Help-Seeking Narratives on Online Platforms: A Qualitative Analysis of Mentions of Clinicians and Personal Networks

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Abstract

Online peer-support communities have become crucial spaces for individuals who are thinking of committing suicide (i.e., suicidal ideation) to express their distress and seek help. However, less is known about how these individuals perceive their help-seeking experience with professional (i.e., clinicians) or informal (i.e., family, friends, and partners) support sources, and how those experiences lead them to continue or discontinue seeking help. This study conducted a qualitative thematic analysis from an anonymous online platform dedicated to suicide-related disclosures, and further analyzed 348 comments explicitly expressing their experiences of help-seeking and mentioning engagement or discontinuation of help-seeking. As a result, most seek help from family (44%) or friends (41%), while they do not seek much help for partners (15%) or mental healthcare professionals (25%). Among professionals, psychologists received the most positive evaluations and were often quoted as "finally someone understands my struggles ". Conversely, psychiatrists and hospitals evoked significant ambivalence linked to systemic barriers (i.e., costs and time). Experiences with crisis hotlines were mixed and highly dependent on the immediate and warm reactions of responders. Across all format categories, empathy was the primary positive driver to continue seeking help, while systemic barriers were dominant sources of discontinuation of support. In addition, a family's attitudes are significant factors in deciding whether to continue seeking further help. These online narratives highlight the importance of "empathic" suicide-prevention.

Keywords: suicide prevention, help-seeking, thematic analysis, clinical empathy, social media

Introduction

Suicide prevention frameworks consistently emphasize the importance of linking people thinking to commit suicide (i.e., suicidal ideation) with timely and effective support. However, many individuals with suicidal ideation do not seek or receive professional help, and even among those who do, many discontinue their treatment (Barnett et al., 2024; Shin et al., 2024). In fact, existing literature has examined and documented multiple barriers, from psychological factors to systemic factors, regarding discontinuation and engagement in treatment (Cox et al., 2024; Shin et al., 2024). In addition, therapeutic relationships with those with suicidal ideation require alliance, trust, and the sense of being understood (Huggett et al., 2022). Together, these findings suggest that the problem is not merely whether care is available, but whether care is experienced as emotionally safe, credible, and worth returning to.

At the same time, much of the previous literature relies on traditional psychological research methods, such as surveys, interviews, or clinical samples (i.e., studies on those who are in the hospital or clinics). While these approaches are essential, they often fail to capture the real-time, naturalistic, and truthful thoughts of individuals with suicidal ideation, particularly those who never sought help or discontinued treatment (Klimes-Dougan et al., 2023). Online (semi-) anonymous platforms have become important and emotionally safe spaces where people can disclose suicidal ideation, share their treatment experiences, and seek support from others. Recent reviews also highlight that social media can provide valuable insight into how suicidal distress is framed and communicated (Trentarossi et al., 2025).

Based on the previous literature (e.g., Barnett et al., 2024; Trentarossi et al., 2025), the present study had two aims. Firstly, it aimed to identify posts in which users explicitly mentioned experiences with mental health care or support. Second, it aimed to analyze posts that described stopping or engaging in care. By examining discontinuation in users' own language, this study seeks to contribute to a more experience-near understanding of why mental health care is sometimes abandoned even in the context of severe suicidal distress.

Method

Data Source and Sampling

The data were drawn from public posts on online platforms, where individuals express their suicidal ideation or mental healthcare experience. The present study used public archive data from 2022 to 2024. The study proceeded in two stages. In the first stages, posts were identified if they explicitly mentioned experiences with mental health care or support in general (739 posts). In the second stage, a subset of 348 posts was extracted from the broader set because they described stopping, refusing, avoiding, or otherwise disengaging from mental healthcare. Posts were included in this subset if they contained: (1) an explicit statement of suicidal ideation and (2) an explicit statement of disengagement or engagement in seeking help (i.e., I stopped seeking help anymore). Posts were excluded if they were non-English, reposts, or memes.

Analytic Procedure

This study employed thematic analysis. Thematic analysis is appropriate when the aim is to identify and interpret patterns or meaning across a data set (Braun & Clarke, 2022). The 348 discontinuation-related posts were analyzed using thematic analysis informed by Braun and

Clarke's guidance (See Braun & Clarke, 2022, for a review). Initial coding focused on identifying how and why users described stopping or avoiding care. Secondly, related codes were grouped into broader candidate themes. The analysis emphasized interpretive patterns rather than simple topic counting. The goal was not only to record what users mentioned, but to understand how disengagement was mentioned. In this way, the analysis aimed to capture discontinuation as a lived process rather than as a binary service-use outcome.

Results

Statistics

739 posts were identified that explicitly mentioned experiences with mental health care or support. Within this group, a specific subset of 348 posts was extracted because they contained detailed narratives regarding discontinuation, avoidance, or refusal of professional treatment. While clinicians (i.e., psychologists, psychiatrists, hospitals) were referenced in approximately 25%, personal networks were mentioned more often: family (44%), friends (41%), and partners (15%). Among clinicians, psychologists were typically the most positively portrayed as support sources, whereas psychiatrists and hospitals frequently evoked dissatisfaction.

The thematic analysis of the 348 discontinuation-related posts indicated that disengagement from mental health care was rarely explained as a simple unwillingness to improve. Instead, users often described discontinuation as the result of cumulative experiences that made care feel unsafe, unhelpful, invalidating, or unsustainable. Several interrelated themes emerged.

Theme 1: Feeling Unheard, Unseen, or Emotionally Invalidated

A prominent theme was the feeling that providers did not genuinely understand the reality of distress or suicidal ideation. Many often described that mental health care managers or assessors managed or assessed their condition, but did not recognize or validate their emotional struggles. In these narratives, discontinuation followed the experience of leaving treatment because they believed clinicians did not understand them. This aligns with previous literature suggesting quality of care as a central component of help-seeking (Shin et al., 2024).

Theme 2: Cold, Rushed, or Impersonal Professional Encounters

Relatedly, many portrayed clinicians, particularly psychiatrists, as scripted or cold. These posts did not necessarily reject expertise itself. Rather, they suggested that expertise in mental healthcare without warmth or "human connection" was insufficient for them to trust and continue treatment. This pattern is also consistent with evidence that therapeutic alliance and the sense of being understood are central to suicidal clients' engagement with care (Huggett et al., 2022).

Theme 3: Coercion, Control, and Traumatic Care Experiences

Another recurrent theme saturated was about prior experience of coercion or traumatic treatment, especially involving hospitals or crisis responses (e.g., crisis intervention center, 72-hour rule, etc). Many described the fear of involuntary hospitalization or restraint. In these accounts, discontinuation was often framed as self-protection based on previous experiences. Some also mentioned specific words that they heard in crisis as well (i.e., My psychiatrists told

me...). These findings are also consistent with previous literature suggesting fear of negative service responses is a major reason to avoid seeking help (Calear et al., 2014; Shin et al., 2024).

Theme 4: Help-Seeking as Futile

Many posts reflected exhaustion after repeated attempts to seek help. Many described that they have already tried hard by going to therapy, medication, or crisis support, but none of them had improved their situation. Related to theme 3, this sense of futility often appeared in those who had multiple disappointing experiences. The broader literature likewise suggests that unmet needs and poor experiences within services can undermine ongoing engagement even after initial contact has been made (Shin et al., 2024).

Theme 5: Stigma, Shame, and Fear of Judgment

Users also described discontinuing or avoiding care because they believe that talking about their suicidal ideation or any other mental health struggles is socially not accepted. Some also feared being judged by clinicians, regardless of previous psychiatric history. Others described stigma within family or social environments that made continued care feel humiliating or burdensome. These narratives are consistent with evidence linking stigma and unfavorable perceptions of services to lower help-seeking for suicidal distress and self-harm (Calear et al., 2014; Cox et al., 2024; Wyllie et al., 2025).

Theme 6: Burden and Relational Ambivalence

Some expressed wanting support while feeling that they were “too much” for others. They described guilt about disturbing clinicians to take up their time and/or repeating the same suffering without any major improvements. In these cases, discontinuation was shaped by relational ambivalence rather than rejection of help. This theme resonates with findings that family, peer, and provider interactions can either facilitate or inhibit further engagement depending on how support is experienced (Shin et al., 2024).

Theme 7: Structural Problems Experienced as Personal Abandonment

Structural barriers also appeared repeatedly, including costs, waiting time, and difficulty in finding healthcare. However, many often expressed structural barriers with psychological experience, such as the experience of being left alone or isolated. This mirrors evidence showing that financial constraints, service organization, and navigational difficulties remain important barriers to help-seeking, especially when they interact with emotional vulnerability and low trust (Barnett et al., 2024; Cox et al., 2024; Shin et al., 2024).

Discussion

This study examined narratives of discontinuation of mental healthcare in posts on social media. The findings suggest that disengagement from care among individuals with suicidal ideation is best understood as a relational and experiential process rather than a simple failure to comply with treatment. In other words, one of the clearest implications is that access alone is not enough. In the present dataset, users repeatedly described care as something that became difficult to return to when it felt invalidating, impersonal, coercive, or ineffective. This is consistent with prior evidence that interactions with professionals, unmet needs, and the emotional climate of care are central to suicide-related help-seeking experiences (Huggett et

al., 2022; Shin et al., 2024). Thus, discontinuation of treatment should not be treated simply as nonadherence. Many, in this study, for example, had already sought care, sometimes repeatedly. Their disengagement often followed a negative experience with clinicians. In that sense, stopping care was not described as a lack of motivation but as the consequence of mistrust. This framing is important because conventional service models may interpret dropout as a patient-level failure when it may in fact reflect failures of relational safety, continuity, or responsiveness.

The theme of coercion is particularly significant for suicide prevention. While hospitalization and crisis intervention are necessary, clinicians have to be aware of co-occurring mental healthcare as a leading cause of avoidance in future help-seeking. This tension echoes wider concerns in suicide prevention research as well as to preserve an immediate but emotionally safe environment (Shin et al., 2024). Another important contribution is the centrality of emotional validation. Across themes, many appeared to evaluate care not only by whether it existed, but by whether it made them feel understood. This is compatible with the broader literature on therapeutic alliance, which suggests that trust and interpersonal connection are not peripheral to suicide-related treatment (Huggett et al., 2022).

Finally, the study underscores the value of online narratives for understanding treatment disengagement. Reviews of digital suicide research note that online posts can offer unique insight into how suicidal ideation is expressed and interpreted in naturalistic environments, especially where anonymity enables direct disclosure (Trentarossi et al., 2025). The present findings extend that insight by showing that such data can also illuminate how people make sense of failed or abandoned treatment pathways.

Limitations

Several limitations should be noted. First, the data came from a single online community and therefore do not represent all people experiencing suicidal ideation. Social Media users are a self-selecting population, and their narratives may differ from those of individuals who do not post publicly or anonymously. Second, the posts are self-reported narratives rather than verified treatment records. However, the focus of this study is precisely on how individuals interpret and narrate their experiences, because these interpretations shape future help-seeking behavior. Third, the thematic analysis identifies recurring patterns of meaning rather than causal predictors. The themes, therefore, should not be interpreted as prevalence estimates or definitive causal pathways.

Conclusion

Discontinuation of mental health care among individuals experiencing suicidal ideation is not well-explained as a matter of poor motivation or noncompliance. In the narrative analysis, disengagement often followed experiences of invalidation, impersonal treatment, coercion, stigma, futility, and mistrust. These findings suggest that effective suicide prevention requires not only making care available but making it feel safe, humane, and worth returning to. Examining public narratives on social media helps illuminate why some individuals withdraw from care even after reaching it, and why sustaining help-seeking may depend as much on relational experience as on access itself.

Declaration of Generative AI and AI-Assisted Technologies in the Writing Process

The author declares that Grammarly, an AI-assisted writing software, was used in proofreading and refining the language used in the manuscript. The usage was limited to correcting grammatical and spelling errors and rephrasing statements for accuracy and clarity. The author further declares that, apart from Grammarly, no other AI or AI-assisted technologies have been used to generate content in writing the manuscript. The ideas, design, procedures, findings, analyses, and discussion are originally written and derived from careful and systematic conduct of the research.

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