress for young self</p> <p>Struggled with processing change</p> <p>Need to punish self</p> <p>Low mood and blunted affect during adolescence</p> <p>Strong/intense emotions then devoid of emotion.</p> <p>Need to feel something</p>	<p>Researcher And what was happening around the age of 11 and throughout adolescence that kinda prompted you to start self-harming? Were they kind of like family difficulties or so?</p> <p>Thomas I think it was mainly, there was quite a large amount of stress around that time. I think for me, I think it was lots of in that period. There's lots of like transitional periods going from primary to secondary and then college to so and so on and so forth. And at the time, I hadn't received my diagnosis of ASD, so it was got an undiagnosed I was dealing with a lot of stress, not quite understanding it. And during that period, I had very low self-esteem and kind of had quite a large hatred towards myself and it's yeah.</p> <p>Researcher Yeah, it's a big, big, big transitional periods of going from primary school secondary school, having to lots of different changes and meeting new people, I guess. And maybe I don't want to put words into your mouth so I apologize Thomas, but maybe struggling with or not understanding why you might be struggling with it more than other people perhaps.</p> <p>Thomas Yeah, I think that was that was an element of that is kind of everyone seemed to get it go and think quite well as I was struggling with lots of different things and it was I think it was that sort of period was quite difficult time for me to sort of understand what was going on and and there was a large element of I just didn't like myself and thought that was the best way of of causing damage.</p> <p>Researcher I Can understand. If you had to describe like the feelings dominant feelings that were coming up for you around that time of your life before you self-harmed, what would you say they were? You kind of said already in like the self-hatred, but.</p> <p>Thomas There were periods of quite low moods and something, but those there were periods of quite low move but also, periods of just nothing. I didn't feel anything and it was a sort of way to feel something. Yeah, it was, It's a bit hard to describe. It was like there was, there were periods where there were really strong feelings of emotions of like quite low mood for an extended period of time. And then I would go into a period of just nothing, I think that kind of caused it in some ways.</p> <p>Researcher So it was around that time the feeling of nothingness. That he kind of made drew you closer towards self-harm to feel something as well.</p>	<p>Struggled with transitions which caused a lot of stress for him. Struggled with moving from primary school to secondary school, then to college etc. Didn't have Dx of ASC at this point so him and other probably struggled with his different understanding and needs at the time. Also noted he had low self-esteem and hatred to self, possibly due to lack of ASC and understanding of himself.</p> <p>Could not manage lots of different stresses as an adolescent. Didn't understand himself and who he was, maybe why he was somewhat different. Wanted to punish himself because he didn't like who he was – to cause damage.</p> <p>Periods of low mood during adolescence but periods of nothing...blunted.</p> <p>Describes strong feelings of emotions but then an absence of emotion. Possibly due to avoiding feeling? Believes this lack of feeling led to SH</p>

Appendix I

Generating Personal Experiential Themes from Experiential Statements – Example from Oliver



Appendix J

Master Table of Themes

Group Experiential Theme	Subthemes	Key Quotes
You feel like your pain stopped	Overwhelming and intense emotions	<p>Oliver: <i>"So my self harm is I do it 'cause I don't know how to control my anger. So I take it on myself instead."</i></p> <p>Troy: <i>"It was almost something an outlet in some ways for a lot of the things that would otherwise just sort of bottle up spiral out of control it just inside me, rather than have. I'm sort of with nowhere to go. You know, could potentially spiral into even more negative directions."</i></p> <p>Thomas: <i>"It was like there were periods where there were really strong feelings of emotions of like quite low mood for an extended period of time."</i></p> <p>Freddie: <i>"So sometimes it's out of anger. I remember often doing it, feeling so angry that I didn't know what to do with myself, so I took it</i></p>

		<p><i>out myself and sometimes just out of feeling upset. Feeling worthless?”</i></p> <p><i>Adam: “So like I said, it used to be something would happen when I was feeling just I guess, like intensely just shameful or upset with myself . I think I still have strong feelings like that sometimes”</i></p> <p><i>Luke: “I was very much “a bottle it up and deal with it later” kind and I think that's what caused it to spill over.”</i></p>
	<p><i>Relief. Every Time.</i></p>	<p><i>Oliver: And then I just kind of just move on really like the problem didn't really get addressed, but it's like at least I'm not feeling as bad anymore.”</i></p> <p><i>Troy: “...you know, almost being exciting and sort of like to feel something, almost like a relief or release in some senses.”</i></p> <p><i>Thomas: “ In some ways it's it was a mixed like there's sometimes be kind of a feeling of relief”</i></p>

		<p>Freddie: <i>"...I guess also the feeling of pain as well kind of gives you something else to focus on rather than what's going on in your head and it almost externalizes what you're feeling. You know you're feeling mental pain and you know, [this] kind of stuff and it turns into physical pain. And then once the physical pain stops, you know, you see the blood coming out once you stop it. Then I guess you kind of feel better. You feel like your pain stopped."</i></p> <p>Matthew: <i>"Relief. Every time."</i></p>
<p>I deserve this</p>	<p>It was like a punishment</p>	<p>Oliver: <i>"And the only way I could kind of justify it is hit myself as like oh, you deserve this. You're not right."</i></p> <p>Thomas: <i>"Sometimes it was just to cause an element of damage and [to] cause pain to oneself, but yeah, that was the main thing to [it] kind of. It was like a punishment, almost."</i></p> <p>Adam: <i>"I guess it was just like a sort of self-flagellating sort of thing, that's not quite the right term, but just like I don't know, like I've done something wrong or I'm not right. So I should do this because it'll I</i></p>

		<p><i>don't know just make it feel like I'm doing something to - I guess like get what I deserve with it."</i></p> <p><i>Matthew: "The only thing I did was starve myself. Intentionally starve myself because I considered that a worthy sacrifice or punishment or whatever you wanna call it."</i></p>
	<p>I just hated myself</p>	<p><i>Troy: "There was a sense of self dislike and self frustration."</i></p> <p><i>Thomas: "... but then also sort of a feeling of hatred thinking :Was this enough? Did I harm myself enough?"</i></p> <p><i>Matthew: "I know I hurt myself a good few times because I was just quite low, I just hated myself."</i></p> <p><i>Luke: "Focused around like feeling worthless or that people didn't actually like me. That was the key threads that I'd pull up."</i></p>
<p>Misunderstood, judged, and dismissed</p>		<p><i>Troy: "Yeah, and there's definitely a sort of, if you were to show [self-harm] there's definitely a sort of a stigma of attention seeking. ... sort of 'Oh my God' or judgment or that background level of that underlying tone of 'are you just doing this for attention?'"</i></p>

	<p>Thomas: <i>"I think [there is] a sort of the reaction of saying 'I've self-harmed' - I feel like the reaction people have isn't very helpful. It's a bit of like a shock. 'Why you doing this?' sort of thing and it's not particularly helpful."</i></p> <p>Freddie: <i>"...and my mom is of the generation who just doesn't really understand mental health. She's been through a lot in her life. She's lived through four civil wars and things - that very much a 'pull up the bootstraps' and get on with [it] type of person."</i></p> <p>Matthew: <i>"That was the problem. Yeah, they never considered me risky enough"</i></p> <p>Luke: <i>"...never with someone that I've actually told, but I have had discussions with people around [me] viewing self-harm as attention seeking or, yeah, mainly like crying for attention which makes it feel uncomfortable for me to then bring up the topic...."</i></p>
<p>A sense of connectedness: towards recovery</p>	<p>Oliver: <i>"And then I told a few of my friends as well. I was like, 'I'm doing this'. I realised it's not right and they're like 'Yeah, OK. If you ever need us, we'll be here'."</i></p> <p>Troy: <i>"I went back to the private counsellor that I [had] gone to when I was about 11 whilst I was on this waiting list and [told] her about self-harm...She was so incredibly nonchalant about it in a caring but nonjudgmental way, a sort of, 'yeah, I get it'."</i></p>

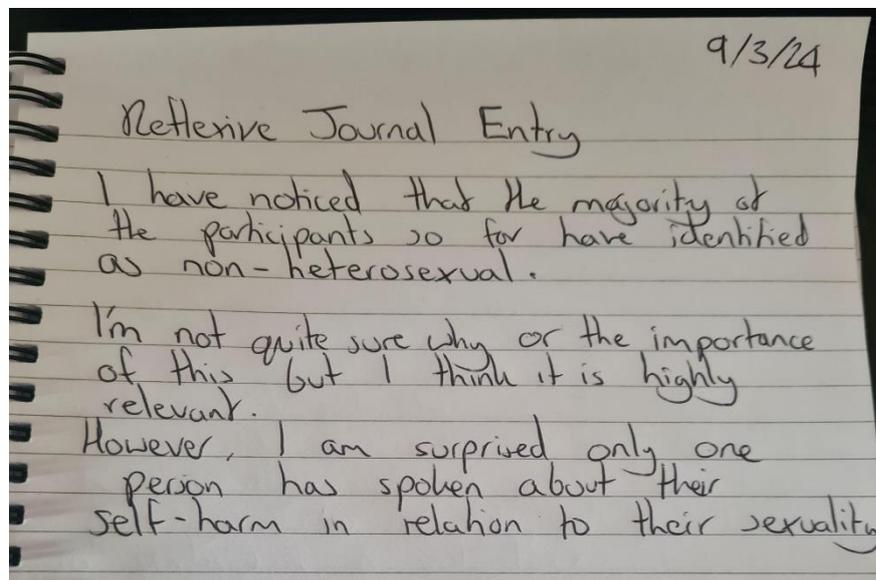
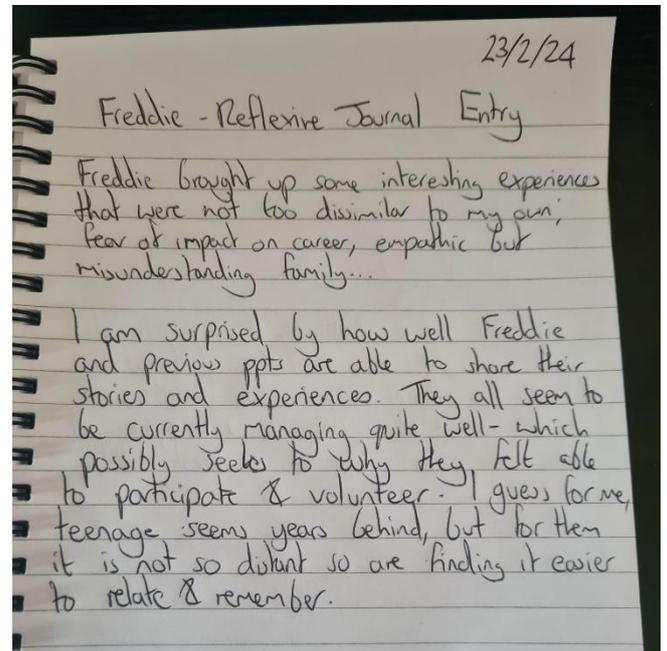
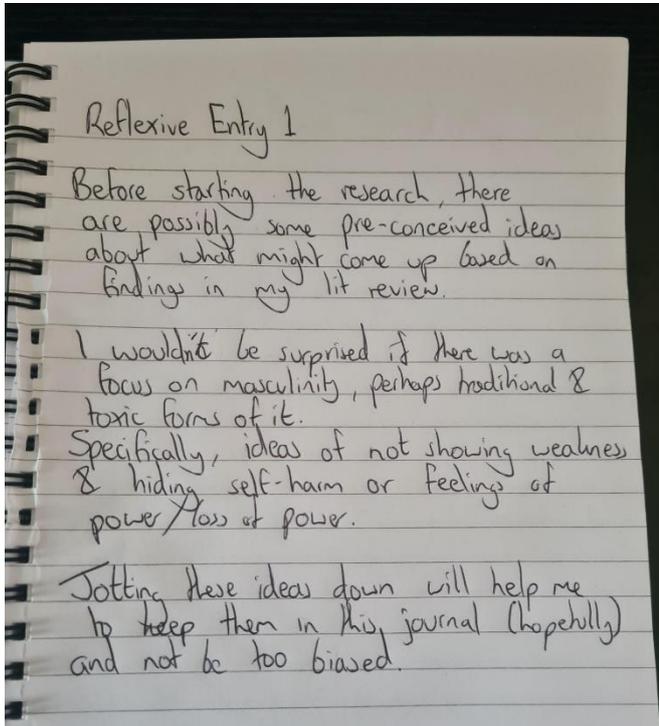
	<p>Freddie: <i>“Yeah, I guess talking to people, talking to people and I'm really lucky with the people I'm living with.”</i></p> <p>Adam: <i>“I think the main thing was really just connecting with other people and like, gain[ing] a bit more like self-respect really.”</i></p> <p>Luke: <i>“They were very polite about it. They took me aside and chatted with me about it and offered support, so I appreciated that. Yeah, they didn't make a massive deal of it, but did urge me to reach out and chat with someone and started me towards working through some more workshop style stuff at university, support wise.”</i></p>
<p>Self-kindness rather than self-harm (accepting emotion)</p>	<p>Troy: <i>“You know, I think self-kindness rather than self-harm is how it's sort of developed over time.”</i></p> <p>Freddie: <i>“Going out for coffee for myself, I think is one of the best things I can do for my mental health. Because I like a good coffee me. And yeah, just for like myself. Just say whether I'm studying, reading a book or just doing nothing - I find that really makes me feel better, and I think that's one of my main coping mechanisms. Or going to the beach. Going to beach works great as well.”</i></p>

Adam: *“But I think knowing that’s one way to treat myself has taught me to just step back every time I do feel shame and think, OK, this is something that I’m feeling, it’s OK to be feeling this, but it’s not OK to treat yourself badly because of this, you know.”*

Luke: *“I thought it was silly to originally start, but I’ve been journaling and meditating and that seems to be helping in that it gives me like space to process what I’m actually feeling rather than bottling everything up and then exploding.”*

Appendix K

Excerpts from researcher's reflexive journal



Paper 3: Executive Summary

"I think self-kindness rather than self-harm is how it's sort of developed over time."

**The experiences of young men who engaged in self-harm during adolescence and help-seeking behaviours:
An Interpretative Phenomenological Analysis (IPA)**

This paper has been written to provide a summary for those who participated in this study. It can also be used to share with Child and Adolescent Mental Health Services and the general public.

Word count: 1,986

Background

Male self-harm has risen within recent years within the UK (McManus et al., 2019), with rates almost tripling since the turn of the Millennium. Onset of self-harm tends to occur during early adolescence for male and female genders (Hawton et al., 2012; Gillies et al. 2018). Prevalence of self-harm is lower in males during early adolescence (males 8.5%, females 22.8%) but becomes much closer in late adolescence (males 20.1%, females 28.2%). This suggests that between early and late adolescence, there is rapid increase in young male self-harm (Patalay & Fitzsimons, 2021). Adolescent self-harmers are 17 times more likely to die by suicide than their peers (Morgan et al., 2017) whereas adolescent and young adult males are more than twice as likely than their female peers to die by suicide (Miranda-Mendizabal et al., 2019). Much of the literature exploring adolescent self-harm has been focused on females' experiences (Wadman et al., 2018; Miller et al., 2021). The research on males' experiences either focuses on those who have already sought formal support (Hassett & Isbister, 2017) or focuses on adult males' experiences (Russell et al., 2010; Adamson & Braham, 2011). It is important that the experiences of young men are not left unheard due to the strong links between prevalence of repeated self-harm during adolescence and death by suicide in adulthood (Olfson et al., 2018).

Early identification of self-harm is important and vital to minimise the impact of potential unhealthy coping strategies becoming entrenched patterns of behaviours (Birtwistle et al., 2018). Males are also much less likely than females to access support for their self-harm (Steinhoff et al. 2020), a trend which is mirrored in male help-seeking in general (Galdas et al., 2005; NHS, 2021). Therefore, it is particularly pertinent to understand male experiences of their early self-harm and help they may or may not have sought, in order to inform wider understanding and service strategies.

Aims

The present research aimed to explore the experiences of young men who have self-harmed during adolescence.

The present research also aimed to understand how young males managed their self-harm, how they explored seeking help for their self-harm, and any help-seeking behaviours they used, if at all.

Method

The study was advertised on social media sites such as Instagram, Facebook, and Reddit. Posters were also displayed within the local University campus and the study was disseminated to local regional colleges. Young males who wanted to take part were asked to complete a registration form with their details and were subsequently contacted by the lead researcher via email.

Who could take part?

- Participants were young males (aged 18-24)
- Had previously self-harmed during adolescence (between 12-16)
- Currently live in the UK

Who did take part

- 7 young males who met the above criteria took part in the research
- They were between the ages of 19 and 22
- Most participants began self-harming during their early teenage years
- 3 of the participants had never accessed formal mental health services for their self-harm as an adolescent

Participants took part in online interviews which were recorded and transcribed. Pseudonyms were used to protect their confidentiality and anonymity. The interviews and transcripts were then analysed using a method called Interpretative Phenomenological Analysis (IPA).

What is IPA?

IPA is a qualitative approach to analysing interviews and transcripts which aims to provide an in-depth exploration of personal lived experience (Smith et al., 2022). It can

be particularly useful when not much is known about a topic and for emotive subject matters (Smith & Osborn, 2014), such as self-harm.

What did the research find?

Using the analysis above, the researcher attempted to find links and connections between the individual interviews that explained the experiences of these participants' self-harm and help-seeking.

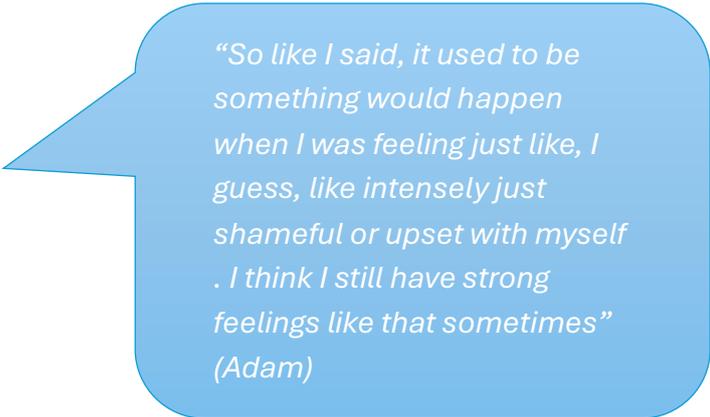
Through a process of analysis, five Group Themes and four subthemes emerged from the data. These themes are described below with quotations from participants that supported these themes.

Theme 1: You feel like your pain stopped

The first theme describes the sense that participants used self-harm as a means to end their emotional pain. Self-harm was seen as a strategy to bring relief to difficult and overwhelming feelings or emotions.

Subtheme: Overwhelming and intense emotions

The majority of participants described struggling with overwhelming emotions that directly precipitated their self-harm as adolescents and feeling unsure of how to manage their emotions. The emotion varied between participants but all noted that the intensity of the emotion or the feeling of being overwhelmed led directly to them using self-harm as a way to manage it.



*“So like I said, it used to be something would happen when I was feeling just like, I guess, like intensely just shameful or upset with myself . I think I still have strong feelings like that sometimes”
(Adam)*

Subtheme: Relief. Every time.

There was also a sense of relief felt when they completed self-harm, likely from their painful emotions. This inevitably led to the reinforcing of the self-harm and a need to feel this relief again.

"...you know, almost being exciting and sort of like to feel something like a, almost like a relief or release in some senses." (Troy)

Theme 2: I deserve this

This theme describes the experiences of some participants' belief that they 'deserved' their self-harm and the pain they inflicted upon themselves. This was experienced as either to punish themselves or due to strong feelings of self-hatred and worthlessness.

Subtheme: It was like a punishment

The majority of the participants also described a need to punish themselves as a driver for their self-harm. Two participants spoke about needing to punish themselves as a consequence for past wrongdoings whereas the other four felt the need to punish themselves due to specific characteristics they had. For example, being/feeling different to others or because of a general lack of self-worth and a self-hatred.

"Sometimes it was just to cause an element of damage and got cause pain to oneself, but yeah, that was the main thing was to kind of it was like a punishment, almost." (Thomas)

Subtheme: I just hated myself

There was also a sense that participants expressed a strong feeling of self-hatred during their

"I know I hurt myself a good few times because I was just quite low, I just hated myself." (Matthew)

adolescence which, in some cases, precipitated their self-harm or perpetuated it.

Theme 3: Misunderstood, judged, and dismissed

In this theme, participants spoke about a barrier to help-seeking they encountered throughout their adolescence. They described experiences where they felt misunderstood, dismissed, and unheard when they reached out to others for support regarding their self-harm or general mental health. Most described unhelpful experiences with friends and families but others also described poor experiences with mental health services that left them feeling dismissed too.

“Yeah, and there's definitely a sort of, if you were to show [self-harm] there's definitely a sort of a stigma of attention seeking. ... sort of ‘Oh my God’ or judgment or that background level of that underlying tone of ‘are you just doing this for attention?’” (Troy)

*“That was the problem. Yeah, they never considered me risky enough”
(Matthew – when discussing accessing services as an adolescent)*

Theme 4: A Sense of Connectedness: Towards Recovery

Though participants struggled with experiences of being dismissed, unheard and feeling misunderstood throughout their adolescence, it was an increasing sense of connectedness to others and themselves that led them to develop healthier ways of coping. Some of the participants spoke about pivotal times when people listened and were non-judgemental at a time when everyone else left them feeling unheard. They then believed that there was some support and help out there, to help with their steps towards recovery from self-harm.

“I went back to the private counsellor that I [had] gone to when I was about 11 whilst I was on this waiting list and [told] her about self-harm... She was so incredibly nonchalant about it in a caring but nonjudgmental way, a sort of, ‘yeah, I get it.’” (Troy)

In later experiences, participants also then spoke about how invaluable the support of family and friends have been with their general wellbeing, as well as their self-harm. Feeling connected to others increased their sense of worth and self-respect which led them to treat themselves better.

"I think the main thing was really just connecting with other people and like, gain[ing] a bit more like self-respect really." (Adam)

Theme 5: Self-kindness rather than self-harm

This theme referred to the ways that participants related to themselves that helped with their self-harm recovery. They reflected that treating themselves with more compassion or kindness often helped with their ability to manage distressing emotions when they arise and possibly counteracted this need for punishment too. Also, allowing themselves to feel and experience the emotion, rather than bottling it up, also helped with managing distressing periods.

"I thought it was silly to originally start, but I've been journaling and meditating and that seems to be helping in that it gives me like space to process what I'm actually feeling rather than bottling everything up and then exploding."

(Luke)

"But I think knowing that's one way to treat myself has taught me to just step back every time I do feel shame and think, OK, this is something that I'm feeling, it's OK to be feeling this, but it's not OK to treat yourself badly because of this, you know." (Adam)

There was also a broad emphasis on self-care and doing things for themselves to support their overall wellbeing.

"...being kind to yourself, leaving the work at home, going for a coffee, just sit and have an afternoon of, you know relaxation outside of being in a library." (Troy)

What did this say about young men's experiences?

The results largely supported previous research into the area regarding motivations for self-harm in males. For example, using it as a punishment, overwhelming feelings being a trigger and that it comes with a sense of relief once it has been completed.

There was also insight into how young men felt as adolescents when either trying to seek support for their self-harm or it had been seen by others. There was a sense of feeling misunderstood and unheard by family members or friends and also dismissed by health services. However, most participants shared that at least one positive interaction was able to change this perspective and encourage them to continue to reach out to others. Feeling connected and heard was a key factor for maintaining their wellbeing and many of the participants offered interesting insights and reflections into how they manage their emotions in the present. For example, instead of bottling emotions up, allowing themselves to experience them and create room for their emotions; as well as feeling comfortable to be able to talk to important people around them.

Some limitations to the research

- The majority of participants identified as non-heterosexual but sexuality was not a theme despite this being a contributing factor for self-harm in other studies. Perhaps participants did not feel comfortable with sharing these experiences given the research was not focused on sexuality.
- The majority of participants were white-British sample so are therefore more likely to seek help and talk about their experiences based on previous research in this area.
- Participants were also majority highly educated which means they would be more likely to disclose their self-harm and would be less influenced by constructs such as 'masculinity' that may impede help-seeking.

How will this research be useful?

- It highlights that more support is needed in schools for young boys regarding expressing and feeling their emotions.
- There also needs to be a wider understanding on how you to support young males when they disclose their self-harm e.g. compassionate understanding rather than dismissive and questioning.
- Utilising therapeutic approaches with young men on how to manage their emotions and self-harm behaviours e.g. Acceptance and Commitment Therapy (ACT), Compassion-Focused Therapy (CFT), and Dialectical Behavioural Therapy (DBT).
- It highlights the importance of friends and family in young males' experiences of recovery from self-harm.

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