Counselling and Psychotherapy Research, December 2011; 11(4): 317–324

Routledge
Taylor & Francis Group

Self-help strategies to reduce emotional distress: What do people do and why? A qualitative study

ELIZABETH MARLEY*

Glenrothes, Fife, Scotland, UK

Abstract

Background: Some people with psychological distress do not seek professional help but opt instead for self-help strategies to reduce their symptoms. Little is known about these strategies. *Aim*: To investigate which self-help approaches might be employed to reduce the effects of emotional distress, and the reasons for these choices. *Method: S*emi-structured interviews with 11 clerical employees generated data analysed using grounded theory. *Findings:* Managing distress is a complex and multi-dimensional process unique to each individual. The use of self-help options is determined by the interconnection between the person's core beliefs, their social networks, and ideas about coping. Such beliefs may hinder help-seeking. People tend to engage in activities that are familiar to them already, rather than attempt new ones. The purpose of self-help strategies is to distract the person from their problems and to contribute to physical and mental well-being. Implications for practice are discussed.

Keywords: grounded theory; emotional distress; self-help; help-seeking; counselling

Introduction

Even though one in four people will experience a mental health problem at some point (Audit Scotland, 2009), research indicates that many people experiencing psychological distress, who could benefit from professional help, do not seek counselling (Jorm, Griffiths, Christensen, Parslow, & Rogers, 2004; Roness, Mykletun, & Dahl, 2005; Vogel, Wester, Wei, & Boysen, 2005). Programmes have been developed in Scotland to alleviate common mental health problems, incorporating some guided self-help, yet waiting times for certain psychological services remain long (Audit-Scotland, 2009). In England, the Improving Access to Psychological Therapies (IAPT) programme aims to support Primary Care Trusts within the National Health Service and expand access to evidence-based therapies (predominantly CBT) to help treat depression, anxiety and phobias by a system of stepped care (Improving Access to Psychological Therapies [iapt.nhs.uk], 2010).

Guided self-help in primary care is normally defined as a therapeutic approach delivered via books, CD-ROMs or internet-based resources, but with minimal professional support. The aim of such methods is to educate and empower clients by providing them with accessible interventions in a cost-effective way. Such self-help should comprise both information and instruction on developing skills to cope with and self-manage their symptoms and related difficulties (Lewis et al., 2003). Self-help as defined above is therefore limited in its scope (books, internet), and offers users little contact with professionals. In another study, Audin, Bekker, Barkham, and Foster (2003) found that counsellors in primary care believed that guided self-help could provide benefits for clients, including increased insight, self-esteem, and well-being. However, they also felt this type of help required considerable motivation on the part of the client and should be delivered as a component of one-to-one counselling rather than as a replacement for counselling.

*Email: liz_marley@hotmail.com

ISSN 1473-3145 print/1746-1405 online
http://dx.doi.org/10.1080/14733145.2010.533780

Although research suggests that many people engage in self-help to overcome emotional distress (Jorm et al., 2000a, 2000b; Kessler et al., 2001), there is a lack of robust research about self-help (Lucock, Barber, Jones, & Lovell, 2007) and where counselling might fit into such strategies.

Some studies (Jorm et al., 2000b; Jorm et al., 2004; Jorm et al., 2006) have explained preference for self-help strategies over professional treatment as arising from respondents: (a) not recognising symptoms of depression in themselves; (b) believing that only the most serious symptoms would merit professional help; or (c) having limited mental health literacy. Others (e.g. Jorm et al., 2000b; Lauber, Nordt, Wulf, Falcato, & Rossler, 2005) have suggested that, even though the public expresses beliefs about the efficacy of help such as counselling, in reality in a follow-up study, few respondents with depression actually saw a counsellor. This may indicate respondents giving socially desirable answers to researchers rather than reflecting their own preferences.

There is further research (Angermeyer, Matschinger, & Riedel-Heller, 2001; Corrigan, 2004; Corrigan & O'Shaughnessy, 2007; Jorm et al., 2004; Lauber, Nordt, Falcato, & Rossler, 2001; Lauber et al., 2005; Meltzer et al., 2003; Riedel-Heller, Matschinger, & Angermeyer, 2005; Roness et al., 2005) proposing that pessimism about the effectiveness of medical interventions, stoical attitudes, the risk of stigmatisation or how symptoms are defined (i.e. as mental illness or a natural response to a life event) may also contribute to a preference for self-help solutions. Other studies suggest that people may have a range of measures to cope with depression, e.g. talking to family/friends, exercise, cutting down on commitments, all of which are cheap and readily accessible (Lucock et al., 2007; Norcross, 2006).

Few studies exist to explain self-help strategies from the client's perspective. One of these, Lucock et al. (2007), reported five self-help themes: structuring the day, empowerment, engaging others to help yourself, physical health and well-being, and spirituality. In another study, Faulkner and Layzell (2000) found most people had a combination of two or three supports, people or activities, with the 'overwhelmingly predominant theme' (p. 3) being relationships with others.

The aim of this study was to explore participants' actual experiences of psychological distress, their self-help options, and the reasons for and benefits of such choices.

Method

Participants

Eleven participants (two men, nine women) offered to take part in the research after hearing about it from a friend of the researcher. This contact had given an outline of the study to colleagues and subsequently compiled a list of potential participants which was emailed to the researcher. Each person was then telephoned by the researcher to explain about the study in detail, to answer any queries and to confirm each person's willingness to participate. The researcher knew two of the participants; the remainder were either acquaintances or unknown. These participants provided a number of common factors: all were clerical workers with similar income levels; all lived in and around the same geographical area of Scotland, and all described their ethnicity as white Scottish/British. Their ages ranged from 27–60 years (average 45).

Data collection

Semi-structured face-to-face interviews took place either in the home of the researcher or the participant (chosen by the participant). Questions addressed two areas: self-help strategies to reduce emotional distress; and attitudes about counselling. (Due to the volume of data arising from both subjects and word limitations here, only the former topic is addressed in this paper.) Participants were asked to talk about 'an emotionally difficult or stressful experience' in their life, how they felt physically and emotionally during that time, and what they did to feel better. To avoid potential researcher bias, the participants defined 'emotional distress' themselves. Presenting issues included bereavement, depression, and relationship problems. As a starting point, self-help options were divided into four groups: people, medicines, activities, and treatments; these were informed by two studies by Jorm et al. (2000b, 2004). Each group was typed up on cards so participants could consider all the options in turn during interview (see Table I). Each interview was recorded, conducted in a conversational style, and lasted around one hour. Recordings were transcribed and analysed by the researcher.

Table I. Self-help options.

People	Partner, family member, close friend, GP, social worker, chemist, counsellor, psychologist, psychiatrist, homeopath, minister, telephone helpline e.g. Samaritans (anyone else?)
Medicines	Vitamins/minerals, tonics/herbal medicines e.g. ginseng/St John's Wort/Chinese, pain relievers e.g. aspirin/paracetemol; antidepressants, sleeping pills, tranquillisers, anti-psychotics (anything else?)
Activities	Aromatherapy, attending courses/classes on relaxation/stress management, being more physically active, e.g. playing more sport/going to the gym/walking, being with pets, browsing internet, cut down on commitments, cutting out alcohol, dance/movement, distraction, drink more alcohol or have occasional alcoholic drink, eat more, e.g. chocolate, gardening, getting out and about more/socialising, giving up smoking, dieting or avoiding certain foods e.g. caffeine/sugar, massage or other beauty treatment, humour, music, meditation, reading self-help books, reflexology, reiki, sex, singing, shopping, sleeping more, smoking more, taking a holiday or occasional days off work, taking up new activity, prayer, watching TV, yoga (anything else?)
Treatments	Counselling, psychotherapy, hypnosis, admission to psychiatric ward of hospital, ECT, CBT (anything else?)

Analysis

In accordance with the grounded theory approach (Strauss & Corbin, 1990), immersion in the data occurred through the initial coding of each line of text. Coding was analysed further to identify more significant or frequent codes from which conceptual categories began to emerge. At the same time, memos were kept to record ideas, themes and questions around the categories, breaking them down into component parts. Throughout the analysis, the data were compared and contrasted to discover processes and patterns within the different individual experiences, beliefs and situations, at all times keeping close to the texts.

Ethics

The University Research Ethics Committee granted approval for this study. Formal information letters were sent out in advance to all participants. Consent forms detailing the participants' right to withdraw or not answer any question were signed prior to interview. Participants reported that prior knowledge of the researcher and the study created a degree of personal connection, enabling them to freely discuss their emotional experiences while also feeling reassured that they could withdraw at any time. Participants confirmed they were not currently undergoing any psychological treatment and were aware that, due to the potentially distressing nature of the interviews, contact numbers for any relevant charitable counselling services would be available if required – however, none was needed.

Findings

Analysis of the self-help data revealed five main categories detailing how participants dealt with their distress. Each category and its associated sub-categories (highlighted in italics in the text) are presented in Table II.

Experiencing an emotional event

All participants experienced unpleasant physical symptoms, including anxiety, stress, panic, feeling sick, headaches, crying, pains, double vision, sensitivity to noise, and disturbed sleeping patterns. At the same time, they had to cope with a diverse range of emotional symptoms, such as feeling numb, angry, confused, depressed, in despair, embarrassed, and isolated.

Integral to the experience of distress is *coping with change and loss*. Relationship problems, becoming a long-term carer, relocating/work issues, and suffering bereavements were typical emotional events described by participants leading to major changes in their lives. Such changes resulted in significant losses of close relationships, security, social life,

Table II. Overview of categories.

Category	Sub-category
Experiencing an emotional event	Coping with change and loss
	Paths & stages of distress
Self-help: relationship with others	
Self Help: other choices	Medicines, Activities, Treatments
	Benefits
	Frequency
Factors influencing self-help choices	Cheap
	Easily accessible
	Enjoyable
	Having control
	Familiarity
Barriers to help-seeking	Delays
	Coping with paradox
	Fearing disclosure/stigma
	Influence of core beliefs

routine, health and well-being, future plans, financial security, sense of self, and confidence.

The data also suggest that experiencing an emotional event involves what might be called '*paths*' (see Figure 1) and 'stages'. Participants said:

> I went through a phase where it was really bad. (P3)

> I did actually get to a point where I just wanted to chuck everything. (P8)

> I am that used to dealing with everything ... and then it got to the stage where I can't. (P10)

Paths and stages do not relate to specific periods of time, nor that one person's distress is lesser or greater than another's, rather they are determined by the extent to which a person can actively engage in self-help. Figure 1 is intended to be a simple conceptual representation only – it does not convey all factors involved in participants' distress.

Self-help: relationships with others

Having quality relationships with others appears to be crucial to minimising distress. Two participants sought immediate help from family members:

> I talked to just everybody ... I am really close to my family. (P7)

> That is the huge thing – if you've got a good family, it's nine tenths. (P5)

Two others knew they had family support but did not discuss their feelings openly:

> I would go straight to my mum's ... for a cup of tea, em, but not let on what was wrong ... I would just totally calm down ... it probably took a good year or so before I ever mentioned anything to my mum. (P2)

Four participants turned to partners or close friends for support, but not families:

> Family members, I pretty much didn't offload as much on to them, because I think they all had their own stuff. (P1)

By contrast, three participants stood out as being very isolated, believing they had no one to support them. Each experienced distress over a prolonged period, turning only to their general practitioners (GPs) latterly for help with physical symptoms:

> I just wanted somebody to come and cuddle me or something. I just felt lonely and deserted and abandoned. (P11)

This evidence suggests that talking to others reduces distress through sharing the experience and receiving both acceptance and emotional support.

Self-help: Other choices

Eight participants took medication to ease their physical symptoms. Four tried herbal or pharmaceutical remedies, while four received medication from their GPs, including sleeping pills, tranquillisers or antidepressants (two people also took medication for other health problems).

Views about herbal-type remedies were generally positive, being recommended by friends or in magazines. They were considered to be more 'natural', whilst antidepressants were viewed more negatively:

> I didn't really ever want to go back on antidepressants because, em, they are messing about with obviously your chemicals ... they've got side effects 'n' everything, but ... I just sort of thought of more natural ways that I could control my anxiety myself. (P1)

Participants then considered activities from the options list (see Table I). Despite the number of choices offered, it was found that each person had a few specific and unique self-help activities they would turn to depending on their personal circumstances at any given time. Preferred activities were broadly divided into four groups: energetic, relaxing, distracting, and seeking information. These are summarised with their associated benefits below in Table III.

Participants said about their activities:

> I could get the physical bit just by grabbing my furniture and moving it, exhausting myself ... my furniture had to take the brunt of me being angry and stressed at my work. (P10)

> I like to just go and lie on my bed and be quiet... not go for a sleep, just to chill out completely. (P2)

Despite these groupings, it is clear that any activity could comprise both an energetic/relaxing/

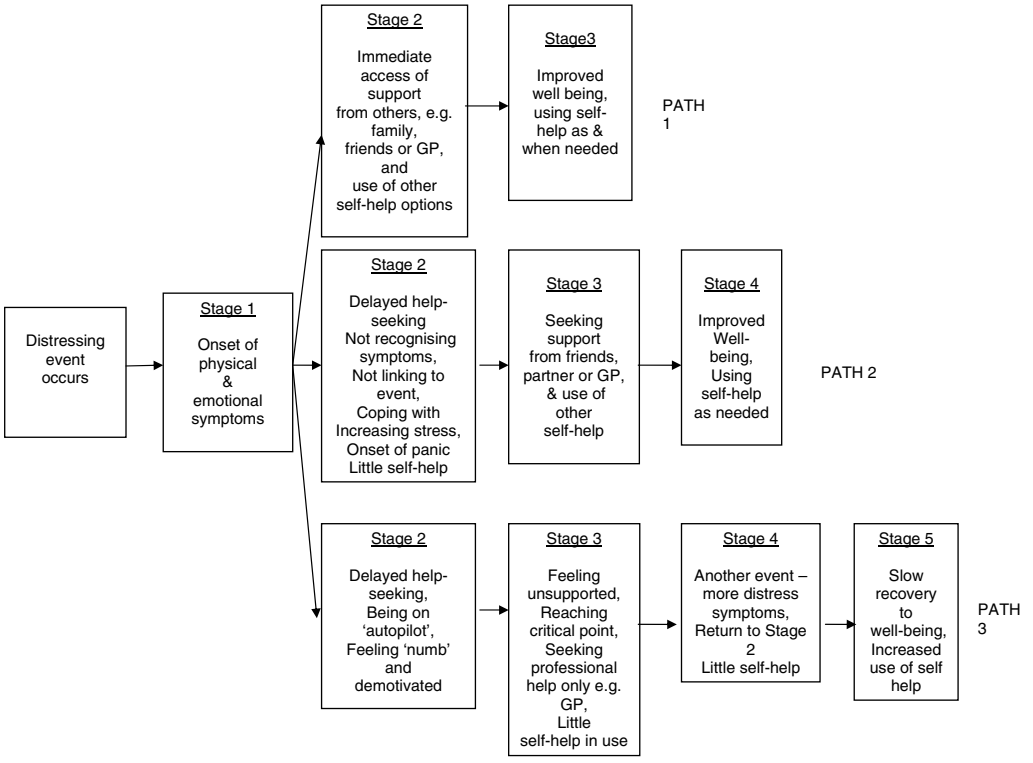

Figure 1. Simple model of experience of distress.

informative element *and* be distracting. Indeed, all participants referred to the importance of distraction from their problems as a key benefit of their self-help actions. The goal of self-help then is to bring about *both* physical and mental well-being.

Four participants had experience of professional treatments. Two had seen a counsellor, one a hypnotherapist and counsellor, and the fourth a psychologist, psychiatrist and latterly a counsellor. Although the main benefit of professional help was talking through problems, opinions about professional treatments were mixed:

> It was helpful because I was talking about it, but I wanted somebody to ask me really hard questions … whereas she was so 'time will heal' and whatever, that's not what I actually needed at the time. (P3)

> I went to a hypnotherapist because I thought I was going to have a nervous breakdown then and the

Table III. Overview of activities and benefits.

	Participants' activities	Benefits
Energetic	Sport – cycling, cricket, football, weights, badminton; dancing, moving furniture & cleaning, hillwalking	Expending energy, feeling more lively, avoiding boredom, interacting with others or being by oneself, being outside, enjoying the fresh air/nature, having a sense of freedom, doing something productive, having fun.
Relaxing	Aromatherapy massage, reflexology, music, mediation tape, yoga, eating chocolate, drinking alcohol, lying on a bed, walking the dog, reading, going to the hairdresser, baking, knitting, stroking a cat, sleeping more, keeping a journal, drinking coffee, having a laugh	Focusing the mind, achieving sense of calm, having peace and quiet, having peace of mind, seeing the funny side, doing something productive.
Distracting	Shopping, socialising, driving, getting out of the house or situation, watching TV, keeping busy, gardening, getting dressed up, work, playing poker	Taking your mind off the problem, having a change of scenery, getting away from worries, having structure in the day.
Seeking information	Self-help books, internet websites/forums, magazines	Taking control, feeling positive, improving self-care, developing self-awareness, finding new ways to cope.

> way they talk to you 'n' everything, they just make me feel so relaxed ... they did give me a counsellor eventually, but it was a man ... and it's not just because he was a man, I just couldn't take to him at all .... the counsellor ... she was really brilliant. (P6)

The importance of the client having a positive relational connection with the professional is clearly demonstrated here. However, negative experiences did not appear to put participants off seeking further professional help.

All participants increased the frequency of use of their preferred options initially or regularly until they began to feel better, then they would reduce them or 'dip in and out' as required.

Factors influencing self-help options

Participants' self-help options were cheap, easily accessible and enjoyable. For some participants, having control of their activity was extremely important. One participant stated:

> It's my quiet time, 'cos the television's not on, the music's not on, it's just me in the living room, nobody comes in ... I'll do the living room, it's exhausting but it belongs to me. (P10)

The participants' familiarity with their chosen options, most of which had been accessed since childhood or early adulthood, was notable:

> I was dancing from three years old, so it's something that's in me anyway. So I suppose you will go back to what's in you to make you feel better. (P11)

Surprisingly, only three participants tried something new to ease their distress, and these activities were abandoned because the anticipated benefits did not materialise:

> Swimming is not something I would normally do ... it was somewhere to get out ... I don't really know if there was a benefit... because in a way I was still thinking ... I mean it didn't really take my mind off it. (P7)

New activities only seemed to appeal to sufferers of panic who were willing to try new ways of minimising anxiety levels.

Barriers to seeking help

Participants outlined various factors that inhibited engagement in self-help, including delays, coping with paradox, fearing disclosure/stigma, and the influence of core beliefs.

Delays in help-seeking had two main causes: (i) not recognising or linking emotional and physical symptoms to the distressing event; and (ii) suppressing emotions, i.e. 'feeling numb' or being on 'autopilot'.

All participants struggled with paradox; an inner conflict between mind and body to distinguish and prioritise between what they 'should' do versus how they actually felt. As one participant said:

> I wouldn't feel like doing stuff ... I thought, is my body telling me to do less or is it because I need the activity? I was never quite sure ... I'd think I can't be bothered and I'd think, is it just me? (P9)

In addition, fear of disclosure and stigma affected participants' willingness to discuss their distress. Over half of them felt it was important to 'put on a front' and keep their feelings 'private'. By so doing, they tried to keep their lives as normal as possible, yet by suppressing their emotions they prolonged their distress. They also feared being thought weak, lazy, 'mental' or 'psycho', and that people might treat them differently.

Three quarters of participants believed stigma about mental health issues, taking antidepressants and seeing a counsellor is still prevalent, although three felt there was a little less stigma now than in the past due to increased media advertising about mental health issues:

> Being stressed is OK, everyone is stressed; being depressed is not so OK but people might say, 'I've been feeling down myself'. But, being clinically or severely depressed, there's a little step back and, if you say you have a mental health problem, it would be a full yard and then you're a basket case. (P3)

Finally, individual core beliefs can act as a barrier to self-help. All but one participant referred to self-esteem issues; not being good enough; not meeting others' expectations; feeling responsible for others; and having low self-confidence, all of which added to their distress. These views seemed to be largely unconscious and had their roots in their families of origin:

> I was kinda brought up as to 'self-praise is no honour'. (P4)

> I was pushed in the background . . . I think it stems from there . . . always being in the background. (P6)

Discussion

This study suggests that the experience of emotional distress and subsequent use of self-help is complex and multi-dimensional, involving a number of factors: becoming aware of physical and emotional symptoms; going through different paths/stages; and overcoming barriers to engagement in self-help strategies.

All participants employed several self-help options, often with a particular specific preference. However, the predominant factor in limiting distress was accessing support from others, a finding which supports Faulkner and Layzell's study (2000), and confirms their suggested self-help benefits of emotional support (being there), peace of mind and relaxation, taking control, security and safety, and pleasure. This study also supports previous research findings (e.g. Jorm et al., 2000b; Lewis et al., 2003; Norcross, 2006) that self-help options should be simple, cheap, easily accessible and fit around individuals' personal circumstances.

However, in Jorm et al.'s (2004) study, actions to reduce psychological distress were thought to peak and decline during three 'waves' of mild, moderate and severe distress, with readily-available options, such as exercise or music in the first wave, new activities in the second, and professional treatments in the third. These findings are only partly supported here.

First, this study found easily accessible self-help was not restricted to mild distress; instead self-help could be used throughout the stages of distress. Second, that people would try new actions for more moderate distress is also not supported. Most participants continued to access familiar self-help activities. It could be that trying something new is just too difficult, or because it is yet another change to cope with, though the data do not clarify this. Finally, the suggestion that people seek professional help (including counselling) when more severely distressed is also only partly supported; they do, but mostly when a person feels very isolated and/or where help is needed for specific physical symptoms like panic. A 'wave' model is therefore perhaps too simplistic and fails to take account of the complex nature of an individual's response to distress.

Many previous studies (Jorm et al., 2004; Lauber et al., 2005) were based on vignettes rather than respondents' own experience or actual preferences. In this study, although comprising a small sample, the participants' distressing episodes encompassed a wide range of typical significant life events and were described openly and in detail. It has therefore been possible to identify specific processes relating to emotional distress and self-help. However, further research may be required to identify whether the findings are unique to Scotland or are consistent across different socio-economic groups.

Implications for practice

The use of 'self', i.e. thinking through and making decisions about what might best help oneself reduce emotional distress, is a largely unconscious process. It seems people just do what they instinctively know will make them feel better, although getting to the point of action can be hampered by delays and confusion.

People have a variety of self-help options available to them, the most important of which is having quality relationships with others. For those who feel they have no one to talk to, counselling can offer a supportive, accepting and therapeutic relationship. Counsellors may be in a position to help clients explore stages of distress, bring into awareness their already established unique self-help preferences and encourage reconnection with them, and identify and work through any negative core beliefs that may hinder recovery. It is also important that counselling should be available quickly. As one participant explained:

> . . . there are times in your life when you think I've got to talk to somebody now . . . I have desperately just needed to . . . get it out my system . . . maybe a week's waiting time would have been about the max I could have gone . . . then the moment would be lost . . . then you've maybe coped . . . but it's not got rid of the underlying thing . . . that's how I felt . . . there's plenty [of help] for drugs and booze but nothing . . . [for people] beaten up and heartbroken . . . there should be a counsellor attached to every practice, God almighty, they've got everything else.

Conclusions

By recognising that each distressed individual has different needs and potential ways of coping, counselling and guided-self-help programmes might therefore reflect individual preferences to maximise uptake and compliance, whilst also providing a quality supportive relationship. It is the human element within self-help that is key to reducing distress; this cannot be overstated.

Acknowledgements

The researcher wishes to extend grateful thanks to all the participants for their willingness to take part and for sharing their personal stories.

References

Angermeyer, M.C., Matschinger, H., & Riedel-Heller, S.G. (2001). What to do about mental disorders – Help-seeking recommendations of the lay public. *Acta Psychiatrica Scandinavica*, *103*, 220–225.

Audin, K., Bekker, H.L., Barkham, M., & Foster, J. (2003). Self-help in primary care mental health: A survey of counsellors and psychotherapists' views and current practice. *Primary Care Mental Health*, *1*, 89–100.

Audit Scotland (2009). Overview of Mental Health Services in Scotland. Retrieved August 18, 2010, from http://www.audit-scotland.gov.uk

Corrigan, P. (2004). How stigma interferes with mental health care. *American Psychologist*, *59* (7), 614–625.

Corrigan, P.W., & O'Shaughnessy, J.R. (2007). Changing mental illness stigma as it exists in the real world. *Australian Psychologist*, *42* (2), 90–97.

Faulkner, A., & Layzell, S. (2000). *Strategies for living: A summary report of user-led research into people's strategies for living with mental distress*. London: The Mental Health Foundation.

Improving Access to Psychological Therapies (IAPT) (2010). Good practice guidance on the use of self-help materials within IAPT services. Retrieved August 18, 2010, from http://www.iapt.nhs.uk/wp-content/uploads

Jorm, A.F., Barney, L.J., Christensen, H., Highet, N.J., Kelly, C.M., & Kitchener, B.A. (2006). Research on mental health literacy: What we know and what we still need to know. *Australian and New Zealand Journal of Psychiatry*, *40*, 3–5.

Jorm, A.F., Griffiths, K.M., Christensen, H., Parslow, R.A., & Rogers, B. (2004). Actions taken to cope with depression at different levels of severity: a community survey. *Psychological Medicine*, *34*, 293–299.

Jorm, A.F., Medway, J., Christensen, H., Korten, A.E., Jacomb, P.A., & Rodgers, B. (2000a). Attitudes towards people with depression: Effects on the public's help-seeking and outcome when experiencing common psychiatric symptoms. *Australian and New Zealand Journal of Psychiatry*, *34*, 612–618.

Jorm, A.F., Medway, J., Christensen, H., Korten, A.E., Jacomb, P.A., & Rodgers, B. (2000b). Public beliefs about the helpfulness of interventions for depression: Effects on actions taken when experiencing anxiety and depression symptoms. *Australian and New Zealand Journal of Psychiatry*, *34*, 619–626.

Kessler, R.C., Soukup, J., Davis, R.B., Foster, D.F., Wilkey, S.A., Van Rompay, M.I., & Eisenberg, D.M. (2001). The use of complementary and alternative therapies to treat anxiety and depression in the United States. *American Journal of Psychiatry*, *158*, 1386–1391.

Lauber, C., Nordt, C., Falcato, L., & Rossler, W. (2001). Lay recommendations on how to treat mental disorders. *Social Psychiatry & Psychiatric Epidemiology*, *36*, 553–556.

Lauber, C., Nordt, C., Wulf, R., Falcato, L., & Rossler, W. (2005). Lay beliefs about treatments for people with mental illness and their implications for antistigma strategies. *Canadian Journal of Psychiatry*, *50*, 745–752.

Lewis, G., Anderson, L., Araya, R., Elgie, R., Harrison, G., Proudfoot, J., Schmidt, U., Sharpe, D., Weightman, A., & Williams, C. (2003). Self-help interventions for mental health problems. Retrieved August 18, 2010, from http/www.dh.gov.uk/publications

Lucock, M., Barber, R., Jones, A., & Lovell, J. (2007). Service users' views of self-help strategies and research in the UK. *Journal of Mental Health*, *16* (6), 795–805.

Meltzer, H., Bebbington, P., Brugha, T., Farrell, R., Jenkins, R., & Lewis, G. (2003). The reluctance to seek treatment for neurotic disorders. *International Review of Psychiatry*, *15*, 123–128.

Norcross, J.C. (2006). Integrating self-help into psychotherapy: 16 practical suggestions. *Professional Psychology: Research & Practice*, *37* (6), 683–693.

Riedel-Heller, S.G., Matschinger, H., & Angermeyer, M.C. (2005). Mental disorders – Who and what might help? Help-seeking and treatment preferences of the lay public. *Social Psychiatry & Psychiatric Epidemiology*, *40*, 167–174.

Roness, A., Mykletun, A., & Dahl, A.A. (2005). Help-seeking behaviour in patients with anxiety disorder and depression. *Acta Psychiatrica Scandinavica*, *111*, 51–58.

Strauss, A., & Corbin, J. (1990). *Basics of qualitative research: Grounded Theory procedures & techniques*. London: Sage.

Vogel, D.L., Wester, S.R., Wei, M., & Boysen, G.A. (2005). The role of outcome expectations and attitudes on decisions to seek professional help. *Journal of Counseling Psychology*, *52* (4), 459–470.

Biography

Elizabeth Marley is a private practitioner with a special interest in relationship issues. This study formed part of the researcher's Masters Degree in Counselling at the University of Abertay Dundee.