

A qualitative study of help seeking and primary care consultation prior to suicide

Christabel Owens, Helen Lambert, Jenny Donovan and Keith R Lloyd

ABSTRACT

Background

Many suicides may be preventable through medical intervention, but many people do not seek help from a medical practitioner prior to suicide. Little is known about how consulting decisions are made at this time.

Aim

To explore how distressed individuals and members of their lay networks had made decisions to seek or not to seek help from a medical practitioner in the period leading up to suicide.

Design of study

Qualitative analysis of psychological autopsy data.

Setting

One large English county.

Method

Semi-structured interviews with close relatives or friends of suicide victims were conducted as part of a psychological autopsy study. Sixty-six interviews were transcribed verbatim and analysed using a thematic approach.

Results

Relatives and friends often played a key role in determining whether or not suicidal individuals sought medical help. Half the sample had consulted in their final month and many were persuaded to do so by a relative or friend. Of those who did not consult, some were characterised as help-resisters but many others had omitted to do so because no-one around them was aware of the seriousness of their distress or considered it to be medically significant. A range of lay interventions and coping strategies was identified, including seeking non-medical help.

Conclusion

Greater attention needs to be given to the potential role of lay networks in managing psychological distress and preventing suicide. A balanced approach to suicide prevention is recommended that builds on lay knowledge and combines medical and non-medical strategies.

Keywords

health knowledge, attitudes, practice; mental disorders; patient acceptance of health care; qualitative research; suicide.

INTRODUCTION

GPs have long been regarded as having a key role to play in suicide prevention through the identification and clinical management of individuals at risk.¹⁻³ Three-quarters of those who commit suicide are not in receipt of specialist mental health care at the time of death⁴ and for this group a visit to their GP represents the sole opportunity for medical intervention. However, the extent to which, in practice, GPs can intervene to prevent individual suicides is debatable, given low consultation rates⁵⁻⁸ and the absence of clear indicators of risk.^{6,7,9}

The decision to consult is the first, and arguably the biggest, obstacle on the pathway to medical care for the suicidal.¹⁰ Little is known about why so few seek medical help at this time of crisis. We used qualitative methods to explore how help-seeking decisions were made (or not made) in the period leading up to suicide, drawing on accounts given by close relatives of the deceased. In particular, we examined the way in which the individual's emotional distress had been construed by family members and what actions had been taken to try to deal with it.

METHOD

Semi-structured interviews with relatives or close friends of 100 suicide victims were conducted as part of a case-controlled psychological autopsy

C Owens, BEd, MA, PhD, research fellow, Peninsula Medical School, Universities of Exeter & Plymouth, Exeter. H Lambert, MA, PhD, senior lecturer in medical anthropology; J Donovan, BA, PhD, professor of social medicine, Department of Social Medicine, University of Bristol, Bristol. KR Lloyd, MD, MSc, MRCPsych, professor of psychological medicine, Clinical School, University of Wales, Swansea.

Address for correspondence

Dr Christabel Owens, Mental Health Research Group, Peninsula Medical School, Wonford House, Dryden Road, Exeter EX2 5AF. E-mail: c.v.owens@ex.ac.uk

Submitted: 10 September 2004; **Editor's response:**

1 December 2004; **final acceptance:** 18 February 2005.

©British Journal of General Practice 2005; 55: 503–509.

How this fits in

Half or more of those who take their own lives do not consult a doctor in the month before suicide. Little is known about how help-seeking decisions are made at this time. Members of the family and immediate social network may play a key role in determining whether or not suicidal individuals seek help from a medical practitioner or try alternative ways of alleviating distress. The potential role of lay networks in suicide prevention has received insufficient attention.

study. The psychological autopsy is a well-established method of investigating completed suicides and uses interviews with relatives, together with medical and coroners' records, to construct a detailed picture of each deceased individual, the circumstances of his/her life and the events leading up to the death.^{11,12} This study focused specifically on individuals who were not in contact with secondary mental health services. A detailed account of the original sampling and data-collection methods has been given elsewhere, together with results of quantitative data analysis.^{4,10}

Table 1. Characteristics of cases included in qualitative study (n = 66).

	Male (n = 45)	Female (n = 21)
Age		
18–30 years	14	4
31–65 years	23	10
≥66 years	8	7
Informant		
Parent	14	7
Partner	15	6
Child	7	6
Sibling	7	1
Other	2	1
Mode of death		
Poisoning: analgesics	1	7
Poisoning: psychotropic agents	3	5
Poisoning: gases and vapours	14	5
Hanging, strangulation, suffocation	16	3
Drowning	2	—
Firearms	3	—
Cutting and piercing	2	—
Jumping from high places	3	1
Jumping in front of moving object	1	—
Burning	—	—
Consulted a GP in the month before death		
For any reason	20	13
Psychological problem recorded in notes	12	9
Treatment offered	10	9

We transcribed the audiotapes of interviews with family members verbatim and subjected them to thematic analysis using qualitative techniques. We excluded informants who were medical or health professionals (n = 6), since the focus was on lay understandings of suicide and antecedent distress. Seven interviews were not taped at the informants' request, 12 were discarded because of poor tape quality and 9 remained untranscribed at the end of the study period. The last group contained minimal narrative. This yielded 66 transcripts out of the original 100 cases. We used purposive sampling in the initial selection of cases for analysis to ensure maximum variation in respect of age and sex of cases, chosen means of death and the relationship of informant to deceased.

All four members of the research team read several transcripts and independently identified key themes. An agreed coding frame was drawn up and applied to further transcripts. Themes were redefined, amalgamated or subdivided as new transcripts were worked through. Data pertaining to each theme were examined closely using methods of constant comparison to identify important similarities and differences and establish interpretive categories. Cases that contradicted emergent findings were sought, examined and used to refine the analysis as it proceeded. Detailed descriptive accounts of the major themes were produced, illustrated by extensive quotations. These were discussed at regular team meetings and formed the basis for the analysis presented here. Analysis continued until data saturation was reached; that is, until additional transcripts yielded no substantially new ideas. All names used are pseudonyms.

RESULTS

The 66 cases were evenly divided; exactly half had consulted their GP in the month before suicide. Characteristics of the sample are given in Table 1.

Consulters

Some of those who sought medical help did so of their own accord (self-referral). Others were persuaded to do so by a close friend or relative (lay referral). While not all accounts made it clear how the consulting process had been initiated, in at least 12 of the 33 consulting cases it is obvious that significant others played a key role. In the following example, the parents picked up both physiological and behavioural clues and deduced that urgent medical attention was required:

'She was on the phone crying her eyes out ... and so of course we knew something was

wrong ... Then she came back here and stayed for a week, very depressed. We'd never seen her like it before, had we? Her eyes were darting all over the place and she was slow with her speech ... and we said, "You've got to get down the doctor's".' (Father of 073, female aged 24 years.)

Another informant had taken full responsibility for organising her husband's medical care:

'He wasn't a person that was willing to go to the doctor, you know. I would go with him, get him to the doctor ... I got tablets for him. Yes, I got some tablets because he seemed down again ... When I went to the doctor the last time with him I said something ought to be sorted out, you know, he should see a specialist or something ... And then on the Tuesday ... he said to Paul [son], "I can't go on with the business," and then Paul broke down and I came in and rung up the doctor ...' (Wife of 047, male aged 57 years.)

In each case there was recognition, either by the individual or by someone close to them, not only that the situation was serious enough for action to be taken, but also that it constituted a medical problem and was an appropriate case for the doctor.

Consulting a doctor did not prevent any of these cases from taking their lives. Some relatives attributed this to the deceased individual; others blamed individual doctors or the healthcare system. Non-disclosure of psychological distress was implicated in several accounts, particularly where the distressed individual consulted alone:

'I don't think he told him, when he went there, the whole story. I didn't go with him. I felt that ... it shouldn't be necessary for me to go with him ... Perhaps that was a mistake on my behalf ...' (Wife of 042, male aged 40 years.)

In just over a third of cases (12 out of 33), the consultation appears to have focused on physical complaints alone, with no mention of psychological problems in the GP notes (Table 1). Non-compliance with suggested treatments was also reported by several relatives:

'He stopped taking the medication because it gave him nightmares, made him sweaty, feel bad and gave him dizzy spells.' (Father of 077, male aged 18 years.)

'She had appointment after appointment to

attend clinics but she just didn't go, didn't go at all.' (Father of 088, female aged 38 years.)

In a few cases, relatives described a pattern of long-term help seeking that was highly dysfunctional and unlikely to lead to a satisfactory outcome. These individuals were said to have sought medical attention compulsively or inappropriately, made excessive demands or manipulated the medical system for their own ends. The informants present this behaviour as symptomatic of psychological problems that were never fully addressed:

'She was always at the doctor's surgery ... She always seemed to be in pain and ill. Whether it was real or not, it's very difficult to say ... She used to imagine she had multiple sclerosis and things like that. She was a hypochondriac, there was no doubt about that. I'm sure the doctor would say so ... But the doctors were good and tried to go into everything. She was well served by the doctors. They were wonderful, they had such patience with her.' (Mother of 079, female aged 37 years.)

'He was involved in drugs ... hard drugs as well ... It's been a problem for well over 20 years ... He was being given lots of drugs, analgesics, diazepam, [laughs] he was on them all. He was a great manipulator of people. The fact that he could walk into a doctor's and get a regular prescription of a whole cocktail of things ... I think it's quite shocking ... The doctor hadn't even asked, "Why's this guy needing all these repeat prescriptions for things?"' (Brother of 019, male aged 43 years.)

Several relatives expressed anger with individual doctors for failing to assess the situation fully and to treat the individual as at risk, even when specific concerns had been voiced:

'Next day I took her to the doctors... and he just ignored what I was telling him. He just gave her a packet of antidepressants and that was all. I mean, after she died he come down and he apologised and I said, "It's too late now ... If you'd helped her when I asked you to this may never have happened."' (Mother of 065, female aged 24 years.)

Others blamed organisational factors, particularly the slowness of the referral process. Several cases were waiting for appointments with mental health specialists at the time of their death:

'He recommended her for counselling, which she wanted ... She wanted someone to help her ... but she was thinking it would be within days.' (Mother of 073, female aged 24 years.)

There were accounts in which a combination of these factors was present and others in which no reason was given for the lack of effective outcome.

Non-consulters

Half the sample had not sought medical advice in their final month. They had neither consulted of their own accord nor been persuaded to do so by others. A number of barriers to consultation were discernible within their relatives' accounts. Some individuals were characterised as 'help-resisters' by nature. These cases, typically middle-aged to older males, were depicted as self-reliant, resourceful characters who expected to be able to solve their own problems, or as stoical individuals who were determined to soldier on unaided:

'He was always a man that did. He would put things right ... If the roof fell in he would be the first to strike, "I'll sort it out," you know, very self-reliant, very independent, very practical ... Not the sort to go running off to get help.' (Wife of 083, male aged 56 years.)

'He never complained. I mean he had a tummy ulcer from when he was 14 but he never complained about it ... He'd go to work even on the days he felt really, really bad.' (Wife of 025, male aged 52 years.)

Some were described as having a deep-seated distrust of the medical profession and aversion to medication:

'She wasn't a person to take medicine if she could avoid it ... Mother never thought very much of doctors at all, you see. Very over-rated people, she thought.' (Son of 013, female aged 77 years.)

Many relatives confessed to having been unaware of the severity of the individual's distress. Again, this was often attributed to the character of the deceased person. Cases were portrayed as habitual non-confiders or as having practised deliberate deception, artfully concealing the true nature and extent of their troubles from those around them:

'He was a man that would always keep things to himself ... I tried to get things out of him ... but he just couldn't discuss it.' (Daughter of 072, male aged 65 years.)

'Well, she didn't open up easily ... She says in her diary that she'd just go into the loo and cry there, which I had absolutely no idea about.' (Mother of 095, female aged 25 years.)

'Everything was just brushed off with a very calm and convincing answer ... He fooled us all.' (Wife of 087, male aged 47 years.)

Several relatives discovered afterwards that conspiracies of silence had operated within the family. One 24-year-old, for example, had been covering up frequent episodes of self-harm with the collusion of her partner. Many admitted to having been deceived by the deceased's ability to appear to function normally.

Other informants blamed their own character or circumstances. Several admitted to having been too busy with their own lives or preoccupied with other problems to heed signs of distress:

'I was away quite a bit ... I was very busy working from August to December so I wasn't around that much.' (Wife of 083, male aged 56 years.)

'I was worried about the OTHER daughter.' (Mother of 095, female aged 25 years.)

Relationships built on mutual trust were also seen as having acted as a barrier to awareness:

'There was no reason at all for me to doubt him ... I suppose if I was one of these people that dived into everything that came through the letter-box, um, I might have picked up on a few things but ... we'd always been so open with each other. We'd been together for so long.' (Wife of 087, male aged 47 years.)

Habituation to psychological disturbance had occurred within many families, so that deviant behaviours ceased to be regarded as such and came to be defined as normal and entirely characteristic of the person:

'We sort of learned to live with it really. There was no way we were going to tie him down. He wasn't conventional like other people, if you know what I mean, so we just ... we got so used to him that we didn't really expect anything else.' (Mother of 026, male aged 24 years.)

Several adult children confessed that they had grown tired of what they saw as the distressed 'performances' of their elderly parents and had learned to ignore them:

'One always had the "here-we-go-again" kind of feeling.' (Son of 049, female aged 85 years.)

Almost all the relatives had been aware that something was wrong and many had picked up signs of distress, ranging from unusual quietness and increased alcohol consumption to explicit talk of suicide, but not all had seen these as indicating a need for intervention. Many had interpreted them as a perfectly normal response to adverse events and had assumed that the individual would simply 'get over it' in their own time or cheer up when circumstances improved:

'Couples when they break up, they ARE down, aren't they? You don't think, "Oh, is he going to commit suicide?" ... Relationships break up all the time.' (Mother of 070, male aged 24 years.)

'There were times when he was low when he would say that, you know, he couldn't see any point in going on ... I didn't really take it seriously because under the circumstances ... considering the situation, the pain and the discomfort and everything else, it was within normal boundaries ... It seemed, you know, just healthy moaning.' (Daughter of 045, male aged 77 years.)

Even when relatives recognised that the distress was serious enough to require intervention, it frequently did not occur to them to seek help from the doctor. Their interventions and coping strategies fall into three categories: practical problem-solving, talking solutions and distractions. Many focused their attention on the causes of distress (for example, joblessness, debt and loneliness) and took pragmatic measures to tackle these:

'He said he was lonely and fed up ... and we found him the dog.' ... *'Yeah, because he said, "I could do with a dog for some company." So we said, "Oh, all right then." So we spent the weekend looking for a dog, didn't we, for him.'* (Parents of 026, male aged 24 years.)

'She wouldn't let him see Thomas [baby son] ... That week he said to me, "I'll never be able to do the things with Tom that Dad did with me." ... I said, "Yes you will. Just get yourself sorted out. See a solicitor." And he did. He made an appointment with a solicitor.' (Mother of 080, male aged 25 years.)

Distressed individuals had consulted a range of non-medical professionals, including financial advisors, solicitors, relationship counsellors and

employment agencies. The assumption underlying these actions was that if the source of unhappiness was removed or dealt with then the distress would resolve itself automatically, as the following quotation clearly indicates:

'He was in despair at the collapse of his business [but] if there had been a complete turnaround, like someone had said, "Here's a good contract for you," a bit like winning the lottery I suppose, then it all would have changed instantly.' (Wife of 083, male aged 56 years.)

Other relatives judged that some kind of talking therapy might help. Some had made private arrangements for counselling rather than going through their GP, while others had tried to provide it themselves:

'And we talked and counselled and sometimes it went on for days like this, a massive counselling session ... and I'd say, "Let's go and sit on the moor." We'd sit on the moor and talk about it, you know, a high-energy place ... and he would be fine for a few days, and then it would build up again.' (Wife of 062, male aged 46 years.)

The remaining interventions were diversions of various kinds. Several relatives believed that fresh experiences or pleasures would be sufficient to lift the mood and convince the unhappy individual that life was worth living:

'I kept organising holidays ... I kept trying to find another focus ... you know, "We're going to London for the day." We did all sorts of things ... and what I kept trying to show him was that actually there is a very good life out there.' (Wife of 062, male aged 46 years.)

Relatives' accounts often revealed a striking absence of 'illness thinking'. Emotional distress, while it may have been a cause for concern, was not construed as a medical problem, nor was the doctor seen as an obvious source of help. In many of these cases there was no decision not to seek medical advice; questions of health and illness simply did not enter the discourse within the family.

DISCUSSION

Summary of main findings

Members of the family and immediate social network may play a key role in determining whether or not suicidal individuals seek help from a medical practitioner. Half the sample had consulted in their final month and many of these were persuaded to do

so by a relative or friend. Being accompanied by a family member may also make it more likely that psychological problems are disclosed. Of those who did not consult, some were characterised as help-resisters but many others did not do so because no-one around them was aware of the seriousness of their distress or considered it to be medically significant. We identified a range of lay interventions and coping strategies, including seeking non-medical help.

Comparison with existing literature

Medical sociologists have repeatedly drawn attention to the fact that doctors and lay people have different ideas about what is medically relevant,¹³⁻¹⁵ and that a complex, culturally-dependent process of symptom evaluation precedes every decision to consult.¹⁶⁻¹⁹ Both the sufferer and significant others play a part in that process. Lay referral and sanctioning by family members, friends or colleagues are known to be important influences on help-seeking behaviour.^{14,18,20-23} In the case of mental disorders, it is often only when it becomes apparent to others that an individual's mood or behaviour is deviating from normal that medical help is sought.²⁴

Our findings illustrate how difficult it is for lay people to know where the boundary between normal and abnormal mental states lies and when it has been crossed. Secrecy on the part of distressed individuals, their apparent ability to perform normal work and social functions and the fact that emotional distress is, after all, a predictable response to adverse circumstances all militate against intervention on the part of relatives and friends. It would also appear that families develop raised thresholds in response to long-term psychological disturbance and that living together may predispose them to accept each other's behaviour without question.

Our findings suggest that there may also be individuals at risk of suicide at the opposite end of the readiness-to-consult spectrum, who over-emphasise the significance of symptoms and engage in compulsive help seeking. Pilowsky's concept of 'abnormal illness behaviour' may be appropriate to this group.²⁵

Strengths and limitations of this study

The views represented in this study are those of bereaved persons. Their accounts of what happened in the weeks leading up to suicide are retrospective and are inevitably coloured by the event itself and its impact upon their own lives. Their grief, anger and sense of guilt are apparent throughout and make them less than impartial informants. Nevertheless, their stories offer important insights into the micro-

social contexts in which these suicides occurred, the way in which the victim's distress was interpreted by significant others and the knowledge and beliefs that influenced help-seeking decisions. An understanding of these factors provides a valuable basis from which to widen opportunity for suicide prevention.

Implications for clinical practice

Jorm has drawn attention to the low level of mental health literacy in the general population²⁶ and this would appear to be supported by our data on non-consultation. Few relatives in the non-consulting group had any awareness of the possibility of mental illness. However, it is not clear how such knowledge would have helped. Those who consulted a doctor also died. We have no measure of how many suicides are prevented by consulting a doctor, but for the individuals in the study it was not an effective strategy. Equally, it may be that many suicides are prevented by lay interventions, such as practical problem solving, family counselling sessions and diversions. Such intuitive lay responses to despair should not be dismissed. There is evidence that they are preferred to medical interventions²⁷ and, if effective, they may also help to reduce the burden on health services.

Further work is needed to explore the potential role of lay networks in managing psychological distress and preventing suicide, particularly in those not in contact with specialist services. We currently know little about this. Identification of risk is likely to remain problematic in both lay and medical contexts. However, where individuals do consult, with or without family members, concerns about psychological health should be taken seriously and referrals, where appropriate, need to be swift.

Funding body

NHS Executive South West Region (RS/02/04.01/Owens)

Ethics committee

Exeter District Research Ethics Committee (study number 783); North Devon Ethics Committee (study number 783); Torbay Local Research Ethics committee; Plymouth Local Research Ethics Committee (study number 785)

Competing interests

None

Acknowledgements

We thank all study participants, Nicholas Booth who helped design the psychological autopsy study, Anne Brackenridge who assisted with data collection and Valerie Beardsworth who transcribed the interviews. Thanks are also due to the anonymous reviewers for their helpful comments.

REFERENCES

1. Barraclough B, Bunch J, Nelson B, Sainsbury P. A hundred cases of suicide: clinical aspects. *Br J Psychiatry* 1974; **125**: 355-373.
2. Rutz W, von Knorring L, Walinder J. Long-term effects of an educational program for general practitioners given by the Swedish Committee for the Prevention and Treatment of Depression. *Acta Psychiatr Scand* 1992; **85**: 83-88.
3. Haste F, Charlton J, Jenkins R. Potential for suicide prevention in

- primary care? An analysis of factors associated with suicide. *Br J Gen Pract* 1998; **48**: 1759–1763.
4. Owens C, Booth N, Briscoe M, *et al*. Suicide outside the care of mental health services: a case-controlled psychological autopsy study. *Crisis* 2003; **24**: 113–121.
 5. Vassilas CA, Morgan HG. General practitioners' contact with victims of suicide. *BMJ* 1993; **307**: 300–301.
 6. Matthews K, Milne S, Ashcroft GW. Role of doctors in the prevention of suicide: the final consultation. *Br J Gen Pract* 1994; **44**: 345–348.
 7. Power K, Davies C, Swanson V, *et al*. Case-control study of GP attendance rates with or without a psychiatric history. *Br J Gen Pract* 1997; **47**: 211–215.
 8. Luoma J, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: a review of the evidence. *Am J Psychiatry* 2002; **159**: 909–916.
 9. Diekstra RFW, van Egmond M. Suicide and attempted suicide in general practice, 1979–1986. *Acta Psychiatr Scand* 1989; **79**: 268–275.
 10. Owens C, Lloyd KR, Campbell J. Access to health care prior to suicide: findings from a psychological autopsy study. *Br J Gen Pract* 2004; **54**: 279–281.
 11. Shneidman, ES. The psychological autopsy. *Suicide Life Threat Behav* 1981; **11**: 325–340.
 12. Hawton K, Appleby L, Platt S, *et al*. The psychological autopsy approach to studying suicide: a review of methodological issues. *J Affect Disord* 1998; **50**: 269–276.
 13. Mechanic D. *Medical sociology: a selective view*. New York: Free Press, 1968.
 14. Freidson E. *Profession of medicine*. New York: Harper & Row, 1970.
 15. Prior L, Wood F, Lewis G, Pill R. Stigma revisited: disclosure of emotional problems in primary care consultations in Wales. *Soc Sci Med* 2003; **56**: 2191–2200.
 16. Mechanic D. The concept of illness behaviour. *J Chronic Dis* 1962; **15**: 189–194.
 17. Robinson D. *The process of becoming ill*. London: Routledge & Kegan Paul, 1971.
 18. Zola IK. Pathways to the doctor — from person to patient. *Soc Sci Med* 1973; **7**: 677–689.
 19. Young JT. Illness behaviour: a selective review and synthesis. *Social Health Illn* 2004; **26**: 1–31.
 20. Elliott-Binns CP. An analysis of lay medicine. *J R Coll Gen Pract* 1973; **23**: 255–264.
 21. McKinlay J. Social networks, lay consultation and help-seeking behaviour. *Soc Forces* 1973; **51**: 275–292.
 22. Scambler A, Scambler G. Kinship and friendship networks and women's demand for primary care. *J R Coll Gen Pract* 1981; **31**: 746–750.
 23. Cornford CS, Cornford HM. 'I'm only here because of my family.' A study of lay referral networks. *Br J Gen Pract* 1999; **49**: 617–620.
 24. Yarrow MR, Schwartz CG, Murphy HS, Deasy LC. The psychological meaning of mental illness in the family. *J Soc Issues* 1955; **11**: 12–24.
 25. Pilowsky I. Abnormal illness behaviour. *Br J Med Psychol* 1969; **42**: 347–351.
 26. Jorm AF. Mental health literacy: public knowledge and beliefs about mental disorders. *Br J Psychiatry* 2000; **177**: 396–401.
 27. Rogers A, Pilgrim D. The contribution of lay knowledge to the understanding and promotion of mental health. *J Mental Health* 1997; **6**: 23–35.

half page