Understanding Families and Suicide Risk
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Executive summary

The overall goal of the research reported here was to develop a better understanding of the dynamic and proximal family factors that become relevant when a young family member is at risk of suicide. Of particular interest were the experiences of families who have faced this challenge. From their perspective, we were interested in what family dynamics have the potential to mitigate suicide risk for a young person and to facilitate family resilience.

This project was completed with support from the Ministry of Health’s Suicide Prevention Research Fund. This fund was established to address two priorities: suicide intervention; and enhancing our knowledge about suicidal behaviour. Under these priorities sit a number of supplementary areas of interest including: the care of people who make non-fatal suicide attempts; the views and experiences of family/whānau and significant others bereaved or affected by suicidal behaviour; and the risk and resiliency factors for suicidal behaviour.

Using a mixed-methodology design, data was collected from family/whānau of young people who had attempted or completed suicide. Families who had no such experiences were also included as a comparison. These groups provided the core research data through semi-structured interviews that explored family history and relationships, strengths, and coping in everyday life and within the context of suicidal risk and behaviour. Psychometric data was collected using a generic measure of psychological distress and a measure of family functioning. A second wave of data collection was undertaken with a number of mental health practitioners who have extensive experience working with at-risk young people and their families. Family data was drawn from 11 families, representing 25 family members in total, over 18 family interview sessions. Eight practitioners were interviewed.

Family strengths

Participants expressed an ideal where family members shared a special bond that enabled them to provide care and support for each other. Information from families and practitioners did not suggest that, on its own, having a strong family bond mitigates suicide risk. Instead the family bond, and the responsibility to care for family members that stems from it, are guiding principles that ground the operation of family dynamics.

Families nominated a range of strengths that they had within their group. There were two clear aspects to family strengths; contributions made by individuals within the family, and strengths that came from the patterns of interaction between family members. Strengths were often person and context specific, dynamic in nature, and included elements such as communication, caring, and an attitude of acceptance or forgiveness.

Family dynamics at times of crisis

Families in this study were asked to comment on how their strengths were or were not relevant at the time that their young person was at risk of suicide. Overall the information provided by families demonstrated that not all family strengths that were evident prior to the young person being at risk, had a protective role in the period leading up to the suicide attempt or completion. Some of the current strengths that families nominated had been developed during the time of crisis.

Data from both practitioners and families highlighted that within the family group, there were individual differences in reactions to adversity. Some family members tended to withdraw, some initiated discussion about the problem at hand, while others tended to offer emotional or practical support. Individual differences were acknowledged by families, and often accepted as characteristic of the person concerned when the family wanted to engage in a joint coping process.
Facing a challenge together required communication between family members, which often proved to be very difficult at a time of crisis. Some families cited lack of communication as being problematic in the time leading up to a suicide attempt or a completed suicide. Families were often shocked by the event, and could not immediately identify what their young family member had been thinking or feeling that could have led to such an extreme action. Some families had been in close contact, but had not talked about problems with their young person. They stated that continuing to talk to each other, despite conflict, was part of being successful when the family was facing a challenge.

Participants whose family member had completed suicide emphasised the ongoing value of being able to talk openly about their loved one. Talking about suicide, and the circumstances in which it had happened, tended to occur for participants who already had established patterns of communication within the family. For participants who did not have these patterns, talking about suicide proved more difficult to achieve.

**General conclusions**

The families that participated in this project were diverse. However, they had some common ideas about what being a family actually means. Family relationships were defined in terms of how people felt about each other, and the responsibilities they had to each other, rather than biological or legal ties. To some extent the characteristics of a family were ideals, which were difficult for families to attain consistently. There is, of course, no guarantee that attainment of these ideals would ensure perfect functioning and a problem-free family life. Families may need reminding about the importance of being involved in each other’s lives, during ordinary times and when facing adversity.

Families need support in developing and maintaining effective communication skills. Young people may also benefit from special attention in this domain, as the most potent influence on their developing communication skills can be their peers and is not necessarily their family or parents. Communication needs change over time, and in different circumstances. Effective communication is a critical component of effective coping, particularly in supporting conflict resolution and joint problem-solving.

It is likely that many of the challenges that families face are initially met from within the repertoire of responses already possessed by the families and the individuals within them. People repeat what has worked previously or has worked in a similar situation, or by applying a solution that they have heard about or found on the internet. In many cases these will suffice, but if they are not, then a response is required that is based on sound principles applied flexibly to a new situation. Problem-solving resources and courses may assist, as these may help families make the minor adjustments that are often required.

Families at risk, or those that are in a chronic state of challenge and stress, may require more extensive family support. This may include support to identify and use their strengths in a flexible way, explore barriers to compromise, accept diversity or change, and avoid common (and less common) problem-solving dead ends.

Some families and parents questioned the decisions that they had made regarding the balance of individual autonomy versus accountability for their young person. They believed that they had allowed their young person too much freedom, without demanding more transparency, and advocated that more care needs to be taken to be aware of the choices and activities of young people. They emphasised that the adolescent years should not be seen as a time of growing away from the family, but of growing up with the family.

In general, families wanted more information about depression, suicide and trauma. They stated a belief that they would have been able to mitigate risk more effectively if they had known what to look out for, including the signs and symptoms of depression, the most common warning signs of suicidal thought and behaviour, and how to recognise a trauma response. There is a popular conception that it is desirable to restrict access to information about suicide in the belief that exposure is likely to increase risk. However, such an approach cannot ignore the information vacuum that this may create, leaving space for potentially unreliable data to be sought from the internet or other sources, and for myth and folklore to go unchallenged.
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1 Introduction

As well as improving the care of individuals at risk of suicide, a key goal for the New Zealand Suicide Prevention Action Plan 2008–2012 (Ministry of Health, 2008) is to support families, whānau, friends and others who are affected when a young person makes or completes a suicide attempt. Beautrais et al. (2006) highlight the need for inclusion of families in suicide prevention, both to reduce childhood exposure to risk factors, and optimise the development of individual and family factors that could aid resilience. What little empirical work there is tends to highlight family factors that increase the risk of suicide, many of which are presented as well-established patterns of thinking, feeling, behaving or relating. There is a significant deficit in the research literature concerning what it is that families do when a family member is at risk of suicide that can lead to good outcomes, for both the individual and the family.

1.1 Suicide: an overview of the New Zealand context

1.1.1 Suicide rates

New Zealand has a high rate of suicide compared to similar developed countries worldwide. On average, 500 New Zealanders die each year by suicide, and at least 10 times that number present with injuries from deliberate self-harm (Beautrais, 2006; Ministry of Health, 2007, 2008). A recent survey of New Zealand secondary school pupils’ health and well-being found that 19 per cent of female students and 9 per cent of male students reported that they had thought seriously about suicide in the previous 12 months (Adolescent Health Research Group, 2008a). Suicide attempts were reported by 7 per cent of male and 3 per cent of female students in that survey.

1.1.2 High suicide risk groups

Data collated about suicide in the New Zealand population (Beautrais, 2006; Ministry of Health, 2007) indicates that there are several groups within our society that have a higher proportion of people engaging in suicidal behaviour.

Young adults have been found to be more likely to engage in suicidal behaviour. For example, the rate of attempted suicide was higher in young people aged between 16 and 24 years (Beautrais, 2006). During 2007, the hospitalisation rates as a consequence of self-harm were highest in the 15 to 19 year old age group (Ministry of Health, 2009). This is consistent with trends in data collected between 2004 and 2006 (Ministry of Health, 2007). In contrast, the data for completed suicides across all age groups in the Ministry of Health’s Suicide Facts report (2007) shows a trend whereby older age groups had higher rates of completed suicide. That is, the rate of completed suicides was higher for adults aged between 35 and 39 years (19.4 deaths per 100,000 population), than for adolescents (13.1 deaths per 100,000 population) or young adults (17.7 deaths per 100,000 population).

There are also marked gender differences in suicidal behaviour. More females (82.2 per 100,000 population) than males (45.5 per 100,000 population) were hospitalised as a result of self-harm in 2007 (Ministry of Health, 2009). In contrast, more males completed suicide than females (in a ratio of 3.6:1) (Ministry of Health, 2009). In 2007, the 30-34 year old age group had the highest rate of death by suicide for males (33.9 deaths per 100,000 population). In 2006, the highest suicide rates for males had been in the 15-19 year old age group. In 2007, the 40-44 year old age range had the highest rate of death by suicide among females (10.3 deaths per 100,000 population), while in 2006 the 35-39 year old age group had been the highest.
People who were more poorly resourced (e.g., from low-income households or higher deprivation areas) were more at risk of attempting suicide (Ministry of Health, 2009). Completed suicides were disproportionately higher in the most deprived areas (13.3 deaths per 100,000 population), compared to the rate in the least deprived areas of the population (7.7 deaths per 100,000) (Ministry of Health, 2009).

Differences in rates of suicide attempt and suicide completion across various ethnic groups in New Zealand are well documented in Te Rau Hinengaro: The New Zealand Mental Health Survey (Beautrais, 2006), national summaries of suicide statistics (Ministry of Health, 2007, 2009), and the recent survey of New Zealand secondary school students (Adolescent Health Research Group, 2008b). Māori and Pacific people have significantly higher rates of suicide attempts, even after adjustment for the socio-demographic factors described above. Among Māori, death by suicide is highest in the under 45 years of age group (Ministry of Health, 2009). Māori males had the highest rate of deaths by suicide in 2007 (25.9 deaths per 100,000). Results from the Adolescent Health Research Group’s survey of secondary students reported a similar trend for gender, with 9.6 per cent of female Māori students reporting a suicide attempt in the last year, compared to 4.4 per cent of male Māori students. A positive trend from the survey was the finding that significantly fewer Māori students reported a suicide attempt in the 2007 survey than the 2001 survey.

Pacific females have been found to have a higher rate of suicide attempts than Pacific males (Foliaki et al., 2006), and the rate for both groups is higher than expected for the general population. Pacific youth who were born in New Zealand, or were under 18 years old at age of migration, had a significantly higher rate of suicide attempt than those who migrated after the age of 18 years.

Te Rau Hinengaro: The New Zealand Mental Health Survey showed that many different types of distress are associated with suicidal behaviour, but disorders in mood are the most significant mental health risk factor for suicide attempt (Beautrais, 2006). Co-morbidity of mental health problems was also a risk factor, with the rate of suicide attempts increasing among those who were identified as having more than one area of concern.

1.2 Factors in the family context that have been linked to suicide risk

There is good evidence that cumulative adverse events or experiences, within the early family context, increase the risk of later suicidal behaviour for youth (Fergusson et al., 2003). Suicidal behaviour may be more likely to develop when individual vulnerabilities that have developed over time converge with current individual and familial risk factors in the young person’s life (Fergusson et al., 2000).

Longitudinal data from New Zealand’s Christchurch Health and Development Study (Fergusson, 1995; Fergusson et al., 2003; Fergusson et al., 2000) revealed increased rates of attempted suicide among participants from dysfunctional family backgrounds. Family factors identified in this study that predisposed people to suicide risk were lack of early maternal care, parent or caregiver mental health status, parent or caregiver substance use, parent or caregiver offending problems, childhood exposure to parental change and family conflict, and more frequent changes in school or residence during this period. Fergusson and colleagues also found that regular or severe physical punishment, childhood sexual abuse, and poor parent–child attachment at age 15 years were related to increased risk of suicidal behaviour in youth.

Later analysis by Fergusson et al. (2003) explored both vulnerability and possible resiliency factors in youth who developed depressive disorders. Such disorders are a significant risk factor for suicidal behaviour. Of those in the cohort who had experienced depression, the majority did not go on to develop suicidal behaviour.
As expected, the family factors found in earlier analyses (noted in the paragraph above) continued to be related to higher rates of suicidal ideation or behaviour when the young person was depressed. In addition, a new family factor was found to be relevant. Having a family history of suicidal behaviour was also related to higher rates of suicidal ideation when young people were depressed.

Positive family characteristics and attributes were more prevalent in the group with depression, but for whom there were no concerns about suicide. Positive factors included the absence of childhood sexual abuse, and no family history of suicide. However, a chivvying s the authors noted, the Christchurch Health and Development Study is unlikely to have included all of the potential risk and resiliency factors in its data collection or analysis.

1.3 Current family factors that have been linked to suicidal behaviour

Dynamics within a young person’s current family context have also been linked to the development of suicide risk. Several areas of family functioning that are potentially relevant are outlined below, along with examples of studies that have linked them to suicide risk. Information on family functioning and suicide risk primarily comes from surveys of youth in the general population, and to a lesser extent, investigations of youth and adults in the clinical population. Very few empirical studies have collected information directly from the family members of an individual at risk of suicide.

1.3.1 Level of family cohesion

Family cohesion has been included in several Western models of family functioning, and in general refers to the emotional connection between family members (Kalil, 2003). As Kalil notes, the degree of cohesion within a family needs to be considered in conjunction with other dimensions in models of family functioning. Family cohesion is also likely to be culture specific.

A link between current family cohesion and suicide risk has been found in clinical samples of youth and adults who have made a suicide attempt. Greene et al. (1995) investigated family cohesion and control using semi-structured interviews with nine American pre-adolescent children who were at risk of suicide, and their families. These families indicated that they were not particularly close to each other, or to their extended families, whom they would not ask for help. Greene et al. concluded that the emotional cohesion or emotional bonding between family members was impaired when normal family functioning was undermined. Compton et al. (2005) examined family functioning in 100 African-Americans admitted to hospital following a suicide attempt. The age of participants in their study ranged from 18 to 64 years. Compton and colleagues matched the clinical case group to a control group attending an urgent medical care service. On admission, the group who had made a suicide attempt were found to have significantly poorer family adaptability and family cohesion, as measured by the Family Adaptability and Cohesion Evaluation Scale (Olson et al., 1985).

Surveys of secondary and tertiary-level students have also supported the idea that there is a link between poor family cohesion and suicidal behaviour. A survey of Hong Kong Chinese students aged between 14 and 20 years, (Lee et al., 2006) found a negative correlation between family cohesion as measured by the Family Environment Scale (Moos and Moos, 1981), and suicidal ideation. Lee et al. highlight the importance of family acceptance and family support in the culture of these students, and reiterate that family dynamics must be considered when investigating the development of suicide risk. Gencoz and Or (2006) looked at the relationship between family dynamics and probability of suicide in a sample of Turkish university students aged between 17 and 38 years. Lack of family cohesion, as measured by the Family Environment Questionnaire (Fowler, 1980), emerged as a unique contributor to high suicide probability for the students after controlling for the impact of poor academic performance and low mood.
A survey of African-American students by Harris and Milock (2000) found that positive configuration of family cohesion was related to lower suicide risk. A higher level of family cohesion, as measured by the Family Environment Scale, was associated with fewer instances of suicidal ideation and depression for the students.

1.3.2 Perceived level of parental involvement

In a large survey study of adolescents, Flouri and Buchanan (2002) found that youth who reported having made a suicide attempt also had lower levels of perceived parental involvement (i.e., parents who listened to the adolescent’s views, or parents who took notice of the adolescent) compared to youth who had not made a suicide attempt. Randell et al.’s (2006) survey of American youth aged between 14 and 19 years found that adolescents at the highest risk of suicide could be reliably differentiated from those in the lower risk categories by levels of perceived parental involvement and family support for school activities.

Parents of pre-adolescent children with high suicide risk in Greene et al.’s (1995) study expressed that their at-risk child was difficult to manage. The authors noted that their participants’ family context typically lacked rules, enforcement of rules, and consistent adult supervision of children outside the home. Despite this seemingly disengaged stance, when there was an imminent risk of harm to the child, parents acted protectively and typically took an active leadership role on the child’s behalf.

1.3.3 Perceived level of family support

Sun and Long (2008) conducted semi-structured interviews with adult Chinese patients who had been discharged from hospital care after a suicide attempt. They also collected data from the family members who were providing care for the patients. A key theme in the patients’ interview data was the link they made between perceived family support and improvement in suicidal ideation during this time. Families of the patients described finding the care tasks particularly difficult, as they did not know how to prevent a suicide. Despite high levels of distress, families were able to create a nurturing home environment by conveying their care and concern for their at-risk family member.

Lee et al. (2006) found that Hong Kong Chinese students who perceived their level of family support to be low had higher rates of depression and suicidal ideation than those who did not. Harris and Milock (2000) found that a higher perceived level of family support was associated with fewer instances of suicidal ideation and depression for African-American students. Randell et al. (2006) also found that perceived levels of family support differentiated youth at high and low risk of suicide. Youth who identified that there would be support available from family if they were experiencing low moods or thinking about suicide had relatively low levels of self-reported suicide risk.

1.3.4 Conflict within the family

Cavanaugh et al. (1999) incorporated family factors into their retrospective investigation of the life events of adults who were thought to have died by suicide. Information about events in the last six months of life was provided by family members of the deceased person. This data was compared with the life events of a living case-matched control group, who were similar in age, gender and psychiatric diagnosis. Cavanaugh et al. found that the adults who had completed suicide were more likely than the control group to have experienced adverse interpersonal events with other family members.

Krupinski et al. (1998) compared the family settings and relationships of young people who had completed suicide, made a suicide attempt and been admitted to hospital, or made an attempt and been placed back with their families. Interview information given by the young people in the latter two groups was corroborated by family. The majority of young people who had made a suicide attempt described their family relationships as distant or cool. The reason given by participants for attempting suicide was typically to do with conflict in family relationships.
Official information given by families at the time that their relative died was collated for the deceased group. Notes left by the deceased at the time of the suicide were also included. In contrast to the attempt group, information from the group who had completed suicide indicated that these people had felt positively about their families. The reasons given for taking their own life were more influenced by having a mental health issue and feeling worthless, than by family conflict.

In a survey of adolescents from the general population, Lee et al. (2006) found that parent–adolescent conflict was positively correlated with suicidal ideation. Similarly, Flouri and Buchanan (2002) found that youth from the general population who reported having made a suicide attempt were more likely than other survey respondents to report conflict in their family. Youth with a higher risk of suicide in Randell et al.’s (2006) survey also had more experiences of conflict with parents and more experiences of family violence than youth with no risk. In addition, youth who reported unfair rules at home, lack of positive shared activities with family, and a lack of parental positive regard were more likely to be at higher risk of suicide than their peers.

In a survey of American college students and their parents, Carris et al., (1998) found that family rigidity (the inability of a family to change its power structures, role relationships and rules) had an indirect effect on suicidal behaviour via the youth’s problem-solving skills. Bertera (2007) examined positive and negative socio-emotional interactions between adolescents, aged 15-19 years, and the members of their families. More frequent negative social interactions with family were associated with higher suicide ideation scores for youth of all ages.

1.3.5 Limitations of current research

The available data supports the general idea that family dynamics have an important role in the development and management of suicidal behaviour, but it is difficult to interpret beyond this point (Greene Bush & Pargament, 1995). There are methodological problems with many of the studies of family factors in suicide risk. For example, much of the research with a clinical population has been done with small sample sizes across several age groups (Greene Bush & Pargament, 1995). Many of the survey studies have only looked at the perspective of one family member, which does not provide information on how the family functions as a whole. Few studies have examined the contribution of family factors relative to other known risks, such as poor mental health and substance use disorders.

There are also some difficulties with the way in which family functioning has been measured. The measures use predetermined constructs that have typically been developed in Western cultures and may not capture more relevant family dynamics across different ethnic populations. This is an issue to consider when investigating the development and management of youth suicide risk in New Zealand families, as it is largely Māori youth who have the highest rates of attempted and completed suicide.

Not everyone who is exposed to adversity goes on to develop psychological difficulties, and not everyone who has psychological difficulties goes on to attempt suicide. This is one of the most concerning deficits in the literature cited above. Very few studies examined the family dynamics and characteristics of young people who had risk factors, but who did not go on to develop suicidal behaviour. Beautrais et al. (2006) note that the available data does not focus directly on what helps families to cope well when a young person is at risk of suicide.
1.4 Family resilience: an overview

1.4.1 Resilience concepts

Individuals and groups of people who are “able to withstand and rebound from disruptive life challenges” are usually thought of as resilient. Luthar et al. (2000) described resilience as “a dynamic process encompassing positive adaptation within the context of significant adversity”. The meaning of the terms such as resilience, resilient and resiliency has been the subject of debate (see Luthar et al., 2000 for a review). They have been used in many ways, for example in referring to a trait, a process or an outcome. However, some constructs are generally agreed upon within the resilience literature (Mackay, 2003). Typically resilience refers to a dynamic process of adaptation, where risk factors, vulnerability factors and protective factors interact to produce a desirable outcome.

- Risk factors are associated with a particular adversity occurring at a particular time of life (e.g., current depression is a risk factor for youth suicide). There are no particular standards as to what types of life events are considered to be adverse. Risk factors may come from an acute event, a persistent challenge, or a “pile up” of seemingly minor stressors (Walsh, 2003).

- Vulnerability factors are those characteristics of the individual or group that increase the likelihood of a poor outcome in adverse situations. These may be historical, proximal (e.g., the direct effect of early abuse and neglect) or distal (e.g., the indirect effects of living in a lower socio-economic area) (Mackay, 2003).

- In general, protective factors mitigate the negative influence of risk, reducing the likelihood of a poor outcome.

It is also generally agreed that resilience needs to be seen in the context of the systems within which an individual or a group is living. Mackay (2003) emphasised that resilience is a continuous variable, rather than a category. Different people can be seen as more or less resilient across the same type of adversity. Mackay (2003) and Luthar et al. (2000) also noted that resilience is not a stable trait, as people can be seen as resilient under some adverse conditions, but not others.

Another key debate within the resilience literature is how protective factors are defined. Fergusson et al. (2003) argue that vulnerability and protective factors are related, but are also distinct processes that should be conceptualised differently. For example, while exposure to childhood adversity is a vulnerability factor that contributes to increased risk, it is not useful to then infer that the absence of childhood adversity makes a person resilient. Instead, Fergusson et al. described protective factors as “those factors that are beneficial when exposed to a risk factor, but confer no (or less) benefit to those not exposed to the risk factor” (p.62). Luthar et al. (2000) highlighted that the focus of resilience work has expanded beyond static or intra-individual protective factors, and into protective processes or dynamics that occur within the systems in which children live.

Patterson (2002) differentiated between family strengths and protective factors. Family strengths can be thought of as the day-to-day patterns of thinking and ways of behaving that enable a family to successfully face the demands of everyday life. These strengths may or may not serve as protective factors when a family is facing extraordinary demands. Some strengths may help the family through a crisis in the short term, but become dysfunctional if the adversity persists over time (Walsh, 2003). Patterson (2002) and Walsh (2003) proposed that new family strengths can develop during the process of adapting to adverse circumstances. Growth may happen when a family is challenged in a way that demands coping resources that it does not already have, but is not so adverse as to be overwhelming. When resilience is seen as a process, rather than a trait (Patterson, 2002), researchers can begin to understand individual differences in resilience across different contexts and in response to different types of stressors.
1.4.2 What is family resilience?

Early research primarily identified resilience as comprising of a collection of personal attributes (e.g., intelligence) that mitigate risk and lead to good outcomes for children experiencing adversity. As the understanding of resilience has evolved, it is apparent that resilience factors are also located within the systems in which children live, including their families (Luthar et al., 2000). Current conceptualisations of resilience look at how personal attributes, family attributes and environmental characteristics work together to increase the likelihood of positive outcomes for children. What is a good outcome is judged based on the unique context of each family. There is no single set of criteria for a healthy family or whānau. For example, what a family unit might be expected to achieve differs across the family life cycle (McCubbin et al., 1997; Walsh, 2003) and, more broadly, across cultural groups (Black and Lobo, 2008).

Current models of family resilience have been influenced by numerous areas of child and family research. These include family stress and coping studies, investigations into how family units function, the impact of different parenting approaches on child development, and the impact of the family context on child development (see Black and Lobo, 2008; Kalil, 2003; Mackay, 2003; Patterson, 2002; Walsh, 2003 for reviews). However, Kalil (2003) notes a unique and important difference between previous work, and that being currently undertaken in the area of family resilience. Instead of risk factors and problematic outcomes, resilience work is concerned with family strengths, positive adaptations, and what leads to better outcomes for the family as a whole.

The clinical application of family resilience leads a practitioner to be more positive and future-orientated than traditional practice frameworks (Simon et al., 2005; Walsh, 2003). Family resilience is more focused on what strengths and resources families have that can resolve problems, rather than how the problems started in the first place. Family resilience models have not been widely applied in research or clinical practice (Simon et al., 2005) and have not been used in youth suicide research to date (Beautrais et al., 2006). However, gaining insight into how processes of resilience are developed and implemented by families, could contribute to understanding how good outcomes are achieved when a young person is at risk.

1.4.3 What dynamic family factors distinguish families who cope well with adversity?

There is a great deal of theoretical work on family resilience, but very little empirical research has been completed to date (Kalil, 2003; Mackay, 2003). The currently proposed models of family resilience are made up of family functioning processes or family dynamics that are thought to contribute to good outcomes under adversity (Patterson, 2002).

Patterson (2002, p. 240) specifically defines family resilience as;

*the patterns of relational functioning that have become established within a family, which serve to facilitate the accomplishment of family functions and individual development tasks, can be examined in terms of how well they protect the family from undesirable outcomes when exposed to risks or demands*.

Patterson has put forward four key relational processes that help families to function in day-to-day life, but could also have a protective function under adverse circumstances.

- Family cohesion, being the balance between connectedness and individualisation of family members.
- Family flexibility, being the balance between change in response to new demands and the retention of long-standing characteristics that form the identity of the family.
- Patterns of affective and instrumental communication between family members are both highlighted as pivotal in adaptive family functioning.
- Family meanings about the specific problem at hand, their own identity as a family, and the context they live in, also contribute to the process of adaptation.
Walsh (2003) has compiled a family resilience framework with three domains. Walsh’s model emphasises the idea of “bouncing forward” rather than “bouncing back” from adversity. Certain events, such as losing a family member to suicide, have permanent consequences that mean previous patterns of family functioning may not be able to be restored. Hence a family that “bounces forward” into a new sense of normality is also considered to be resilient. The three domains identified by Walsh are as follows.

- **Family belief systems** – form the basis for the other domains. How family members make sense of themselves as a unit, and the stressors they face, will influence how they react to adversity as a group.
- **Family organisational patterns** – refers to how a family structures itself under stress. It includes how flexible a family structure can be, its connectedness (i.e., family cohesion), and what social or economic supports can be accessed by the family.
- **Family communication and problem solving** – refers to the main coping processes that foster resilience. There are three specific processes within this latter domain. They are: clear communication, which refers to family members being able to develop a shared understanding of the problem at hand; emotional expression, which refers to the degree to which the family members can express emotions and be supported; and problem solving, which refers to shared decision making and achievement of conflict resolution.

McCubbin et al.’s (1997) Resiliency Model of Family Stress, Adjustment, and Adaptation proposed two important phases that a family goes through when facing a challenge. Firstly there is a period of adjustment, where a family uses its established protective factors to manage the situation. If these factors are not sufficient, then the family faces a crisis, and moves into the adaptation phase. The family may need to develop new family processes, such as new ways of coping, in order to recover from the crisis. McCubbin et al. referred to the processes that facilitate good outcomes in this phase as “recovery factors”.

McCubbin et al. proposed a list of general family protective factors which takes into consideration aspects of family life that are important at all stages of the family developmental cycle. These included family celebrations, family hardness, family time and routines, and family traditions. The extent to which these factors facilitate adaptation can only be determined by looking at how the family functions in the context of the challenges that a particular type of crisis brings. Family-level processes, such as those associated with low suicide risk, have also been found to help families cope with other adverse circumstances (Mackay, 2003).

### 1.5 Conclusion and rationale for the current study

The relevance of dynamic family factors in the development and management of suicide risk is indicated in studies linking family functioning to suicide risk. Relationships between these variables have been found in the general population of young people and in clinical samples of young people with mental health concerns. However, we cannot determine from research to date what it is that families actually do that helps them and the young person at risk of suicide. Family resilience frameworks may provide some insight. There are consistencies between findings from the research into family factors and suicide risk, in that both highlight the importance of dynamic family factors. However, the resilience frameworks have a different focus. They ask the question, “What dynamic family factors could have protective function when a young person is at risk of suicide?”

This current research project is focused on this knowledge gap. Specifically, are there family interaction patterns or practices that mitigate risk of suicidal behaviour in young family members? Are there family dynamics that could contribute to better outcomes for both the family and the young person? There is little data relating to proximal factors, those characteristics and dynamic features of everyday family life that are more idiosyncratic and open to change.
To date little attention has been paid to the psychological aspects of day-to-day family life that may provide both the context within which suicidal risk and behaviour is located (prevention), and in which the effects of suicidal behaviour are most keenly felt (postvention).

In 2006, the New Zealand Government released its *New Zealand Suicide Prevention Strategy, 2006–2016* (Associate Minister of Health, 2006). This was followed in 2008 by the *New Zealand Suicide Prevention Action Plan, 2008–2012* (Ministry of Health, 2008), which translated the goals of the strategy into specific actions. The Ministry of Health established a suicide prevention fund to resource small-scale projects that addressed two priorities: research in the area of suicide intervention; and research focussed on enhancing the knowledge available about suicidal behaviour. The project reported here addresses a number of the specific targets within these two priority areas, focussing especially on those that are related to families.

The overall goal of this project was to develop a better understanding of dynamic family factors association with suicide risk and management for New Zealand families/whānau. To achieve this aim, this project planned to collect information from families with a diverse range of experiences related to suicide. Three different groups of families were included:

- families that had lost a young person (postvention)
- families that had a young person at risk of suicide (prevention)
- families that had a young person with no identified risk factors (prevention).

Of particular interest was how the experiences of these families could contribute to our understanding of resilience, and contribute to the ongoing development of a framework for a family intervention strategy through the enhancement of family resilience (Walsh, 2003).
2 Project design

2.1 Advantages of a qualitative methodology

The questions posed for this project are exploratory in nature. While there are several possible a priori hypotheses that could be derived from the literature pertaining to suicide, families and resilience, none were specified at the beginning of this research. Instead, the aim was to obtain an account of what family dynamics were important from the perspectives of families themselves, and document the dynamics that they identified as contributing to the management of suicide risk. Exploratory research questions such as these are well suited to a qualitative methodology.

At present there is no well-developed psychometric instrument that captures data pertaining to family resilience. There are measures of family domains of functioning (e.g., the Family Assessment Measure-III used in this study), some of which could be said to be strengths. However, family assessment measures do not extend to identifying what aspects of the family’s functioning facilitate resilience under adversity.

Given the multi-dimensional and contextual nature of resilience it would be misleading to derive a global score that represents a family’s overall resilience. Instead, Luthar et al. (2000) recommend that researchers avoid making global statements about a particular family’s resilience, and limit their interpretation to the specific domains in which resilience is found to have occurred. In the current study the domains under investigation are those that are relevant in the development and management of suicide risk.

Interpretive phenomenological analysis (IPA) was chosen as the main data analysis technique for this study. Although it is a relatively recently developed qualitative approach, IPA is now being used widely by researchers in health, clinical, and social psychology (Brocki and Wearden, 2006; Reid et al., 2005; Smith, 2004). IPA has been used successfully to investigate suicide attempts in later life (Crocker et al., 2006). It has also been used to analyse data from group interviews (see Brocki and Wearden, 2006, for review). IPA is an approach to understanding the experiences an individual has in life, how they make sense of them, and what meanings those experiences hold (Smith and Osborn, 2008; Smith and Eatough, 2006). The approach is phenomenological, in that it involves a detailed examination of the participant’s experience. However, the research is also active in the search for meaning and understanding. That is, while the participant is trying to make sense of his or her experience, the researcher is trying to make sense of the participant who is trying to make sense of their world. A double hermeneutic is involved: an empathic hermeneutic, where the researcher is trying to understand what it is like for the participant; and a questioning hermeneutic, where the researcher asks critical questions of the texts from participants (e.g., Do I have the sense of something going on here that maybe the participants themselves are unaware of?).

Interpretive phenomenological analysis is not suited to testing a priori hypotheses, or generating findings that can be generalised to the population as a whole. This stance makes it particularly suited to the area of family resilience and suicide, as this is a particularly undeveloped area. In addition, a particular advantage of IPA for the current study is that it is suited to small sample sizes. Completed suicide is a tragic, but relatively low-frequency event in everyday family life (i.e., there are approximately 500 deaths from suicide per year in New Zealand). This meant that the potential pool for recruitment to this research group was small.
2.2 Focus of the data collection

Data collection was focussed on the family, rather than on the individual who had attempted or completed suicide. It did not examine details of the attempted or completed suicide itself. Rather, data collection was focussed on gathering information about the families of those who had completed suicide, and those who had made suicide attempts. This included the views and perceptions of the family held by those family members who had a history of suicidal behaviour, as well as the views and experiences of other family members.

2.3 Protocol amendments made during the data collection phase

The initial plan was to collect data from four groups of families:

- families where a young person had completed suicide
- families where a young person had attempted suicide
- families where a young person had a mental health concern
- families where there are no concerns about mental health or suicidal behaviour.

We included the final control group in an attempt to capture data from families that had no contact with mental health services, and where suicidal behaviour was not associated with a psychiatric disorder.

Most local health and support workers expressed interest in the project, and responded positively to the idea of learning more about family dynamics that facilitate resilience. However, this enthusiasm did not generate referrals of families into the project by practitioners. Unfortunately, the number of families who volunteered was well below the projected recruitment. This raised concerns about what we may be able to usefully conclude by the end of the project. Consequently, two major protocol amendments were made. Firstly, in March 2009, the recruitment drive was extended to include contacting families via secondary schools. This did not increase recruitment rates to a desirable level.

In September 2009, collecting data and information from secondary sources, which could contribute to our analysis of family dynamics and suicide risk, was considered. Secondary sources were thought to add value to the project by corroborating or challenging the data that had already been collected, and further highlighting dynamic family factors, strengths, and coping or resilience issues that had not yet been heard about from the family participants. For this reason, the project was extended to include interviews with local workers who provide services for at-risk youth and their families. This group potentially consisted of people working in tertiary care (e.g., psychiatrists, psychologists, social workers), primary care (e.g., general practitioners), family support workers (e.g., in the non-government organisation sector), and school guidance counsellors. Interviews with practitioners had the same core focal area as the interviews with families, namely, what family dynamics can be thought of as resilience factors that enable families to cope well when a young person is at risk?
2.4 Inclusion and exclusion criteria for participants

Young people aged between 16 and 24 years were the initial priority group, because there was a higher incidence of completed suicide in this population at the time the project began. However, as recruitment difficulties were encountered, a decision was made to extend the age range. This enabled two more families who volunteered to be included. One of these families had a person aged 30 years who had attempted suicide. The other family had lost their 25-year-old daughter to suicide.

There were no inclusion or exclusion criteria based on ethnicity. Recruitment planned to establish a connection with Māori families, as a key goal of the project was to engage this higher risk group.

There were no inclusion or exclusion criteria based on the composition of families. Participants themselves identified the people who made up their family, and this included people who were and were not legally or biologically related to each other.

This project was not focused on any particular characteristics of suicidal behaviour, such as the young person’s intent to die or the degree of lethality of their attempt. If the families themselves genuinely believed that their young person had made an attempt to take their own life, or had taken their own life, then they were eligible to participate regardless of any legal or medical conclusion made.

2.5 Ethical approval

Ethical approval was obtained for the project from the Northern-Y Regional Ethics Committee, and the research subcommittee of the Waikato District Health Board’s Kaumātua Kaunihera Committee.

2.6 Bi-cultural considerations

Consideration was given to ensuring that, as far as possible, this project was conducted in a way that was consistent with the articles of the Treaty of Waitangi (that is, that the rights and needs of Māori were recognised). This involves:

- the protection of Māori rights, values, culture and practices
- the right to participate fully in any activities that impact on Māori, including governance, management, and implementation of projects and programmes
- engagement with Māori in full partnership.

These considerations were especially important in this project, given the over-representation of Māori in the youth suicide statistics.

Te Whakauruora. Restoration of Health: Māori Suicide Prevention Resource (Ihimaera and MacDonald, 2009, p. 22) emphasises that the experience of “suicidal feelings, thoughts, emotional, and actions for some Māori are captured within a cultural and spiritual context”. A key message of this resource is that suicide is viewed differently by Māori. Those working with Māori at risk of suicide and their whānau are advised to acknowledge this, and ensure that the processes they undertake “explore and allow for cultural and spiritual expression” (Ibid, p. 23).

To help meet these needs, a Māori researcher and interviewer was recruited for the project team, with the final project design details not confirmed until this person was involved. Research procedures (i.e., recruitment methods, interview protocols) were left as flexible as possible to enable the research team to be responsive to the needs of each participant. Recruitment posters were available in a Te Reo Māori, and we endeavoured to recruit Māori participants through contacts and venues that were relevant for local Māori.
In all instances when it was necessary or desirable that a meeting protocol particular to Māori was observed during the interviews, this was pursued in a seamless and highly competent fashion. All participants were made aware that these processes would be followed if they deemed it to be important.

We were also aware of the more collective nature of Māori whānau culture, and the difficulties that may arise for individual family members in commenting on whānau issues. These were dealt with on a case-by-case basis, taking direction from those family members present. However, it was clear that the overall nature of the project made such sensitivity and confidentiality important for all participants, and in the end there were no additional demands for the application of specific protocols or processes made by any participants, family or practitioners.
3 Data collection with families

3.1 Recruitment of families

3.1.1 Development of recruitment materials for families

The recruitment materials developed for this project are presented in Appendix A. A colour poster advertising the project was produced in English and Te Reo Māori. Other materials included an A4 tri-fold leaflet that families could pick up from an agency and take home. In the later stages of the project, this was replaced with an A5-size handout, which was placed in an envelope with an information sheet that families could take home. In addition, web pages (linked to The Psychology Centre website) were developed. These contained project information and a link for potential participants to send expressions of interest to the research team.

If families indicated through any of the recruitment avenues that they were interested, they were then sent a participant information sheet (see Appendix B) with a covering letter. A research team member typically contacted the family within a week of the information being sent out.

The same information sheet was also provided to practitioners in those agencies where the project was advertised. This was done to ensure that practitioners themselves had a good understanding of the project, so that they could pass the information onto families in their agency.

3.1.2 Advertising the project to families

The catchment area for this project encompassed both urban and rural Waikato. Within the Waikato district, no specific support systems were identified for families who had lost a family member to suicide. While all families in this situation are made aware that Victim Support services are available to them, they do not necessarily engage with the service at the time of the suicide. For those who do, Victim Support may facilitate a pathway into other local care services, such as counselling, depending on what the family requires.

Within the Waikato district there are multiple organisations at a primary and secondary care level that could have a role in supporting youth with mental health concerns or suicide risk. As there was no one best place to advertise the study, all organisations providing health services to people aged between 16 and 24 years of age and their families were considered to be appropriate. Advertising the project widely was advantageous in reaching as many different types of families as possible. The following organisations agreed to help recruit families to the project by informing their practitioners about the project, and in some cases directly informing families.

Government organisations

The project was introduced to the Health Waikato Adult Mental Health and Addictions Services teams, and the Child and Youth Mental Health team during their regular meetings. Posters were placed in the waiting rooms of these organisations, and leaflets were left on the reception counter where clients could access them. The In-patient Consult Liaison Team arranged for the material to be displayed at the Health Waikato Accident and Emergency Department. No mental health teams at Health Waikato declined to take part in the project. Hauora Waikato Māori Mental Health Services was also approached, but did not respond.
Primary health services

The project was initially presented to the local primary health care organisations through an article in their regular newsletter. Email and telephone contact was then made with the largest general practices asking if they would be willing to display the project materials in the patient waiting area. No primary care services declined to take part in the project.

Non-government organisations (NGOs)

The Webhealth (www.webhealth.co.nz) listing of mental health services in the Waikato was used to identify possible NGOs, through which participants could be recruited. This included mental health consumer and family support groups. A local NGO that is specifically aimed at families of people with mental health concerns agreed to take part. It used the advertising materials in day-to-day contact with clients, and also sent out an advertisement in its regular newsletter. Citizens Advice Bureau and two rural church-based groups also agreed to place recruitment materials in their agencies.

Two NGOs, one urban and one rural, whose service design is aimed specifically at Māori families were approached. A dialogue about the project was begun with another large service provider, however they remained uncertain as to the suitability of the project for their client group and had not decided by the end of the recruitment period. The concerns of this agency were that the research team was not familiar enough to their families. Specifically, they were concerned that because the research team had not spent any face-to-face time with families before passing on the invitation to participate, families would not trust the team enough to volunteer.

Local shopping centre

A local shopping centre was contacted and asked about the feasibility of setting up an information stand about the project and handing out pamphlets to shoppers on a night that they were open late. This approach was rejected by the shopping centre on the grounds that seeing a project concerned with suicide while in the mall was not consistent with the shopping experience that they were trying to create for their customers.

Local tertiary training provider for Māori

A discussion about the project was also started with a large provider of tertiary training for Māori. It was requested that the invitation to participate be extended to the staff working at the organisation. The research committee at the organisation declined this request based on the grounds that the project methodology did not advance mātauranga Māori or exist within an indigenous paradigm.

Local high schools

The project was extended to local secondary schools in order to move from a more passive recruitment strategy to a more active stance where families received the information at home via the school newsletter. The principals of six local high schools were approached with a request to advertise the project in their school newsletters. Of these, three schools showed an interest in the project, and one went on to extend the invitation to the members of the board of trustees of the school. The school staff and guidance counsellors who declined to advertise to their students did so on the grounds that the material was too sensitive.

Direct advertising to the public

The project was also advertised directly to the public. Press coverage was secured and advertisements for the project were placed in the Waikato Times. Similarly, information was placed in a local free paper, The Hamilton Press. Webhealth put an advertisement for the project on its community e-noticeboard, and in its e-newsletter. Information was also available directly from The Psychology Centre website. A second round of paid-for recruitment advertising was also undertaken, with advertisements placed in six local free newspapers throughout the Waikato region.
3.2 Demographic data collection

General demographic information was collated during the interviews with families, and from the questionnaires. Of interest, was the make-up of each family, as identified by the family members themselves. This included the size of the family, and how each person was related (e.g., biologically related, step-family or family friend). The age and gender of each person who participated was noted. More specific information was collated regarding the young person who had either attempted or completed suicide. Information included the person’s age, gender, ethnicity, mental health history, and living circumstances at the time of the attempted or completed suicide.

3.3 Psychometric data collection

3.3.1 Outcome Questionnaire-30.2 (OQ-30.2) and Youth Outcome Questionnaire-30.2 (Y-OQ-30.2)

The OQ-30.2 (Lambert et al., 2005) and its equivalent for people under 18 years of age, the Y-OQ-30.2 (Burlingame et al., 2004), are standardised questionnaires designed to detect possible mental health problems.

The OQ measures used in this project were made up of 30 items each. A sample of the questions from the OQ-30.2 is included in Appendix C. Each item relates to a psychological or social problem that the respondent may have experienced (e.g., I feel worthless; I have had disagreements at work). The OQ items include a question that asks respondents about current suicidal ideation. The respondent is asked to indicate on a five-point scale, ranging from never to almost always, how frequently he or she has experienced that problem over the past week, including today. Normative data for the OQ measures are derived from the American population. A higher score on the OQ-30.2 and the Y-OQ-30.2 suggests that the respondent is experiencing more symptoms of distress, and impaired quality of life.

For the current project, the OQ-30.2 or Y-OQ-30.2 was typically completed at the initial interview. However, when there was insufficient time left, the questionnaire was completed at the follow-up interview. The data from this questionnaire enabled the research team to identify any participants who were clinically distressed at the time of the interview. In the initial research design, this measure was also intended to determine if there were any differences in level of distress across the four groups of families. In particular it was intended to identify any young people in the “no mental health or suicide concerns” group who might nevertheless be experiencing difficulties.

3.3.2 Family Assessment Measure-III (FAM-III)

Based on the process model of family function, the FAM-III (Skinner et al., 1995) emphasises family dynamics rather than family pathology. A sample of the questions from the model is included in Appendix D. It is suitable for respondents aged 10 years and older. It is typically used in a clinical or research setting to identify families that are having significant problems. The FAM-III provides an indication of family functioning on seven sub-scales.

- Task accomplishment – focuses on the roles adopted by family members.
- Role performance – focuses on how well family members are deemed to complete their roles.
- Communication – relates to the movement of information pertaining to the task at hand, and family members’ roles.
- Affective expression – examines the content and timing of expressed emotions, which may facilitate or impede the family’s progress with task accomplishment.
• Involvement – is concerned with the quality of family members’ interest in each other. It includes the ability of the family to meet the emotional and security needs of its members, while supporting each family member’s independent thinking and behaviour.
• Control – focuses on the method by which family members influence each other.
• Values and norms – examines the background against which all of the above processes must be considered.

The FAM-III also has two validation scales: social desirability; and defensiveness.

A T-score over 60 on any sub-scale indicates that that area could be problematic for the family, particularly if all family members score in the problem range for the same item. The greater the number of problem areas, the greater likelihood that the family is experiencing significant difficulty. A T-score under 40 indicates an area of strength for the family. Whether or not family members’ scores are a common perception of family functioning can be determined by comparing the FAM-III scores of each person with the scores of others in the family. The authors note that a difference of 10 points (one standard deviation) between family members may indicate a clinically relevant discrepancy.

This measure was not intended to be a measure of family resilience per se, but rather of family dynamics that could possibly have a role in the development and management of suicide risk. In the original project design, the FAM-III was intended to describe the families in each of the four groups, noting any differences in general functioning between the groups.

3.4 Initial interview data collection

3.4.1 Overview of the interviewing process

The process of data collection consisted of an initial interview, which was the same for families who had experienced an attempted or completed suicide and those who had not. Initial interview data was analysed, before conducting a second interview in which the themes derived from the initial interview were fed back to the family. The second interview then continued on to ask specifically about the time period during which the young person in the family had made or completed a suicide attempt.

3.4.2 Arranging the initial interview with families

Any family member who was interested in the project was able to contact The Psychology Centre for more information. They were also encouraged to contact The Psychology Centre if the information contained within the publicity material was unclear or if they had any questions about their participation in the project. After reviewing the information, people wanting to participate in the project were asked to contact the team member responsible for organising interviews and arrange a time to meet. Families were able to choose from daytime and evening appointments. No weekend meetings were planned. Typically one adult from each family took up the role of being the contact person for that family.

3.4.3 Initial interview process

Introductions, information sheets and consent forms

Two interviewers were present at each interview. They began by introducing themselves, and asking the family to do the same. The family was asked what they knew about the project, as some family members were more familiar with the information sheet (see Appendix B) than others. The overall project was then explained in brief. The process of the initial interview was also explained. The family was invited to ask questions about aspects of the process of the interview, or the project itself. All family members were then happy to go ahead and sign the consent form, indicating that they agreed to participate in the interview process (see Appendix E).
Family time-line

Each interview began by asking the family to create a time-line. This was recorded on a large piece of paper by one interviewer, while the other interviewer directed the activity. The interview questions guiding the family at each step in the process of making the time-line are presented in Table 1.

Table 1. Prompts used to create a family timeline

<table>
<thead>
<tr>
<th>Step number</th>
<th>Prompt given to families</th>
</tr>
</thead>
<tbody>
<tr>
<td>1) Getting the time-line</td>
<td>Firstly we’d like to know how this family are related. We’ll put it on a time-line so we can see who is in it, and when they came along. Who shall we put on first? And who next?</td>
</tr>
<tr>
<td>2) Nominating events</td>
<td>Our time-line goes from (date) to (date). What events have happened for your family that you consider to be important? They might be positive or negative things that have happened, but either way they were significant to you. We’ll note them down on the time-line too.</td>
</tr>
</tbody>
</table>

The family time-line served several purposes. In terms of data collection, the time-line discussion enabled the interviewers to identify how the family was comprised, and learn who was in the family but not present at the interview. In the case of families that had lost a young person to suicide, the discussion concerning critical events provided the interviewer with information about the time and context in which the suicide occurred. The time-line typically took between 30 and 60 minutes to complete, depending on the number of critical events that families wanted to place on it.

Semi-structured interview questions

The high level of flexibility inherent in a semi-structured interview format suited the exploratory nature of this study (Smith and Osborn, 2008). The questions asked by the research team guided the interviews, but allowed the process to unfold in accordance with what the families saw as important. This meant the interview could potentially go into novel areas. This style also allowed the interviewers to reorder the questions as needed, and to gain a more in-depth description by probing interesting material put forward by families. With this approach the interview could potentially produce rich data.

The interview questions for this study were developed in accordance with the criteria for IPA outlined by Smith and Osborn (2008). Firstly, the range of issues to cover in the interview was decided. The goal of the project was to better understand family dynamics that are related to good outcomes in times of adversity, and so the following areas were thought to be useful: the character of the family, the strengths of the family, and how the family responded to adversity. Secondly, the areas were put in a logical order. Specific questions about mental health and suicide were asked in the second interview, as these questions were considered to be sensitive, and not applicable to all interviewees. Thirdly, specific questions were constructed for each area. The aim was to construct neutral questions that were general but not vague, and that could focus the interviewees without being too specific. General prompts were used throughout the conversation (e.g., “Can you tell us more about that?” and “Can you tell us what you mean when you say…?”). More specific prompts were used to help the interviewees talk about family dynamics. Decisions at each stage of question development were made in a group discussion by all four research team members. This entailed brainstorming possible topics and questions at each stage, considering the pros and cons of each option, and arriving at a consensus.
The initial semi-structured interview schedule is shown in Table 2, including the three general areas, main questions, and suggested prompts. The order of the interview questions asked was varied, depending on the discussion that had just taken place during the family time-line. The interviews were recorded with two digital recording devices.

After the semi-structured interview, each participant was asked to complete an Outcome Questionnaire–30.2 or a Youth Outcome Questionnaire–30.2, and the Family Assessment Measure–III. If the initial interview process had taken up to 2 hours already, the questionnaires were completed at the next meeting. The interviewer then invited the family to make any comments on the interview process, explained what would happen next, and closed the interview.

Table 2. Prompts used in the initial semi-structured interview

<table>
<thead>
<tr>
<th>Area</th>
<th>Prompts given to families</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction</td>
<td>• We are going to ask some questions to get you started talking about your family. There are no wrong or right answers, we would just like to hear how you see things. We would like to give everyone the chance to make a comment, so we can understand how it is for the whole family.</td>
</tr>
<tr>
<td>Family meaning and values</td>
<td>Main question: • What does being a family mean to each of you?</td>
</tr>
<tr>
<td></td>
<td>Possible follow-up questions: • What are the things about this family that you value?</td>
</tr>
<tr>
<td></td>
<td>• How do you make sure those things happen? And if they don’t happen, what then?</td>
</tr>
<tr>
<td>Perceived strengths of the family</td>
<td>Main question: • What are the strengths of this family?</td>
</tr>
<tr>
<td></td>
<td>Possible follow-up questions: • What are the key signs that you are doing well as a family? How do they help you?</td>
</tr>
<tr>
<td>Family response to stressful events</td>
<td>Main question: • When there is a challenge, or something stressful comes up, how does your family react?</td>
</tr>
<tr>
<td></td>
<td>Possible follow-up questions: • What are the things about your family that make it easier to cope with a stressful event?</td>
</tr>
<tr>
<td></td>
<td>• Is there anything that makes it harder? How do you manage that?</td>
</tr>
<tr>
<td>Conclusion</td>
<td>• Is there anything that hasn’t come up that you would like us to know about your family?</td>
</tr>
</tbody>
</table>
3.5 Initial interview data analysis

3.5.1 Interview analysis method

Transcribing the interviews

Each interview was transcribed verbatim. This script was then checked for discrepancies by one of the interviewers, who compared it with the audio recording.

Process of IPA

The developers of IPA emphasise that there is no single definitive approach to the process (Smith, 2004). Instead, the researcher is required to undertake an exploratory, flexible and detailed focus on the area under investigation. There are three broad stages to IPA: free textual analysis, refining data by connecting themes in a single interview, and then refining data by connecting themes across interviews. The key tasks of each stage of the IPA approach are outlined in Table 3 (Smith and Eatough, 2006; Smith and Osborn, 2008; Smith et al., 1999).

MAXQDA

Two researchers coded each transcript; one who co-conducted the initial interview, and one who was not involved. Each transcription was reviewed using the qualitative analysis programme MAXQDA. This programme can facilitate all of the tasks required for IPA. It enables the researcher to review the script several times, with increasingly in-depth analysis. Any part of the transcript can be marked by the reader and a memo attached that outlines what the reader responded to in the text and why. The researcher is then able to create, name, and collate themes that they derive from the text. Multiple versions of a text can be collated into one analysis. This allows researchers to collapse themes across the two coders and across groups of participants. Marked text can be retrieved for any theme. This enables the reader to ground their interpretations with the data provided by the interviewees themselves when writing up the results of the interviews.
<table>
<thead>
<tr>
<th>First stage</th>
<th><strong>Free textual analysis of the transcript</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Read through whole transcript of family interview. The advantage of reviewing each family individually first is that it ensures the case has been analysed in full, and is true to the experiences described.</td>
</tr>
<tr>
<td></td>
<td>• Re-read, and make notes of what is interesting or significant about the data. The researcher is free to note whatever it is that he or she notices, and may summarise, paraphrase, recognise links to him or herself, give preliminary interpretations, recognise contradictions and so on. Make clear notes of cognitions (i.e., meaning-making, appraisals) and behaviours that are relevant to the experience being described by the participant.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Document emerging themes</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Re-read again and document emerging themes. Transform initial notes into more concise phrases that reflect what was found in the text. Emerging themes are typically more abstract, and may include psychological terminology. Themes are likely to be repeated throughout the transcript. The number of emerging themes depends upon the quality and depth of the data.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Second stage</th>
<th><strong>Refine the data by connecting the family’s themes</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• List the emergent themes and identify connections, or themes that cluster together.</td>
</tr>
<tr>
<td></td>
<td>• Identify super-ordinate themes. Important themes are most likely to be those that capture the participants’ strongest emotions, cognitions or behaviours. Check clusters of themes against transcript material.</td>
</tr>
<tr>
<td></td>
<td>• At this point themes may be left out if they do not fit well within the emerging structure (i.e., add meaning), or if they are not very rich in evidence from the text.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Produce a table of themes for the family</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>• Produce a table of themes ordered coherently. Note the name of the super-ordinate theme for each cluster of information and list the cluster underneath. For this project, the table of themes was organised according to the predetermined areas under investigation (i.e., family identify, family strengths and coping).</td>
</tr>
<tr>
<td></td>
<td>• Link data and text to each cluster item. Note a particularly good example, which may be used in the write up.</td>
</tr>
<tr>
<td></td>
<td>• At this point in the analysis, each coder and interviewer met to determine an overall table of themes that could be fed back to the family. This was done using the IPA processes described above.</td>
</tr>
<tr>
<td></td>
<td>• Once the family had reviewed the themes, the transcripts for families who had experienced suicide were added into the analysis. The stage one and two processes were repeated using the new information given in the follow-up interview.</td>
</tr>
<tr>
<td>Third stage</td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
</tbody>
</table>
| Group data: connecting the themes across families in a single group | • Produce an overall group table of themes from each family’s final table. Note the name of the super-ordinate theme for each cluster of information. List the cluster underneath. Use an iterative approach where earlier transcripts are reviewed in light of new super-ordinate themes that emerge as the analysis continues.  
  
• Link data and text to each cluster item. Note a particularly good example that may be used in the write up. It may be useful to note one example from each participant whose data is represented by that theme.  
  
• It is possible to organise the table of themes based on the first family’s analysis, but when a new theme is uncovered, go back and look over previous transcripts, reviewing them in light of the new theme. |
| Refine the data by connecting the themes across the groups of families | • The same process used to connect themes within groups of families is used to connect themes across the groups who have and have not experienced suicide. |
3.5.2 Deriving feedback for families.

Feedback to families was drafted when each person coding the script had completed stage two of the IPA process. A joint table of themes was created in a discussion between the two coders and the other team member who had co-conducted the initial interview with the family. Direct quotes from the text were considered when evaluating the themes that each person put forward. Deriving feedback for families followed the IPA stage two procedures. Themes from both coders were organised under the general questions posed to the families in the initial interview.

3.6 Follow-up interview process

A second appointment was arranged with the family to feedback the themes that were derived from the first interview. This interview typically started with the interviewers explaining the process that had been undertaken by the research team to identify the themes. It was emphasised to the family that these themes were preliminary ideas only, and that it was important that they feel free to make comments or additions, and to ask for changes. The interviewers presented one initial interview question and the relevant themes at a time, inviting families to comment at each step. For the group of families that did not have any concerns about their young person the process ended here. They were thanked and given a small gift of a grocery voucher.

For the two groups of families who had experienced an attempted or completed suicide, the interview then continued with more specific questions about how the themes were relevant during the time that their young person was at risk. This second interview was again conducted in a semi-structured format. The prompts used are outlined in Table 4 below. To offer participants privacy regarding sensitive information, the two interviewees who had attempted suicide were asked if they would like to discuss these questions in private. Both declined, preferring to join in the family interview. Both of these participants were considered to be independent adults within the family.
Table 4. Prompts used in the follow-up semi-structured interview

<table>
<thead>
<tr>
<th>Area</th>
<th>Prompts given to families</th>
</tr>
</thead>
</table>
| Feedback                                                             | Describe themes relevant to each question.  
• Use an example from the interview to illustrate  
• Ask for the family’s view after each theme.  
• Ask whether there is anything they would like to change, add, or delete.  
For the mental health concerns only and the no concerns groups the process ends here. |
| Establishing the context of the attempted or completed suicide       | Summarise and check what is already known from the previous discussion about the youth who attempted or completed suicide.  
• How old was the person at the time of the attempted or completed suicide?  
• How long ago was the attempted or completed suicide?  
• Was the person formally assessed for any mental health concerns? If so, what was the outcome of assessment (if known)?  
Main question:  
• Can you describe what was happening for (name of young person) and your family during the time leading up to his/her death/suicide attempt? |
| Time leading up to the attempted or completed suicide                | Main question:  
• Think about the strengths that you have described for your family in our first meeting. Had your family developed these before (the event)?  
• If yes, were you able to put them into action at the time of (the event)?  
Possible follow-up questions:  
• Prompts for this question were taken from the themes fed back to the family. |
| Time after the attempted or completed suicide                        | Main question:  
• Think about the strengths that you have described for your family. What relevance did these have after (name of young person)’s death/suicide attempt?  
Possible follow-up questions:  
• Prompts for this question were taken from the themes fed back to the family. |
| Conclusion                                                           |  
• Is there anything that has not come up that you would like us to know about your family? |
4 Data collection with practitioners

4.1 Recruitment of practitioners

The project was extended to include interviews with local workers who provide services for at-risk youth and their families. An invitation to participate was extended to the agencies that had been involved in the family recruitment phase. The researcher presented this new part of the project at the weekly meeting held by the Health Waikato mental health services for children, youth, and adults. The local NGO that provides services to families was also contacted as part of recruitment.

Practitioners were given the information sheet in Appendix F to consider. Interested practitioners were asked to contact The Psychology Centre via telephone, fax, mail or email, and arrange a time to meet. Day-time appointments were offered to practitioners. The interview was conducted at The Psychology Centre, or at the practitioner’s workplace.

This arm of the project involved a significant protocol change from that originally approved by the Northern-Y Regional Ethics Committee. As such it was formally re-presented to the committee as a protocol amendment, and received committee approval prior to its commencement.

4.2 Interviews with practitioners

4.2.1 Developing questions for practitioners

The interview questions addressed the core question that guided the interviews with families, namely, what family dynamics can be thought of as resilience factors, enabling families to cope well when a young person is at risk? The questions are outlined in Table 5.

The original question about family identity and values was omitted as this is a perspective that is unique to families, and it was unlikely that a practitioner would be able to access this level of data. There were also some new questions added at this point. Consistent with an iterative process of IPA, these questions were derived in part from common themes that emerged in the family interviews. For example, the idea that there was a person within a family who took a lead role at times of crisis had been a reoccurring theme in the family interviews. The value of communication between family members had also been put forward as important by several families. The final set of questions was determined in a joint discussion between the entire research team.
Table 5. Prompts used in the practitioner semi-structured interview

<table>
<thead>
<tr>
<th>Area</th>
<th>Prompts given to practitioners</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Introduction</strong></td>
<td>• Practitioners were thanked for agreeing to take part. A brief rationale for the project was given, and practitioners were asked if they had any questions?</td>
</tr>
<tr>
<td></td>
<td>• Practitioners were reminded that they did not need to give any detail that would identify the young person and his or her family.</td>
</tr>
<tr>
<td></td>
<td>• The consent form was then signed.</td>
</tr>
<tr>
<td><strong>Context of the young person and his or her family</strong></td>
<td>Practitioners were asked the following descriptive information about the young person and their family.</td>
</tr>
<tr>
<td></td>
<td>• Practitioner’s contact with the family? With whom? When? Why?</td>
</tr>
<tr>
<td></td>
<td>• Gender of young person?</td>
</tr>
<tr>
<td></td>
<td>• Approximate age of young person?</td>
</tr>
<tr>
<td></td>
<td>• Who was in the young person’s family?</td>
</tr>
<tr>
<td></td>
<td>• Did the young person attempt or complete suicide?</td>
</tr>
<tr>
<td></td>
<td>• Circumstances around suicide / attempt / behaviour?</td>
</tr>
<tr>
<td></td>
<td>• Was there any history of suicidal behaviour?</td>
</tr>
<tr>
<td><strong>Perceived strengths of the family</strong></td>
<td>Main questions:</td>
</tr>
<tr>
<td></td>
<td>• <em>In your view, what strengths did this family possess?</em></td>
</tr>
<tr>
<td></td>
<td>• <em>What did this family struggle with?</em></td>
</tr>
<tr>
<td></td>
<td>Possible follow-up questions:</td>
</tr>
<tr>
<td></td>
<td>• <em>What did they do well?</em></td>
</tr>
<tr>
<td></td>
<td>• <em>What were they not so good at doing?</em></td>
</tr>
<tr>
<td><strong>Family response to stressful events</strong></td>
<td>Main questions:</td>
</tr>
<tr>
<td></td>
<td>• <em>How did this family cope with challenges?</em></td>
</tr>
<tr>
<td></td>
<td>• <em>Please describe this family’s communication patterns and skills.</em></td>
</tr>
<tr>
<td></td>
<td>• <em>Who occupied the leadership and problem-solving roles in this family?</em></td>
</tr>
<tr>
<td><strong>Application of strengths at the time that the young person was at risk</strong></td>
<td>Main question:</td>
</tr>
<tr>
<td></td>
<td>• <em>How did the family use their strengths when faced with the suicidal behaviour in question?</em></td>
</tr>
<tr>
<td></td>
<td>• <em>If there was a person with a leadership or problem-solving role, how well did they function at the time of the suicidal behaviour?</em></td>
</tr>
<tr>
<td><strong>Conclusion</strong></td>
<td>• <em>Is there anything that hasn’t come up that you would like us to know about this young person and his or her family?</em></td>
</tr>
</tbody>
</table>
4.2.2 Conducting the interviews with practitioners

One research team member conducted the interview with each practitioner. The interviews began with the researcher giving a brief description of the project. Practitioners were reminded that they were not required to give any information that could identify the family they had chosen to talk about. The opportunity for the practitioner to ask questions was given before they signed a consent form (see Appendix G). The interviews were digitally recorded. The interviewer also took detailed notes throughout the session. All of the questions in Table 5 were asked of each practitioner. They were delivered in accordance with a semi-structured interview procedure. For example, the order of the questions varied somewhat, depending on the topic that the practitioner chose to talk about at the time.

4.3 Practitioner data analysis

Each practitioner interview was initially reviewed by the research team member who had conducted the interview. They reviewed the notes they had taken during the interview, and reviewed the audio recording of the interview. The interviews were not transcribed in full. A second research team member then used the audio recording to re-code the interview. The second coding by a separate person was undertaken to ensure that the themes reflected a robust account of the practitioners’ perspectives.

Consistent with the IPA process, each interview was considered individually at first. Each coder documented the emerging themes for each interview, and then organised them into a table in accordance with the main interview questions noted above. The two coders then determined a final table for each practitioner, by refining the themes in a joint discussion. Connections or themes that cluster together were identified. These were then refined by identifying super-ordinate themes.

Finally, themes across practitioner interviews were considered. A larger table with all the practitioner reports was collated. Connection between themes was reviewed in a joint discussion between all three research team members who had conducted interviews. Again, consistent with the IPA approach, themes that clustered together were identified. These were then refined by identifying super-ordinate themes for each interview question.
5 Results

5.1 Participants

Thirty-six families contacted The Psychology Centre for more information about the project. Information packs were sent to the 22 families who met the inclusion criteria. In the final sample, one family was recruited via a local NGO, who had a particular interest in the role of families in mental health. Three families recruited from the high school agreed to participate. Newspaper advertising created the most interest for the community and led to contact from the majority of families for the project.

Eleven family interviews were conducted in total. A total of 25 family members were interviewed. Interview group sizes ranged from having one to six family members present. In families with a young person who had attempted suicide, the young person themselves elected to be present in four interviews. Mothers of the young person were present for all but one interview, and fathers for three interviews. Siblings were present at four of the interviews. Other interviewees included an aunt, a wife of a person who had attempted suicide, and an adult friend who was considered to be part of the family. There were family members missing from all of the interviews. In families where the parents had separated, only one parent was involved. When a family member was not regularly in contact with the interested family member they were not invited by that person. Some siblings in each group of families, and one father in the no concerns group declined to participate.

In the final sample there were five families in the group where a young person had completed suicide. Two of these families identified as New Zealand Māori, and the rest as New Zealand European. There were three families in the group where a young person had attempted suicide. Two of these families identified as New Zealand European, and one as European. One family in this group did not complete the follow-up interview process. The reasons for this are unclear as the research team lost contact with them. Finally, there were three families in the group that had no concerns for their young person. Two of these families identified as New Zealand European, and one as European. No volunteers were recruited to the group where the young person had mental health concerns only.

Six of the families could be described as intact, in that the parents of the young person were still together. Three of the families were single parent families, one had been bereaved by a parent committing suicide, and one was a blended family with children on both sides. All of the young people had siblings, and only one had step-siblings. The siblings ranged in ages from primary school age to adults with homes of their own.

5.1.2 Target young person in the project

In the group of families where a young person had completed suicide, the target young people ranged in age from 16 to 25 years (mean = 20 years) at the time of their death. In the group who had attempted suicide, two were in their mid-teens, and one was an adult aged 30 years at the time of the attempt. Only one person had made multiple attempts at suicide. Overall, seven of the target youth were male, and 4 were female. The group where there were no concerns for the young person were all males, and still at high school.

Two young people were identified as New Zealand Māori, seven as New Zealand European and two as European. At the time of the suicide attempt or completion, two young people were employed in a full-time job, three were at high school, two were unemployed and the status of one was unknown. Five were living with a parent, and three were living out of home. All of the young people in the group with no concerns were living at home at the time of interview. The three young people in the group with no concerns were all at high school at the time of the interviews. Of the young people who had attempted or completed suicide six were identified as having mental health concerns at the time. One did not have any current or historically identified mental health concerns. The mental health status of one was unknown.
5.2 Psychometric data

5.2.1 Outcome Questionnaire - 30.2 and Youth Outcome Questionnaire - 30.2

Twenty-two OQ questionnaires were completed across 10 families. The majority of respondents’ scores (n = 15) did not indicate any concerns. Two people from the completed suicide group, three from the attempted suicide group, and two from the no-concerns group had current OQ scores in the clinical range (total score > 44).

5.2.2 Family Assessment Measure-III (FAM-III)

A T-score was derived for each area of family functioning, as well as an overall score. Twenty three participants across 11 families completed the Family Assessment Measure-III. Overall T-scores for participants in the group who did not have any concerns for their young person were all under 60, indicating that these families saw themselves as having relatively few problems. Similarly, two families in the completed suicide group, and two families in the attempted suicide group indicated that they had relatively few problems overall. One family in the completed suicide group and one in the attempted group had an overall T-score in the range indicating significant family problems. The other two families (one in the completed suicide group and one in the attempted group) disagreed on the extent of problems in the family.

The distribution of problems across areas of family functioning for the attempted and completed suicide groups was similar. In contrast, the no concerns group had only one family that indicated problems, and within this family, concerns were only noticed by some family members. The no concerns groups had more areas of strength across the family functioning domains than the other two groups.

Three families in the group where a young person had completed suicide, and one family who did not have any concerns for their young person only had one interviewee. The other families had between two and four individuals present at the interview, enabling the FAM-III scores to be compared across family members within a family group. Of these, two families were consistent in their view, and five families were inconsistent (i.e., responses at least 10 points apart). Four of the inconsistent families disagreed on problem areas. There was no difference in the degree of family consistency across the completed suicide, attempted suicide and no-concerns groups.

5.3 Interview findings

The data presented here is in the form of thematic groupings. The first section of data presented is the final validated and amalgamated themes drawn from the initial family interviews. The second section presents data generated from the second interviews conducted with the two groups of families who had experienced suicidal behaviour by a young family member.

In places, quotations have been reformatted to remove repetition when this eases readability and does not change the sense of the narrative. Words and phrases may also have been omitted from quotations to protect the identity of the speaker and their family. Where this has been done it is indicated (…), or a descriptor may have been included (e.g., brother). After each quotation, the source of the quotation is identified by giving the group that the family was part of (completed suicide, attempted suicide, or no concerns) and their allocated number within that group. Families were allocated a group number sequentially on the basis of the date that they were first interviewed. In providing quotations, our purpose is not to be exhaustive, or provide every possible quotation applicable to each theme. Rather, we have used the quotations that best illustrate the family dynamics relating to the theme under consideration.
5.3.1 What does being a family mean to you?

The first of the standard questions, and generally the question that was used to begin the recorded section of the interview was, “What does being a family mean to you?” This question was intended to capture information about family meaning and values (see Table 2), which is a common factor across models of family resilience (Walsh, 2003; Patterson, 2002). A total of 13 themes across all three groups were identified in response to this item. These were reviewed and collapsed into five themes, consistent with the iterative process of refining data under the IPA approach (see Table 3). The themes identified fell into the five main groupings listed in Table 6.

| Theme A | • Family bond  
• Connectedness  
• Valuing of independence |
| Theme B | The family is bigger than us |
| Theme C | Sharing our lives |
| Theme D | • This is how we relate  
• Non-judgemental  
• Negotiated settlements  
• Unconditional acceptance and forgiveness |
| Theme E | Taking care of each other |

5.3.1(a) Theme A: family bond

Seven families commented specifically on the nature of the connection between people in families. They identified family relationships as being special and different from other types of relationships. The term close was frequently used to describe how family members were with each other. The following quotations provide examples of the general sense of cohesion between family members. More specifically, the quotes also provide examples of some of the family dynamics that participants used to illustrate what they meant by having a special connection. Connection was made by talking with each other about important topics (e.g., sharing decision-making), and in a more open manner than might be appropriate in other contexts.

Mother – Obviously, there is a bond, naturally. I think we have always had a close knit family. We’ve always tried to communicate openly, include the kids in the decisions and what have you that had to be made. (Completed suicide group, 1)

Mother – I think that a family should be somewhere where you can say whatever you like. Not hurting, but you can say whatever you like and it should be respected, it should still be within that family, shouldn’t be repeated elsewhere, it should be one place you can be completely honest and open and say exactly what you want. (No concerns group, 2)

Some families emphasised that the bond between family members includes a collective sense of responsibility to look after or protect each other.

Sister – When we were growing up we protected one another like we were the pride, you know. But as we’ve gotten older, that pride has drifted...we are there to stick up for one another but I’m very selective of what I stick up for now. (Completed suicide group, 4)
Mother – You’ve got to stay together, you’ve got to be a family, you’ve got to look after each other, like it’s saying already, it doesn’t matter if one is in Switzerland, one is in Timbuktu, they’ve got to realise that they are blood relations and they have to always be together. They can’t grow apart. I don’t mean physical contact, but they’ve got to realise that that is their brother, their family. (No concerns group, 2)

What also appeared to bind and bond many families together was a sense of commitment that could transcend everyday considerations. For example, after comments drawing attention to the untidiness of her home, the following speaker dismisses the concern as being secondary to the maintenance of good relationships within the family.

Mother – The kids and our relationship is way more important than whether the dishes are done. Whereas I came from a house where it was way more important that the dishes were done, the washing was folded, the place was vacuumed, that was the most important thing. (Completed suicide group, 2)

Not all families spoke about attachment and bonding in a positive way. For some, the experience of living in their family was not always emotionally positive and rewarding. In the following quotation the reference to Martha and Mary relates to the biblical story about Martha, the practical worker who prioritised the preparation of a meal, and her sister Mary who was content to sit at the feet of the teacher and listen.

Sister – For our family it’s better to be Martha rather than Mary, because Mary is too close to the heart. ... I don’t think I ever heard the word “love” growing up in my life until I got to my (extended relatives). When I think about that now I think oh my gosh, that’s so true. Love was shown in so many ways, but it was often the physical, the materialistic. (Completed suicide group, 4)

Although there was a considerable emphasis on families being characterised by closeness, a number of participants also emphasised that family is a foundation for the development and expression of one’s individuality and independence. Parents made comments about the importance of nurturing sons and daughters into greater autonomy, as well as the importance of making adjustments to changing roles for themselves.

Daughter – Being a family for me is about honouring each other, respecting each other, which respect is hard to come by, like it has to be earned. It can’t be dished out. Respecting each other’s privacy, respecting each other on a physical, emotional and spiritual level. Just honouring each other really, but allowing each other to grow, wherever they need to go. (Attempted suicide group, 1)

Daughter – We like our space like with our age, like with the (other) kids, we like our space and then when we’re all together all the time it’s like...

Son – It’s not just being together, all the kids, it’s the adults as well, just everyone...

Mother – We’re quite individual, we like to do our own things, we kind of get on each other’s nerves quite a bit.

Father – We encourage independence amongst everybody. (No concerns group, 1)

It is possible to interpret this latter quotation as meaning that it is only by allowing individuals in the family to be independent that the family as a unit continues to function, rather than nurturance of the individual being part of the raison d’etre of family life. However, this family continued to speak candidly about the struggles of living as a family, especially since two families had been blended into a new family configuration through divorce and re-marriage. In many ways this family appeared to be realistic about the tensions that can develop as the family group moves through the stages of its life cycle.
This valuing of individuality is also reflected in the following quotation,

Mother – Our life before, we had friends, the boys had friends, (husband) and I had mutual friends, but (husband) and I have always had a lot of friends where he’s had friends that he’s socialised without me and likewise, and then we’ve had mutual friends, and I think that’s really important. You’re not living in each other’s pockets all the time. (No concerns group, 3)

5.3.1(b) Theme B: the family is bigger than us

Some families indicated that the bond described in Theme A was strongest between people in the nuclear family unit. However, many families also described having this bond with extended family/whānau, and some adult friends. A number of contributors suggested that family was sometimes defined by the presence of relationships of psychological significance, with the presence or absence of blood ties being unnecessary, or at least not of primary importance. For example, the quotations below illustrate that in terms of social support and psychological or emotional engagement, more value may be gained from reliance on friends rather than family.

Mother – I suppose it (family) is the people that you can rely on, not necessarily mothers and fathers, or brothers and sisters, but friends. I know that when (…) passed away, I had two dear friends who were just always in the background, making cups of tea, doing the dishes, just being there, and I would say they were like family to me. I would consider them family and I don’t think it is just a blood relationship. I think it is an emotional, spiritual…you just know. (Completed suicide group, 2)

Son – Family to me…I don’t consider my extended family as family so much. I only see them once or twice a year, or (step-father's family) once or twice a year. I would probably consider (…) and (…), (…), (…), more family than our…

Daughter – …cousins and things.

Interviewer 1 – Who are they?

Son – Friends.

Daughter – They’re friends……

Son – I don’t see them as much, but I consider them as more… I don’t know…

Daughter – You would be more likely to go there instead of…? If you wanted somewhere to go, you’d go there…

Mother – If you could choose your family, they’re the family we’d choose. You don’t choose your brothers and sisters. If you have choice, that’s them. (No concerns group, 1)

5.3.1(c) Theme C: sharing our lives

A number of families perceived that their family was strengthened by shared activities. Through these activities, interest and caring was demonstrated. This also meant that families were committed to, and prioritised spending time together.

Mother – We were all involved in the same sports, weren’t we. (…) was coaching (…), I was managing the team. We all started to play (…) at the same time.
Father – Holidayed together.

Mother – Yes. We did a heck of a lot together. (Completed suicide group, 1)

Mother – Just take an interest in each other.

Daughter – Make sure we all get together in holidays and stuff.

Mother – Talk to each other, actively be interested in each other’s lives and share what times we can together. (Attempted suicide group, 2)

This latter quotation suggests that engagement within the family can operate as a measure for the health of both the individual and the family unit.

However, on occasion the engagement in shared practical activities was seen as a way of family members avoiding making a more overt connection at an emotional level. That is, sharing activities was seen as more supportive of family development and functioning if they were emotionally meaningful.

Sister – So our family didn’t deal with that emotionally at all, we just did things. … I think the wider family dynamics, which is my aunties and uncles (that’s what you’re asking) their upbringing has impacted on the type of love that is shown and the way that it is shown. So their way was to come in and go “okay what should we do here, what do you want us to do?” That’s always physical work rather than the emotional stuff. (Completed suicide group, 4)

5.3.1(d) Theme D: this is how we relate

The key for most participants, with respect to what it meant to them to be a family, appeared to be the manner in which they related to each other. One of the general themes within this group of responses emphasised the participant’s perception of the capacity of the family to offer each other respect and acceptance that was both unconditional and consistent.

One facet of this is that a family member can trust that whatever they say and do, they will be treated with respect and not judged harshly.

Mother – Yes, non-judgemental. I think they’re the main ones, and the ones you can trust. For me, if you can’t trust somebody then there is no point…and I don’t mean whether they’re going to help yourself to a dollar out of your wallet, or whatever. I’m talking about the big trust things. It’s hard to describe. I suppose it is the people you can trust the whole of you with. (Completed suicide group, 2)

Mother – To me being a family is being able to be yourself but still be loved unconditionally by the rest of the family, and not put down and not treated with disdain. Just being accepted for who you are and taking care of each other. (Completed suicide group, 5).

Another area associated with this general theme was the capacity for acceptance – a willingness to receive whatever another family member has to offer even if it is less than one would wish for. Also important was being able to work towards negotiated outcomes, in which all family members felt that they have obtained some of what they needed from the interaction. This includes a capacity to forgive and forget, as well as assertiveness skills and an awareness of the wishes and needs of others.

Mother – They have their moments as kids do, but we all got over it, move on, there’s no point...you cannot love someone one minute, they do something you don’t like the next and you just decide you don’t love them or you don’t like them, or they’re not your son or your daughter any more, you know, you just do it. (Completed suicide group, 2)
Family friend – They’re the ones that it doesn’t seem to matter what they put you through, you still love them and you still hold on to hope, and it is a good thing. We all do teenage sometimes and some of us even revisit it later in life, so a very forgiving family is a real blessing. (Attempted suicide group, 1)

5.3.1(e) Theme E: taking care of each other

This theme relates to service – the taking care of other family members in a way that enhances their well-being. A common element of this theme is the dependability of family members, and the ability to work together to achieve common goals, while also meeting the needs of individual family members. There was a particular appreciation for the need to care for those who were less fortunate or in distress, and an obligation to care for younger people.

Mother – It was just the unconditional thing again that should be so at the top of the list. It shouldn’t matter if you live with the father or if you are not the greatest son or the greatest daughter. Your family shouldn’t be allowed to just write you off. Or shouldn’t want to just write you off. (Completed suicide group, 2)

Mother – Well the four of us, the three kids and me, I think on the whole we’re pretty good at looking after each other. I know it may not seem like it, but we’re almost like a closed community…(...) has her friends outside and as I said you often wake up in the morning and there is a body lying on the couch or, you know, but when it comes to the crunch, they are the most important, and I know that when it comes to the crunch, although I don’t see much of (...), we are all the most important to each other. (Completed suicide group, 2)

Daughter – I think it’s like sticking up for each other and taking care of each other, but also like being friends, like having fun with your family members and being close to them.

Mother – Probably much like (daughter), just being proud, being supportive of each other through whatever choices they make, supporting that, having fun, accepting each other for who we are. I don’t like nastiness. I don’t think families have room for nastiness. Just the whole supporting, being proud of each other, being friends, is really important, being a friend to each other as opposed to brother, sister, mother, daughter relationship. (Attempted suicide group, 2)

Father – Always having somebody that you can depend on, that you can go to with any problem. I think that’s what (...) found. He could always rely on being able to come back and was always welcome to come back here.

Mother – The one thing we really enforced a lot was if you want to come home, that’s not a problem, we won’t judge you. Our home is always home, no matter what. (No concerns group, 3)

There were also a number of examples of how failure to take care of each other within the family was seen as the antithesis of what it meant to be a family. This point was illustrated by examples from both within the families of participants, and from patterns they had seen in other families. However, these were presented as examples of what families are not.

5.3.2 What are the strengths of this family?

The second question asked of all families was an invitation to identify the strengths that they saw within their own family. In general, this question was used by families to provide further detail related to the previous question about what family means to them. That is, after stating how they understood what being a family meant, they then outlined how the positive characteristics of their family matched this.
More specifically, this question was intended to capture information about the current resources and established protective factors within the family, both of which are thought to contribute to the process of resilience under adversity (McCubbin et al., 1997). Analysis of the interview data generated 14 thematic categories within this domain across all families, which were subsequently reduced to encompass five super-ordinate themes consistent with the last phase of IPA analysis (see Table 3).

The five final themes are listed in Table 7.

**Table 7. Main thematic groups in response to the ‘family strengths’ prompt**

<table>
<thead>
<tr>
<th>Theme</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme A</td>
<td>Strength of individuals</td>
</tr>
<tr>
<td>Theme B</td>
<td>Commitment to each other</td>
</tr>
<tr>
<td></td>
<td>- Caring for each other</td>
</tr>
<tr>
<td></td>
<td>- Roles and rules</td>
</tr>
<tr>
<td>Theme C</td>
<td>Communication skills</td>
</tr>
<tr>
<td>Theme D</td>
<td>Forgiveness</td>
</tr>
<tr>
<td>Theme E</td>
<td>Sharing interests and activities</td>
</tr>
</tbody>
</table>

**5.3.2(a) Theme A: strength of individuals**

One common thread in conversations focussing on the strength of families was an acknowledgement of individuals. Parents were vocal in praising the creativity and vitality of their sons and daughters, and adults acknowledged each other for their strength and commitment, and positive contribution to the family. Mothers were mentioned on more than one occasion as being the glue that held families together. Individuality was seen as nurturing strength, allowing each person the opportunity to grow and express themselves.

*Mother – (I am) practical, fix anything, do anything. I think they (children) have their own individual personal strengths that are totally different from mine.* (Completed suicide group, 4)

Most family participants appeared to have little difficulty in identifying strengths and competencies present in those that they considered to be family members. Subsequent discussion with the families included caveats and provisos that indicated individual strengths were not always used consistently.

**5.3.2(b) Theme B: commitment to each other**

There were numerous examples raised by families of caring for each other. The presence of this theme indicates that not only did families see such caring as a general characteristic of families, but also a source of family strength. Practically, this consisted of positive and supportive ways that they had responded to other family members. For example, as the quote below illustrates, this person demonstrated caring by giving her time. The contexts within which caring was demonstrated were many and varied, as was the type of caring responses that were made. In some families it was a breach of rules within the family that prompted some parts of the family to draw closer and provide support. However, the focus within each of the following quotations is not the nature of the issue, but the family’s capacity to respond in a supportive and caring manner.
Mother – What else is a strength? I think in some ways being at home is a strength...It really pleased the older (child) that I could go on his school trips, and the younger one, that I did, so that you’ve got different personalities there too. But just that whole thing that by doing that you know the (children) and you know their friends and you know how they learn because the teachers have been more open with you. They see you all the time or they see how you relate. (No concerns group, 2)

Mother – Probably because we do work as a family unit and we care about each other that makes it easier, no one is working against each other, there is no underlying motives for anyone.

We just want to keep it all together. That makes things easier, a common cause really. (Attempted suicide group, 2)

In some cases caring, or the demonstration of mutual commitment, was subject to either explicit or implicit considerations. For example, there were a number of comments made by participants about the different roles and rules that operated within their family. These were offered as partial explanations for responses that had been made to past challenges. Some of these roles and rules were clear, such as reference to gender roles (e.g., “It’s a boy thing”), or hierarchical family roles (e.g., parents having authority over children). Roles and rules were also bound by cultural practices, such as those associated with ethnicity, religious beliefs and affiliations, being rural and socio-economic status. While these external contextual factors may provide individuals and families with boundaries, and may outline some parameters within which they could operate, they could also be restrictive.

Conversely, some families spoke about the internal family rules that operated at home. These rules often appeared to function in a way that allowed family members to exercise a lot of freedom and flexibility, to remain engaged and committed at home, while also expressing their individuality and maintaining involvement outside the family. In these cases, the rules were not imposed primarily for the restriction of activities, but for the management of quite flexible boundaries and to ensure the safety of family members.

Mother – I feel all this yap yap yap over the years and just dropping these things in, and even having these rules, like you’ve got your licence, there’s responsibilities, no-one in the car, no drinking, not even one, all this stuff, I’ve also got to be able to say, right, you need to make a choice, so I can’t keep putting my finger on it. My husband just says, I’ve got to learn from him too because, they’ll be away, they’ll go away somewhere, and I’ll say right, now da da da, and my husband will say, use your brain, and that’s it. And I get this text, here, still alive, and I thought, oops, I annoyed him. So I’ve got to learn to back off. So that’s a new, not a new thing, a growing up thing. (No concerns group, 2)

5.3.2(c) Theme C: communication skills

There was recognition that having a pattern of clear and open communication was a foundation strength for families. Looking across families, it was clear that there was no uniformity in what communication pattern worked well. Participants had ideas about what pattern of communication they aspired to, but acknowledged that it was not always able to be attained in every situation. However, they did describe processes of communication that were flexible in meeting the needs of individual family members.

Most of the families suggested that the ability to sit down and talk about issues was a useful activity, even if it did not always result in immediate or unanimous agreement being reached. Communication was seen as a process of sharing difficulties, teaching and learning, and resolving issues. There were a number of other instances where families suggested that with open communication it was important to have tolerance and forgiveness between family members. That is, families were seen as providing an important context within which people could vent their feelings and know that they would be listened to, considered, and generally responded to with respect and forgiveness in the longer term.
Mother – I think they probably all react in different ways initially. There have been quite a few times that we have had time to think about it individually and then we’ve got together and sat around the table, haven’t we, and we’ve all had a turn at having our say and then tried to nut it out from there. Some people like to go away into a corner and try and work it out themselves. Others will put up a wall up. I think generally in the end we get to where we need to be. (Completed suicide group, 1)

Mother – We do say to the kids, this is new to us, or if you get something wrong, you say look, I’ve got that wrong.

It sounds like an ideal family but it’s not…I would like to think that they respect that, that we are still human…I think in situations that we use it particularly, it could be a tense situation and I think it defuses what…you know, they think you’re going to come on strong because they’ve done something wrong. (No concerns group, 2)

Mother – Even (…) got better about telling people some things. So I think they’ve learnt and maybe it’s without (family member) having such a daily input in their lives that you can actually rely on other people to help you out when you’re in a sticky situation. Of if you’re not coping go and talk to somebody. (Completed suicide group, 3)

As observed above, talking does not necessarily resolve issues. In the following example there were two different styles of talking, which made it difficult for the interviewees to get to what they thought was necessary and useful. Both participants describe trying to be flexible and work within the communication style of the family.

Sister – I think what happens is there is such a silence and an uncomfortable silence, because you sit there thinking okay what do you do. So you talk about all the mundane things, you talk about oh yeah I remember when I added this bit, or the weather looks good out there…I despise it because I know what it’s doing. I’m just “What’s the problem?” But I’m far too blunt because I just go “Okay is that how you’re really doing?” and I’ve just got to rely more on the wairua, on the spirit of it, the sense of it more…If you’re not asking at the right time and in the right frame of mind, then you’re bound to hit nothing. I haven’t found that one either. I haven’t actually found those moments yet. (Completed suicide group, 4)

Mother – We would be sitting here talk talk talk, and he would be sitting there quietly and he would be going, “Would you please shut up!” because nobody talks at (Dad’s) house, …I think he, because when I asked him things and I think he thought I was just being nosey, because he wasn’t asked. (Completed suicide group, 2)

The final word on communication was not recorded in a transcript, but was offered by a family who had not experienced suicidal behaviour in their family. When the researchers revisited them to present the transcript of the first session and the thematic analysis to them, they were keen to impress on the researchers that effective communication took hard work. The family believed that it was important for young people to know and appreciate that there would always be someone in the family who would listen to them, and that it was important that they learn to persevere if they had something that needed to be heard. That they should not give up.

5.3.2(d) Theme D: forgiveness

A number of participants also rated the importance of compassion and forgiveness between family members as being a family strength. They suggest that sharing the bond of family means that sometimes one has to find a way to accept the things that don’t go as planned, forgive the one who has made things difficult, and move on.
This was desirable, but not always able to be accomplished within families where communication was restricted. Practically, participants described conversations where mistakes were acknowledged as being commonplace and an acceptable part of one’s development, and thus a part of family life.

Father – yeah, and they’ve admitted, (...) and (...) in particular, that over the last four or five years, there are probably things that they should have listened to which I suppose I have sat back and said to them, well, my dad told me things and I thought I knew better and didn’t listen and hindsight is a great thing.

Mother – it’s normal for kids to turn around and go, well whatever you say I am going to do the opposite. A lot of it is trial and error, isn’t it. They find out. (Completed suicide group, 1)

Mother – Although (daughter) and I would welcome back all the shit, all the crap if he could come back… she is very like me. I think probably even my brothers are a lot like me in some respects, but my mum is not. She often says, I’ve got a long memory (...). I just can’t get over things. That’s okay if it is the person who lives down the street, but when it comes to your family, you should be able to … She can’t or won’t. Maybe that’s why I’m like me, because I’ve lived with it and I know what it is like to be on the receiving end of that cool, disapproving. (Completed suicide group, 2)

5.3.2(e) Theme E: sharing interests and activities

As with the previous interview question (i.e., section 5.3.1 “What does being a family mean to you?), there was a focus on shared interests and activities in discussions about family strengths. That is, being united and sharing activities was seen both as a defining characteristic of a family and also a mechanism for strengthening a family. For example, the following quotation makes it clear that when family members are sharing interests, there are plenty of opportunities for the expression of support and pride in the achievements of other family members.

Son – There’s even things like liking the same kind of music and stuff. I really got into music because you used to listen to Jimi Hendrix and stuff, and that’s really where I first started listening to music.

Mother – The thing is that (...) is very musical and we support him in his music and that’s quite positive. He did say we could come and watch him every time he performs and I said maybe not, and (father) told me yes, of course we are, because he has just started... (No concerns group, 3)

5.3.3 How does your family react in challenging situations?

The third area for questioning in the first interview referred to the area of family dynamics under stress. Families were not asked to give specific consideration to their experience of suicide, if this was part of the family history, but rather to talk about general day-to-day challenges. Analysis within this domain generated 16 themes across families, which were reduced to four super-ordinate themes as outlined in Table 8.

Table 8. Main thematic groups in response to the ‘reacting to challenges’ prompt

<table>
<thead>
<tr>
<th>Theme A</th>
<th>Individual differences within the family unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Theme B</td>
<td>Reliance on individuals</td>
</tr>
<tr>
<td>Theme C</td>
<td>Communicating about challenges</td>
</tr>
<tr>
<td>Theme D</td>
<td>Collaboration</td>
</tr>
<tr>
<td></td>
<td>• Looking outside for help</td>
</tr>
<tr>
<td></td>
<td>• The art of compromise</td>
</tr>
</tbody>
</table>
5.3.3(a) Theme A: individual differences within the family unit

Families acknowledged that each individual within a family unit may have a different reaction to challenges. This included ideas about how challenges should and could be addressed. Some families’ patterns of reaction enabled them to reach a point of resolution or an agreed action plan. Some issues were more difficult for families to resolve, even if they were effective problem-solvers in other areas.

Mother – I think they probably all react in different ways initially...

Father – We’ve tried to be inclusive in trying to resolve a problem or challenge, or whatever.

Mother – It doesn’t always work (laughs). We’re not saints.

Father – In (...) and my case we are totally different in how we face a challenge or whatever. We might agree on a path but it might not always be achieved... (Completed suicide group, 1)

Mother – I don’t know that I have any strategies. We just ... I think I wing it a lot.... I don’t read parenting books or anything like that or listen to advice things on TV or the radio. I think whatever comes naturally, whatever feels right at the time is probably what I do.... Every situation is different and you can’t say, right, when she or he does that, I’ll do this or that, and then he’ll do that and say this. (Completed suicide group, 2)

Participants identified family dynamics that made it either easier or harder for them to cope when a challenge came up. A number of families described having a person who would ignore a challenge when it came up, hoping that it would eventually resolve itself. Others described a family member who would tend to get over-involved or engrossed in the details. This latter approach was felt to extend the problem focus in an unhelpful way.

Interviewer – What do you do as a family that makes it easier to cope?

Sister – We did do drugs for a bit.

Mother – Mum and two daughters.

Sister – Us three on the P.

Mother – And we’d just sit there, but we’d have a really good time at home. We’d just sit at home and just have our giggles and talks...

Sister – And this is where (...) is so different aye?...We talked about things, or I might go up and play the pokies for half the night. Then after (sister) died I went a bit AWOL on the P with my friends, but it was good for me at the time, I think it was good for me to get over heaps of stuff. But I don’t do drugs now. (Completed suicide group, 5)

Father – Going back to what (mother) said originally, we all probably handle it slightly differently in our own way. I know if (son) gets stressed he’ll pack up and go (away) for the afternoon.... I get stressed if I get frustrated .... I tend to bottle it up . (Completed suicide group, 1)

Mother – The silent big man you know.... He would have never had really talked over issues and things. And he’s always had a lot of difficulty putting words together and language together. He doesn’t express himself very clearly anyway. (...) he cannot express herself other than by getting angry or upset, slamming doors and things like that. Or she does it by taking it out on the other (people). (Completed suicide group, 3)
Daughter – When mum gives too much information it overburdens me. Like, I want the facts, not just little titbits, I deal with facts. I can deal with emotions but I don’t like dealing with emotion. I want to know the facts and when something is happening and mum over indulges in giving information it’s like, go away (laughs). (Attempted suicide group, 1)

5.3.3(b) Theme B: reliance on individuals

The strengths of individual family members were noted as important to consider when a challenge came up. Family members took up different roles depending on what those strengths were. For example, some individuals were considered to be good at problem solving, while others provided comfort. It was generally mothers who were identified as the individual who carried most responsibility.

Mother – Because I’m a strong person. I’m a lot stronger than people realise a lot of the time. And because I just, you know you’ve got to do this, you’ve got to cope with it, you get on with it...
(Completed suicide group, 4)

Sister – We’re lucky with the family. Everyone’s so different. They’ve all got their own strengths for each other draw on...Everyone has their role at a time of crisis.

Mother – Just get your love and your cuddles, that person for that, someone for something else,...usually I go to (aunty), because she’s probably the only who is stronger than me really. I’m strong, but not as strong. (Completed suicide group, 5)

5.3.3(c) Theme C: communicating about challenges

The first two themes highlighted that within the family there are individual differences that directly relate to how the family reacts when a challenge arises. In order to come together and resolve challenges, a number of families drew attention to the importance of open communication as a core element of coping.

Mother – Yeah, I suppose we were proactive in what we were trying to do there. We did speak to the kids about it, and we said look, we have just got to wait, ride it out, it’s going to get better...
(Completed suicide group, 1)

Mother – Yeah. With (...), on the odd occasion when he gets up my nose it’s, you know, there will be no computer, you know, and he’s...oh, OK. But he’s way taller than me, he’s (age), he’s got to the stage where you can’t grab him by the scruff of the neck and pull him into his room and close the door because it just wouldn’t work...Yeah, we just talk about things.
(Completed suicide group, 2)

Sister – So it had to happen at that point because my (family) was following the tikanga which allowed me to say what I needed to say...We talked about things and I just expressed it in my love. I went in with this other agenda, come on you guys, we really have to do something about this. But after being with my family for three or four days, that couldn’t have been the same agenda. (Completed suicide group, 4)

5.3.3(d) Theme D: collaboration

It was apparent in the narratives that communication made coping with a challenge easier, but it was not, in itself, an adequate or complete solution. Families also emphasised willingness to compromise and to look outside the family for assistance when required as key parts of reacting to a challenge. The first quotation contains an interesting observation about a dynamic that allows the family to work together in a united fashion, that is, when there is a shared focus.

Interviewer – What are the things about your family that make it easier to cope with stress?

Family friend – I can answer that one. It’s a lot easier when that event is outside the three of you.
Mother – I think that’s exactly right. Yes.

Family friend – Because…you as a team have all got strengths that you respect each other’s areas of expertise. There are no egos competing. You just get on with it whereas it is a different matter if the stress is inside that three as opposed to outside it. (Attempted suicide group, 1)

One of the components of collaboration and compromise that was identified by the project participants was the ability to work together to modify goals, both shared family goals and individual goals.

Wife – And I think that you have to do it in bite size. One day at a time.

Husband – One day at a time, definitely.

Wife – And then you can look at a week at a time...yeah, yeah, and it was different goals. It was like getting up to (event), then getting up to the release, then it was getting resettled in (...)..., and then we found out that things were progressing. (Attempted suicide group, 3)

Mother – Yeah, having said that, I hope that in years to come the kids will be able to lean on somebody else. I don’t want it to be I’ve got a problem so mum is the one I need to talk to. I want them to be able to lean on their partner, or their children, or whoever.

Otherwise, it just creates another enclosed community and I don’t know if that is an altogether good thing. (Completed suicide group, 3)

Collaboration was not limited to those within the family. External sources of support were rated by family members as being not just useful, but crucial at some times. This appeared to be an acknowledgement that some problems could not be resolved within the resources of the family, or the problem was so far beyond any previous experience that the family had, that they did not have any ideas or practical resources which would enable them to address the challenge in a productive way.

Wife – I mean I’ve got a counsellor I can go and see. I am actually now going to (...), but I mean I’ve had some people who are just saying how could your (family) still be the same after all this happened. Yeah, I’m bitter about it, I’m very bitter about it, and I think the other day I actually threw it in your face about it. (Attempted suicide group, 3)

Sister – And especially after (child) died, and (mother) went to hospital,...all she wanted was a tōhunga to sort something out...and when we were working with these Māori people who were doing, poutama and tapa wha, like drug and alcohol counselling but they do it in the Māori way. They don’t touch base on the drug and alcohol abuse. They get you to learn about who you are as a Māori, your whakapapa and all that sort of thing, and these people helped us a lot. (Completed suicide group, 5)

Not all experiences of external consultation or collaboration work out well, and talking to others about death, dying and particularly death by suicide, seems to be a difficult topic for many to cope with.

Sister – People don’t know how to talk to you about it. They block off. They don’t know what to say, they don’t know how to offer support.

Mother – A lot of it is communication out there. I know it’s everywhere but so is like when women were abused and they had all these refuges and things. Some women are so abused they don’t know how to go and get the help, they don’t know who to talk to, they don’t even want to talk, some of them, because it’s too hard. I think that’s the same as suicide. You get people that commit suicide and they just want to do it anyway, so nothing is going to stop them. But a lot of them, they just want to die because they don’t know how to cope with what’s going on in their life and they don’t know who to talk to or even how to say it.
**5.3.4 Second interview: how were the strengths identified by the families relevant at the time of the attempted or completed suicide?**

Data was collected from all five families that had experienced a death of a family member by suicide, and two of the three families that had experienced a suicide attempt. The last family could not be contacted to arrange an interview.

A wide range of themes was generated during the discussions about this difficult time for families. Some themes were the same as those identified from the discussions during the first interview. A number of additional themes were also apparent. A full list of the themes identified during the second interviews is provided in Table 9.

**Table 9. Main thematic groups derived from the second interview**

<table>
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<th>Theme A</th>
<th>The central role of good communication</th>
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<td>Theme B</td>
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<td>Skills to identify when a family member is at risk of suicide</td>
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**5.3.4(a) Theme A: the central role of good communication**

Communication between family members during the time immediately after a family member had died was considered to be essential in dealing with practical considerations, and the process of grieving. A number of the families observed a breakdown in communication between the family and the person at risk during the time leading up to his or her suicide attempt or completion. In some cases the young person had completely withdrawn from the family. Others were still in contact, but the family had not been aware of how distressed the young person was. Either way, failure in communication was considered by families to be a major causative factor in promoting suicidal behaviour, or as a major contributing factor to the subsequent difficulties that they experienced in coping. There were several examples that appeared poignant to those taking part in the study.

*Mother – And probably from my point of view too, the communication thing. We’ve always sat down and talked to the kids. I mean, one of the strengths, then you ask yourself why didn’t he (son) speak up.*

*Father – That was the anomaly wasn’t it…*

*Mother – I just still can’t fathom. He did play things fairly close to his chest. He was quite a sensitive kid.*

*(Completed suicide group, 1)*

*Mother – Because he wasn’t living at home, he was living at (father’s) when it happened, from what I understand, what (sister) has told me because she has since then made contact with a few of his friends, he had attached himself to another girl and she broke up with him and he apparently told her that he would do it and she apparently said, well go ahead and do it, I don’t care.*

*(Completed suicide group, 2)*
Mother – I suppose it’s always been a bit of a mystery for me as to why everybody (family) sort of reacted the way they did. I don’t know, maybe there was unsaid words, maybe people thought it was my fault or something. I really don’t know. It always interested me that it was like someone dropped a bomb on us and everybody just sort of flew off in all sorts of other directions and in some cases, unusual reactions. (Completed suicide group, 3)

The following example is of communication, but within a closed system. That is, a small group of family members who were not open to external influences, even when those influences were other family members showing their concern.

Mother – Mainly the three of us. At this stage it was (sister), (youth) and myself and you know I do say that last year I think we did have a closed group, just the three of us. It was very us three and all this shit in the middle that you just keep stirring, stirring, stirring, not getting away from pretty much... I don’t think we dealt with the family that much did we?

Aunty – No you didn’t because that’s where I see, it was just listening to both of you talking you kept it closed. You closed it because basically you were trying to help (young person) at that time but you never reached out.

Sister – No we didn’t. (Completed suicide group, 5)

This family continued to talk about their need for assistance from within the family and from outside agencies but, for various reasons, were unable to find a way to be open to this or to use it to bring about effective change.

The family had a long history of suicide and self-harm behaviour, both within the family and amongst acquaintances. Some of the later comments made by this family suggest that they felt powerless in the face of the almost inevitable force of suicide.

Although it was difficult to communicate when a family member was at risk, this did nothing to dampen the views of some families that trying to communicate was still of vital importance.

Father – If you do see your loved one being a bit strange, a bit weird and there’s something going on in their life, then call them up and talk to them about it. (Completed suicide group, 1)

Mother – Listen. Be more prepared to stop and actually really, really listen. I think that’s something that I would have thought of. I think I might have put my own life aside even a bit more and perhaps listened to (young person) a bit or even listen to the other kids a bit more...Try and find somebody who will stop long enough to listen to you and say your kid seems to be doing strange things – this, that and the other thing. Talk to their friends if you know who their friends are. Just dig a bit and don’t worry about being nosy, go and dig a bit more to find out what you can. (Completed suicide group, 3)

Husband – And even if things don’t necessarily...people on their own and things fall apart, you’ve just got to...the world isn’t stopping, you’ve got to pick yourself up and get on with it. Because there is help and support out there. You’ve just got to, you’ve got to face reality. You’ve got to pick yourself up and get on with it. (Attempted suicide group, 3)

5.3.4(b) Theme B: balance between individual and shared coping

There were several comments from participating family members attesting to the importance of reaching out to family for support. Almost without exception these calls for support were answered swiftly and with sensitivity. It is also clear from the words of the participants that their family members had a range of ways of coping with their own grief, as would be expected. Family members talked about the importance of offering both practical and emotional caring to each other.
Practical caring in a time of crisis also included assistance with a range of everyday tasks, provision of finance, housing, and support to access professional assistance. However, for some of these families practical caring involved making quite significant commitments and sacrifices, including taking other family members into their own home to care for them and provide them with alternative experiences and opportunities, and a degree of safety.

Mother – No, that attempt they asked her (daughter) if she’d like to stay in some, in a mental ward and get treatment and I was all for it because I thought you know maybe she does. But the one they put her in was definitely not for her. So she rung me up the next morning and I went out there and I didn’t think it was right for her either so we took her home. (Completed suicide group, 5)

Some people expressed a need for time and distance from other family members as part of their own coping process. On occasion this was a strategy for avoiding confrontation, although it could also be counter-productive by facilitating avoidance of difficult conversations.

The previous quotations speak of the need for greater involvement, knowing what is happening in each other’s lives, and being present at times of need. The following quotation, which includes the observations of a friend of the family, speaks about the importance of space in providing an opportunity to work through issues in one’s own time.

Friend – From where I was on the outside looking in that period of time was a time for, I think, for each of you guys were included went from crisis to crisis. That was the only strategy. It’s pure survival and dealing with whatever crisis blew up.

Daughter – Yeah that’s right…I needed to pull away and stuff but yeah at that point pulling away was never an option for a while. No offence to (family) but (family’s) idea of coping was really in my face but you know, making sure it wasn’t happening or whatever and I just needed to pull away. (Attempted suicide group, 1)

There were many examples given of family supporting family with great sensitivity, using their knowledge of the family to moderate assistance and give their kin space to grieve and support to move on.

Mother – Well they haven’t given me much time to get better. You know, the process of grief is different for everybody and I have my moments and I have my moments and sometimes I’m fine. Everybody thinks oh she’s all better, we’ll do this, do that and I find myself saturated in things I must be doing but sometimes I don’t really want to do them. And I sometimes just want to be alone and I don’t do that either. But I think they’ve pulled away but not too far away. They’ve sort of tried to pull back and just let me get on with it but they are always there if I need them. (Completed suicide group, 5)

5.3.4(c) Theme C: use your strengths, but acknowledge your limits

One point raised by families was the importance of making full use of the things that they did well, while also recognising the limitations of their own resources. That is, acknowledging that some aspects of the experience were within their control and some aspects were not. “Use your strengths but acknowledge your limits” was related to the theme “Strengths of individuals” (Theme A, section 5.3.2, p. 41), where each person’s abilities contributed to the strength of the family as a whole. It was also related to the theme “Individual differences within the family unit” (Theme A, section 5.3.3, p. 46). Individual differences in how people reacted could make it easier or more difficult for the family as a whole to use their strengths. The general issue of knowing ones own limitations was also related to the theme of “Collaboration” (Theme D, section 5.3.3, p. 46), which identified what patterns of help-seeking families might engage in when a challenge comes up.
Husband – I learned that a long time ago, didn’t I? I remember telling you. I went up to the psychologist in (...) about control. If I can’t control something, it will drive me crazy. I like to control things and if I can’t I’d be like grrr. If you actually can’t control something then you can’t control it. Some things are beyond your control and you can’t do. I am a lot more realistic nowadays. (Attempted suicide group, 3)

Mother – Well, I wonder, because I have been very lucky. Both (young people)…neither of them were any trouble. They didn’t get into trouble, they didn’t cause trouble, so when (young person) came to live with us, I was blind-sided. I had no idea, I had no experience to call on because I couldn’t say, well I remember when (young person) did that and this is what I did or anything like that. But because he did the things he did it didn’t mean I didn’t love him, and I couldn’t get passed them. (Completed suicide group, 2)

Three of the families that had lost a young family member to suicide expressed a view that, to some extent, they believed a suicide attempt by their young person was inevitable.

This seemed to be based on the degree to which families had felt out of control in previous experiences of suicide or trauma, or the difficult circumstances that were surrounding the family at the time of the death.

Mother – No, I don’t know, it is just me thinking over these last couple of years about him and just wondering…but I think what would have happened say in a couple of years, he met a…(partner)…everything was hunky dory and then ten years down the line, for whatever reason they broke up. …That would have been like a major relationship, way more important than these girls, would it have meant that he did it then. I would imagine breaking up with your, I mean I know, breaking up with your partner and your child is way more painful and life changing that just breaking up with a girl you met at school or whatever and especially for someone like (...), these relationships are so important, that is why I think that maybe, if not now, maybe later…Yes, and that is why I think, eventually I would have lost him. (Completed suicide group, 2)

Mother – Well it depends how old the person is. And I mean twelve and ten year olds, that would absolutely break my heart. But because (...) was older and we had often discussed suicide and what it meant to us and each and every one of us and what it meant to me. I think it’s (suicide) your right if you don’t want to be here that’s how I think. And if people were to ask me how do you handle it I just say every day is different. Like you know, there’s no way I even want to see what next week’s going to do, I just go through the hours. But if your child is older I think it’s out of your hands anyway. You know no matter what you say, no matter what you do if that person’s got that seed in their mind and they have some way to bring it to life and that’s what’s going to happen because knowing myself that I did what I did you know, even now I still struggle to not commit suicide, yeah. (Completed suicide group, 5)

5.3.4(d) Theme D: influence of a young person’s peers

When asked about strengths, many participants described family dynamics that gave them insight into how the young people in the family spent their time and who they spent it with. It seemed that well regarded peers may be those who had values that were congruent with the dominant values held by the family. Having knowledge about their young person’s peer group was considered useful in situations where family members were trying to make sense of that person’s behaviour during the time they were at risk. Peers, including romantic or intimate relationships, were a factor that families identified could either increase or mitigate risk for the young person. It was related to Theme C: use your strengths but acknowledge your limits. What peer groups a young person chose, and what partners they selected, was noted by some families as a factor they had limited influence over.
Mother – I wasn’t happy to see him hang out with them (close friends), but there was no, he was just let do whatever he wanted to do, see whoever he wanted to see and maybe just. I mean one of them, (...) ran away and he ran to his place and we went there, I went there with a friend of mine and I knocked, and someone answered the door, “Is (...) here?” No, he is not, I haven’t seen him for weeks”, and he is hiding in the bedroom, hello what sort of adult does that. (Completed suicide group, 2)

Sister – I think one thing that sticks out for me, just going back to the whole gang culture for me is that my family saw colours, wearing of colours, as quite a representation of her life, but I remember saying to my family that I never saw that side of her and I said that quite a lot. (Completed suicide group, 4)

Mother – Her (sister) closest friends, to her are just part of our family and she just. We went through a stage when she was living at home, she would arrive home with four or five of her friends and she would go “Hey ma” and there would be a stream of voices afterwards, “Hey mum, hey ma” and they would all just come in and that was just the way it was, but (sibling) perhaps didn’t. (Completed suicide group, 2)

The following quote is from a family whose strength in maintaining a relationship with their son’s peers was particularly relevant after they had lost him to suicide. The family found their son’s friends to be incredibly supportive after he died.

Mother – We had a lot to do with their friends, always had an open home policy. They spent a lot of time with their friends, and their friends at our place, because (...) and all the neighbourhood kids used to come and converge during the summer and it was great. Same set of friends that they have kept since they were pre-school, probably because we were in the same place all of those years, and they’re like extended family to us, aren’t they.

Father – We had an open rule of that we would rather have everybody and their friends back at our place, instead of wandering the streets or whatever, so right from the age of 14, 15, they all seemed to congregate at our place... (Completed suicide group, 1)

5.3.4(e) Theme E: skills to identify when a family member is at risk of suicide

Some families that had experienced a suicide or suicide attempt commented that, with the benefit of hindsight, they would now be more prepared to see a family member’s behaviour as warning signs that the person might be having trouble. When interpreting these comments, it is important to do so with a degree of caution. As the comments below indicate it is difficult to know exactly what behaviours might be indicative of a possible suicide.

Father – Probably only two weeks prior that he’d ever voiced that he was unhappy or there were a couple of incidents at (activity) that he was unhappy with and also the one that he reckoned that the (training institute) was mucking him around on his enrolment.

Mother – Well he was annoyed and he was a bit stressed out about it but it was no...

Father – It was just like an everyday occurrence. We certainly didn’t pick up any vibe that it was really, really bothering him. The night before (suicide) we saw him, when we left he said I’ll catch you later or whatever, he said he’d had a hell of a night. (Completed suicide group, 1)
Mother – When I think about that weekend though I found out though she had actually got in touch with most of her friends, you know gone to visit and rung them up and had bloody sessions and whatever, yeah. So I think that, once that idea is in there you know you really have to work really hard after that. Because even when I was in the mental ward in (...) Hospital this young girl come in, it was her third attempt and she’s only young, she’s only about twenty. You know we were ...there and well I had no idea that my daughter was going to go down that road.

Aunty – So I think the advice I reckon is if they have one attempt you’ve got to be constantly watching them.

Mother – But it is exhausting, it’s exhausting. (Completed suicide group, 5)

Indicators that the family member with suicidal behaviour was sad, low in mood or depressed were mentioned by more than one family.

Depressed mood and withdrawal from family was seen as a contributing factor to completed suicide. It was also considered to be a useful warning sign, which could alert families to the need to take care of that person.

Husband – I mean at least I had my guard up in a way because I always knew there were tendencies. Whereas how would a normal family who’s had no history of it...I mean, how do you...like the suicide...how would you even know? Teenagers are moody or you know. (Attempted suicide group, 3)

Mother – Oh yeah, then she started saying she hated herself because she’s starting to think mean thoughts. And then I don’t know what...but she started having these feelings that she was going to die soon and stuff like that, yeah. And we all had the same feeling. (Completed suicide group, 5)

Another factor that was rated as being important by participants was the presence of previous trauma, whether this was within the family or external to it. The following quote refers to depression in the post-natal period following a difficult birth.

Mother – Just, oh she was fine until baby got sick. And she’d been really fine ‘til then but even then I mean I thought we were going to lose her while she’s going through the labour because so many things happened. And then she came home and that’s when she said mum I’ve been...you know it’s not good, I’m going to do this and that and the other thing and I said well you know sometimes things happen and stuff like that but yeah.

Sister – She came out of hospital I think with the baby exhausted and all that and then she was what three, four weeks at home sick and then mum rushed up to hospital for the surgery. And how many days was she in there? Two? (Completed suicide group, 5)

Families were aware of the link between depression and suicide in a very general sense. However, the ability to recognise when a family member was depressed had often only been developed within the family after their young person had attempted or completed suicide. Even then, within some families there were members who saw depression as shameful and were unlikely to engage with the depressed person.
5.3.4(f) Theme F: acknowledging the reality of depression and suicide

During the interviews it was apparent that participants were highly motivated to share their histories and make a contribution that could assist other families if possible. In this a primary focus was a message of hope for the future, not only for those who had exhibited suicidal behaviour themselves, but also families who had experienced bereavement through suicide. Overall participants encouraged others to be open and honest with each other about the reality of depression and suicide.

When considering how to talk about depression and suicide risk, one participant, who had made a suicide attempt, offered the following advice.

*Husband – It’s realistic, it’s...if you shy away from mental illness and suicide thoughts, you’re just sweeping it under the carpet. You can’t get to the very cause of things. Someone could be genuinely depressed over a relationship or money issues or whatever, but if you try and pretend that mental illness and suicide isn’t there, you’re not going to succeed in anything. You’re just being ignorant to the fact really.* (Attempted suicide group, 3)

Another participant who had been involved with bereavement by suicide made the following comments.

*Mother – They had the memorial service the next day. It was so lovely and I asked and they never, ever mentioned what he’d done (suicide) – the whole time. He just died suddenly. I thought, oh, get a life, I know they’re kids, I know they are dealing with children around here and young adults, be open and honest about it. You might disagree with me. Be open and be honest about this and tell the (other family members). Yeah, be more honest and open and tell people. I think this secrecy around suicide is wrong.* (Completed suicide group, 3)
6 Results from interviews with practitioner

6.1 Demographics of practitioners

Descriptive data about the practitioner and the family that he or she had chosen to discuss was collated from the interviews. Eight practitioners participated. Five were from a child and youth mental health service. Three were from a local NGO that provides support for families of people with mental health concerns. A range of therapy disciplines was represented, including psychology, nursing, social work, psychiatry and counselling. Seven practitioners discussed an attempted suicide, and one a completed suicide.

Practitioners had typically completed an assessment consistent with the procedures for their agency, and had undertaken therapy with the young person or their family. There was one practitioner who was supporting a mother who had lost her 19 year old daughter by suicide. The family-orientated questions were difficult for this practitioner to answer. One practitioner was supporting the family of a young person with bipolar disorder. The rest of the practitioners were providing a treatment service for the young person themselves, and had met the majority of the family members that the young person lived with. None of the families talked about by the practitioners had participated in the family interviews component of this project.

6.2 Demographics of young people and their families

The age range of the young people that practitioners chose to talk about was between 15 years and 20 years (mean = 17 years). Five were female and three male. One was identified by their practitioner as being of New Zealand European descent, one of European descent, one of New Zealand Māori descent. The ethnicity of two young people was unknown. Four young people were living with intact families groups, three with a single parent and one within a step-family group. Seven were clients who had attempted suicide and one young person had completed suicide. There were two young people who did not have a formal mental health diagnosis. Four had a formal diagnosis of depression, one co-morbid with post-traumatic stress disorder. One had a diagnosis of dysthymia, and the last had a diagnosis of bipolar disorder.

6.3 Family general response to stressful events

Practitioners were asked to comment on how the family coped with challenges, its pattern of communication, and leadership roles within the family. Descriptions of four of the eight families indicated that the family members engaged in joint coping strategies, such as making a management plan and following it. For three families the adults and young people coped separately.

For example, in one family the siblings did not become involved in the problem, and in another the parents sought support from outside the family rather than from each other. It was not clear what the third family did, but it appeared that external support, including support from the service provider, was the most useful for the family that had experienced a completed suicide.
The degree to which families were able to communicate with each other varied before they started therapy. One family was thought to have a useful range of communication skills prior to their young person attempting suicide. Two families had partial strengths in this area, mostly because the mother in the family was thought to facilitate communication. Two were very able to communicate about day-to-day occurrences and practical problems, but not about the psychological well-being of the family members. Two families were thought to have completely impaired communication. One family was able to find ways to talk about the problems and possible solutions over the course of intervention. One was not. For the family that had lost a young person to suicide communication between the nuclear and extended family was assessed as being poor, while communication with other sources of external support was good.

Mothers took a leadership role in the process of coping with challenges in the majority of families. In two families, the father had a more dominant influence in how decisions were made. The role was split between both parents in one family. In two families there was no person who was clearly undertaking the management of the family during challenges. While young people were typically involved in the process, none were described as taking a leadership role.

Practitioner 2 – *The family were very contentious, when we asked them to do something, like homework task, they did it...it felt like a partnership, we were collaboratively saying this would be a way forward then she (mother) would go and do it.*

### 6.4 Perceived strengths of the family

Practitioners were asked to nominate what they saw as the strengths of each family. Common strengths across the eight families were collated into the following three themes.

#### 6.4.1 Theme A: family connection

Practitioners considered it to be a strength when families clearly demonstrated an emotional connection with each other. Families with this particular strength were described as “loving” toward each other, having a “sense of belonging” in the family, “involved” and “united”. For some families, all relationships were characterised by positive connection. For some families, this type of connection was only apparent between some family members. For example, the most loving relationship for one young person was with his sister. In this family, there were significant parental mental health concerns and marital concerns. There were a number of narrative examples of this theme.

Practitioner 1 – *They were an ordinary family, very loving...they were very involved in their children’s interests.*

Practitioner 5 – *The parents are committed to both the kids, and there’s a lot of love and concern but they have not known how to show that or demonstrate it in some ways, but the strength is that they are quite an intact family and they do really care about the young person and she does [care about] them too. It is not conflictual or hostile or anything like that...they have positive regard for each other.*

Practitioner 7 – *They’re very connected, even if it is dysfunctionally from my eyes looking in, but they do care about their mum, they do care about their nan...so they do care about each other, it might be dysfunction in a way that they’re rough to each other but that’s their norm.*
6.4.2 Theme B: helping relationships

In most families there was at least one relationship between the young person and another family member that helped the young person. The majority of families were reported to have “stepped up” and been “100 per cent supportive”.

Practitioner 5 – The two kids had a really good relationship, very supportive of each other and they were able to negotiate things and use their own strengths [communication with parents] in order to make the home a better environment for them.

6.4.3 Theme C: positive attitude toward change

Several families were described as being open to seeing their young person’s problems from another perspective and trying a new process to support that person. There was the idea that families were hopeful about the future for their child, and determined to resolve the problems at hand.

6.5 Perceived challenges for the family

As well as strengths, practitioners were asked to comment on what families found difficult to do. These were collated into the three themes below.

6.5.1 Theme A: recognising the degree of distress experienced by the young person

This was a difficulty faced before the suicide attempt, and then immediately afterward. The majority of families were unaware that in the period leading up to the suicide attempt that the young person was experiencing significantly low mood, and in one case, post-traumatic stress. Some were aware there was a problem, but did not know how significant that problem was to the young person. Some practitioners found that the seemingly sudden incident of harm to their young person caused ongoing fear that it could happen again, and doubt that the family could trust their judgement of whether or not the young person was safe.

Practitioner 2 – By the time he had his first suicide attempt (mother) said he had slipped quite out of reach of her, had become quite withdrawn. She had noticed, but hadn’t acted on it...she hadn’t known how to address it. He was quite horrible to them (younger siblings), to push them away, and of course the mum responded obviously quite negatively to that and protectively towards (younger siblings).

Practitioner 2 – There had been a few angry exchanges between them really (mother and son) and she had said in hindsight, afterwards, that she got a terrific shock when he talked about suicide, but she then realised that they had more and more negative interaction because of his irritability, moodiness.

Practitioner 2 – I think she (mum) just didn’t recognise depression, she had never been depressed herself, no one in the family had been depressed, she just didn’t recognise it at all.

Practitioner 4 – They (parents) were pretty shocked just not knowing the extent of what had been going on, the planning and the attempt.

Practitioner 7 – She was more concerned about the little ones (siblings) and I think it’s because he’s big, he’s here (at home), and he can look after himself, she didn’t really see the severity (of the depression).
6.5.2 Theme B: chronic co-occurring problems
At least half of these families were also trying to managing ongoing problems within the family at the same time. Problems included parent mental and physical health concerns, sibling ill health, marital problems, and a breakdown in the family following parental substance use and domestic violence.
Practitioner 5 – (About parents) it was an intact marriage, not an intact relationship. They were very open to that, they acknowledged their own deficits and were willing to work on those and seek treatment.

6.5.3 Theme C: initial negative reactions from family members
Examples given of negative family dynamics that were challenging for families included the reaction of siblings, some of whom withdrew from the young person. Others did not. Two families were reported to have a tendency to avoid interactions that were characterised by high emotion. Another practitioner described a situation where the extended family blamed the mother of the young person for what had occurred.

Practitioner 8 – They allowed people to come in, they utilised the strengths of others, they didn’t do that pushing away thing, even though there were ugly dynamics between the siblings, and family, pointing the finger at her (mother) they allowed that other stuff to happen.

Practitioner 7 – It affected them (siblings), so they ended up coming to the service just for assessment; more or less it was an intervention, it was that they didn’t understand why their brother would want to do that (make a suicide attempt), and they didn’t know how to voice it.

6.6 Application of strengths at the time that the young person was at risk
Practitioners were also asked to comment on how the families used their strengths when it became apparent that their young person was at risk of suicide. Practitioners described families as using their strengths in a variety of ways, and these were collated into the two themes below.

6.6.1 Theme A: successful engagement in treatment
Practitioners found that families who had a positive or hopeful attitude to change were able to make sense of and follow treatment recommendations collaboratively. The types of practical things that families did included attending scheduled appointments, re-organised parents work schedules to carry out a monitoring and safety plan for their young person, and keeping going with treatment even when the benefits were not immediately apparent.

Practitioner 2 – They sought advice actively, then went and acted on it.

Practitioner 5 – If I was able to provide them with a framework, a theoretical framework, they were much more willing to accept treatment...because dad is very focused and structured and needed things to fit the box...and once I explained the framework Dad really hung on to it,...he was like this is what needs to be done and this is how we’re going to do that.

Practitioner 4 – They were all involved, came to the service and were up for working with us, and to do what needed to happen...and to do things differently, they were open to that.
For the seven families where a young person had made an initial suicide attempt, only one had not regularly engaged in therapy. This family were struggling to make sense of what had happened for their young person, and to carry out the safety and monitoring recommendations from the service provider. This family was described as chaotic and dysfunctional. However, the practitioner could still identify strengths in the form of the family being connected, caring and loving. There were some helping relationships within the immediate family. For this family there was no one who took a lead role in the treatment recommendations. For the mother who had lost a young person to suicide, support from service agencies turned out to be pivotal after her loss, as her own family withdrew.

6.6.2 Theme B: positive changes in family dynamics

Practitioners also described ways in which families changed their dynamics as a result of the suicide attempt. Even families who had a positive set of family dynamics prior to their young person making a suicide attempt, needed to change aspects of the families’ functioning in order to mitigate risk. Overall, parents increased their involvement with their young person and communication with their young about thoughts and feelings. In part these changes in family dynamics stemmed from families being open to practitioner explanations for why their young person was engaging in suicidal behaviour (e.g., depression, trauma), and adjusting the patterns of communication within the family to suit. Practitioners also identified that when family members took a non-judgemental stance about what had happened for the young person, it was easier to engage that person in discussion about thoughts and feelings.

Practitioner 2 – After that (suicide attempt) mum tripled, quadrupled her determination to talk to him, and that he would talk back and you know just literally stuck it out with him and made him talk and he talked to her more than he ever had, for months, for a long, long time.

Practitioner 5 – (Talking about previously inappropriate communication patterns) Once I had identified some of the communication styles and the patterns in the family, and said to them this is how I see it, what do they think about it? They were actually able to reflect on that, what they experience, and were able to acknowledge that yes, this is what is happening in our family and we need to address that.

Practitioner 4 – The attempt has prompted them (the parents) to do things differently, it has made them stop, sit back, and think – we have overlooked her.

6.7 Summary of family and practitioner themes

The final section of results provides a simple comparison between the themes coded by the research team from the family interviews and the practitioner interviews. It is possible that certain thematic groupings and descriptors generated in response to the practitioner interviews will have been primed by coding of the family interviews. However, as different members of the research team worked independently on the various transcripts there is robustness in the process, which serves to provide some verification of the final themes. Table 10 provides a comparison of the codes arrived at from the two sources, families and practitioners. The themes are taken directly from the sections above, and are provided here for ease of comparison.
<table>
<thead>
<tr>
<th>Question area</th>
<th>Themes from first family session</th>
<th>Themes from second family session</th>
<th>Themes from practitioner session</th>
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<tbody>
<tr>
<td><strong>What does being a family mean?</strong></td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>A. Family bond (connectedness, value of independence)</td>
<td>Data not sought during this session</td>
<td>Data not sought during this session</td>
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<tr>
<td></td>
<td>B. The family is bigger than us</td>
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<td></td>
<td>C. Sharing our lives</td>
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<td></td>
<td>D. This is how we relate (non-judgmental, negotiated settlements, unconditional acceptance and forgiveness)</td>
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<td></td>
<td>E. Taking care of each other</td>
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<td><strong>What are the family strengths?</strong></td>
<td>A. Strength of individuals</td>
<td>Data not sought during this session</td>
<td>A. Family connection</td>
</tr>
<tr>
<td></td>
<td>B. Commitment to each other (caring for each other, roles and rules)</td>
<td></td>
<td>B. Helping relationships</td>
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<td></td>
<td>C. Communication skills</td>
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<td>C. Positive attitude toward change</td>
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<td>D. Forgiveness</td>
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<td>E. Sharing interests and achievements</td>
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<tr>
<td><strong>How does the family react in challenging situations?</strong></td>
<td>A. Individual differences within the family unit</td>
<td>Data not sought during this session</td>
<td>A. Recognising the degree of distress experienced by the young person</td>
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<td></td>
<td>B. Reliance on individuals</td>
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<td>B. Chronic co-occurring problems</td>
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<td></td>
<td>C. Communicating about challenges</td>
<td></td>
<td>C. Initial negative reactions from family members</td>
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<td></td>
<td>D. Collaboration (looking outside for help, the art of compromise)</td>
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</tbody>
</table>
| How did family respond at time of suicidal risk? | Data not sought during this session | A. The central role of good communication  
B. Balance between individual and shared coping  
C. Use your strengths, but acknowledge your limits  
D. Influence of a young person’s peers  
E. Skills to identify when a family member is at risk of suicide  
F. Acknowledging the reality of depression and suicide | A. Successful engagement in treatment  
B. Positive change in family dynamics |
7 Conclusion and recommendations

Information provided by families who have experienced suicide, and by practitioners who work with people at risk of suicide, supported the stance that family dynamics have an important role when a person is at risk of suicide. The methods used in this research afforded an opportunity to collect information that makes a unique contribution to the knowledge base on families and suicide risk. The focus was on what families had found to be important from their own experiences, rather than focusing solely on predetermined concepts from the family functioning literature.

More specifically this project focused on family dynamics that could possibly support the process of resilience, mitigating suicide risk for young people. The family strengths described by the participants in this study occurred both within and between individual family members. Strengths came in many different forms, as each family brought a unique set of people with a unique set of life experiences. In an effort to extend this information set, practitioners who worked with people at risk of suicide were also asked to give an opinion on what family strengths were important from their perspective.

The focus of the following discussion is on how the family dynamics identified as strengths were relevant when the family was faced with a suicide attempt, and when the family had lost a young person. Some of the following recommendations are for families who may be in a similar position to the people who contributed to this project. Other recommendations apply to practitioners and agencies that support young people and their families. These recommendations may be useful for practitioners to consider when working with a family, and also for organisations to consider when they are planning services for this group of people. The recommendations also suggest directions for future research that could help fill the knowledge gap regarding suicide, families and resilience.

7.1 What does being a family mean to you?

Participants’ answers to this question clearly identified the family group as being special and different from other types of relationships. The characteristics of a family were largely made up of having a sense of belonging to each other, having a shared way of thinking (i.e., values and beliefs) and shared ways of relating to each other. Based on these constructs, families expressed an ideal where family members provided care and support for each other. As suggested in Walsh’s (2003) and Patterson’s (2002) models of family resilience, the meaning of family, and the shared beliefs among family members, form the basis from which many of the families’ characteristics, such as strengths and responses under stress, were derived.

There were examples of all themes across all three groups of families, indicating that the concepts were relevant regardless of a family’s experience of suicide. In some interviews, the meaning of family was given as a set of ideals, rather than characteristics of the family at that time. Some families had struggled to keep a connection with other family members under conditions of ongoing adversity, as well as losing a family member to suicide. However, this did not lessen the value of these concepts, and they were readily applied in family relationships that were still working well.

These concepts of family were also readily applied to non-relatives who were considered to be an honorary family member (Theme B: the family is bigger than us). These people were held in special regard, over and above other friends. Some interviewees noted that their relationships with friends provided unconditional positive regard and more effective support than their own traditional family relationships could.
Having a more flexible approach to family groups can be advantageous in the process of resilience. When the individual and collective strengths in a person’s family of origin are not enough to manage the demands of the situation, it appears that some families are able to include other sources of strengths.

The theme of family bond was not unlike the concept of connectedness in Walsh’s (2003) model of family resilience, or the concept of family cohesion as discussed by Kalil (2003). Families talked about being connected, but also allowing independence of family members. Patterson (2002) proposed that the balance of family connectedness and individualisation is a relational process that could be protective in adverse circumstances. A question to consider is what happens to the family bond at the time that a person is at risk of suicide?

Surveys by Gencoz and Or (2006), Harris and Milock (2000), and Lee et al. (2006) illustrate the link between a perceived disconnection from family by young people and increased suicide risk. A pivotal aspect of depression is negative problem orientation, hopelessness and withdrawal from others. A young person who is depressed and contemplating suicide may no longer think or behave in ways that facilitate a family bond, and may in fact be involved in conflict with family members (Cavanaugh et al., 1999). These findings suggest that a family bond may be seriously disrupted at the point that people are at risk of suicide. However, the reports from participants in this study indicated that a sense of family bond is still important, and strengthening this bond may be part of a resilience process.

The relevance of a family bond was emphasised by participants who had experienced a suicide attempt or a completed suicide, and by participants who had not. Families did not indicate that the meaning of family somehow changed for them during the more difficult times. However, for families where there had been chronic stressors, withdrawal by the young person, or conflict between family members, it was more difficult to enact the everyday family dynamics illustrated in Theme C: sharing our lives, Theme D: this is how we relate and Theme E: taking care of each other. Practitioners also observed that the families they worked with still maintained a sense of connectedness to each other, despite difficulties in family dynamics. Some practitioners noted that the connection between a young person and their family was stronger with some family members than others during the time of crisis. In particular, they noted that even though the family dynamics may appear dysfunctional from the outside looking in, the pattern did indicate that the family members cared for each other.

Information from families and practitioners does not suggest that, on its own, having a family bond will mitigate suicide risk in a family member. Instead the family bond, and the responsibility to care for the people you are connected to, is a guiding principle that grounds the operation of family dynamics. Asking the question “What does being a family mean to you?” may enable practitioners to identify shared ways of thinking and behaving among a family that characterise the bond between members. It may also highlight differences between family members that make it difficult for them to remain connected. For example, the meanings of family put forward by the participants in this study suggested that people in this type of group can move on from a negative event and into a more positive future (Theme D). It also suggested that each member of the group has a role to play in making sure that happens. However, many families then identified members who did not share values such as aspiring to be non-judgemental, or being able to forgive and forget.

One possible focus for both community and therapeutic endeavour may be to explore and enhance levels of involvement between family members (Theme C: sharing our lives). On the FAM-III, at least some interviewees in the attempted suicide and no concerns groups rated involvement as a particular strength for the family. No one in the group where a young person had been lost to suicide did so. This was not to say that there was a trend toward lack of involvement, but it was not rated as a relative strength. Patterns of sharing may well have changed if the young person is experiencing depression or substance abuse, or if the young person or the family is facing a new stressor that makes demands on time and other resources. Level of involvement between family members can be expected to change as milestones in the typical family life cycle are reached. For example, involvement may change when a young adult leaves the family home for work or study. Factors that mitigate against disconnection from family, and against prolonged conflict within a family, may act protectively by assisting family members, particularly young people, to maintain a sense of belonging at these times.
The potential value of enhancing family bonds to facilitate resilience needs to be considered in conjunction with the other possible protective factors outlined in the discussion below.

7.2 Family strengths

There were two clear aspects to family strengths: contributions made by individuals within the family (Theme A), and strengths that came from the patterns of interaction between family members (Themes B to E).

The strength of individuals who were in pivotal family roles (predominantly mothers) was seen as contributing to the strength of the family as a whole. It appeared that the strengths of individuals were particularly relevant at times of crisis for some families. In other families, the strength of the individual was in the leadership role that they had on a daily basis, organising family life and ensuring that each family member’s needs were met.

Another interesting feature related to the definition or understanding of a strength. This was often both person and context specific. That is, an attribute which may be seen as a strength in one person could be seen as an annoying personality flaw in another. For example, the ability to stoically carry on regardless was seen as a strength, but the idea of ploughing on without regard to anyone else was seen as unhelpful.

The strengths of the group that made up a family were dynamic in nature. These more dynamic factors included involvement (as discussed in section 7.1), communication, caring and forgiveness. The last two strengths are not well represented as separate constructs on typical measures of family functioning, such as the FAM-III used in this study, although they do feature in various models of family resilience.

7.2.1 Diverse patterns of communication

The importance of how families talked to each other was emphasised in the interviews with families themselves, and then targeted directly as a point in the interviews with practitioners. It was apparent that there was no one right way to communicate. Both families and practitioners described a variety of ways of relating that provided a chance for people to listen to each other. These ranged from informal processes outside times of crisis, such as talking in the car, to more formal processes in times of crisis, such as tangihanga.

Some patterns of communication supported the general patterns of sharing that were emphasised in the section “What does being a family mean to you?” Most families gave examples of this type of interaction, which could be about an ordinary event, gossip or a shared interest. Communication became more diverse when families communicated with each other in times of crisis. Communication patterns were further divided into processes that are similar to Walsh’s (2003) model, where sometimes communication was an expression of emotion, and sometimes it was directed toward problem solving and conflict resolution.

Within each family, some people were reported to be better at some forms of communication than others. For example, one family member talked about having people you would go to if you were looking for comfort when distressed, and others you would go to if you were looking to find a solution to a problem. Both areas of strength were considered to be important within the family, although they were not always equally valued. Practitioners had made similar observations about the families that they had been working with. One described a family who were very good at sharing and solving problems, but very rarely expressed what they were feeling to each other.
7.2.2 Dynamics that demonstrated caring

Commitment to the family was demonstrated in exchanges of caring between family members. The exact nature of these types of interactions was quite varied, but all demonstrated a positive and supportive stance toward the other family member. Demonstrations of caring were evident at times of crisis, but also in family members’ everyday interactions. For example, interviewees described recording a TV show for a loved one each week, or going to see a performance that the young person was involved with, as examples of positive exchanges between family members.

Of interest was that in many families caring was demonstrated by family members even though they were currently in conflict with each other. For example, one mother continued to purchase special occasion presents for her family, despite not knowing if she would see them or not. Another family would attend significant family events, despite considerable disagreement between family members as to how much alcohol influenced the occasion. It seems that continuing to show caring in the face of challenges is a strength that indicates that the people are still valued, and that the positive connections between them noted in “What does being a family mean to you?” supersede conflict at any one point in time. This factor was also highlighted in the study by Sun and Long (2008), which followed up individuals who had attempted suicide and had been discharged from hospital to the care of their family. Acts of care from families toward their at-risk family member were linked to a positive recovery process for that individual. Families who had useful support systems and effective strategies to cope with their needs, as well as those of the at-risk family member, were more able to create a nurturing environment.

It was also of note that closeness demonstrated by caring and sharing was not always benign, as the mode of caring could carry its own risks. For example, families sharing drug use as a method of managing stress, or siblings being involved in deviant peer groups together. In these cases, presumably, a harm reduction focus is taken by the family members. What is gained through the immediate interpersonal contact compensates for any longer-term negative consequences in the eyes of those involved.

7.2.3 Giving and receiving forgiveness

The act of forgiving, and then forgetting, was put forward as an ideal by many families, and as a strength by some. The process of forgiving and forgetting was valued, but could be difficult to achieve. Forgiveness was sometimes found in an apology, and sometimes in a process whereby the family agreed to disagree and move on from a problem. For example, one family used humour to reduce the tension associated with problems that they saw as being created by one family member, and as largely insoluble. They indicated that this enabled them to continue the best relationship that they could achieve with that parent. Either way forgiveness seemed to be linked to the family’s ability to communicate about the way they were thinking and feeling when a problem arose. Within this context forgetting was about putting the past behind them and not bearing grudges into the future. While this was seen as a positive attribute, several families were clear about the importance of learning from past events, that is, not forgetting.

7.3 Family reactions to challenging situations

This question referred to the family’s approach to challenges at the time of the first interview. Families were not prompted to discuss how they did or did not use the strengths they had identified at this point, or about their experience of suicide. However, some families did spontaneously include this material. All families had put down challenges that they had faced within the family time-line exercise. Examples of challenges were re-locating to a completely new living context, parental divorce, family violence, child abuse, parental work stress, parents with significant illness, young people with illness or disabilities, and losing a close family member due to terminal illness. None of our families could be described as being completely unfamiliar with adversity.
7.3.1 Managing individuals’ reactions within the family group

Family organisational patterns at times of adversity is a key component of Walsh’s (2003) model of family resilience. How a family structures itself at a time of need may influence the use of strengths and resources that members already have. The experience of the participants in this study emphasised that a flexible structure was required to accommodate individual differences in coping within the family group. These were often recognised as characteristic of the individual concerned and accepted by the rest of the family, regardless of whether or not the individual’s immediate response to a challenge had been helpful or not. For example, some people who could be said to withdraw from the problem were seen as needing space. Others who reacted with high expressed emotion were seen as needing to vent emotion to calm down and then engage in a problem-solving discussion.

Some families also engaged in a joint coping process or collaboration. This was done in part for some families (e.g., parents and young person in crisis) and as a whole for others (e.g., parents, young person in crisis, and siblings, and significant others). Joint coping processes required communication between family members about the challenge at hand, which, as noted below, can be very difficult to achieve at a time of crisis. One potential drawback of relying on a single individual is that the range of solutions that may be applied is limited to that person’s strengths and resources. If the primary source of leadership becomes compromised, for example if that person becomes overwhelmed, then the family group may have to continue without clear direction. This appeared to be the case for some participants, even if only for a limited period of time.

7.3.2 Communication can become difficult even if this is usually a strength

A key strength that had the potential to facilitate or undermine how family members related to each other was communication. There was a different trend across the three groups on the FAM-III communication scale, which indicated that interviewees who had experienced an attempted or completed suicide were less likely to see communication as a strong point for their family. Communication was rated as problematic by the majority of people in the group of interviewees who had lost a family member to suicide. Some interviewees who had a young person who had attempted suicide also rated communication as a problem, but a higher proportion rated it as typical or a strength compared to other families. Finally, the interviewees who were in the no concerns group had the highest number of people rating communication as a strength. Only one interviewee in this group found family communication problematic. The affective expression scale from the FAM-III followed this trend, with one exception. One interviewee in the group where a young person had completed suicide found that expression of affect was a strength for his or her family.

From this data it seems that most families have areas of strength within the construct of communication, but it would be erroneous to group these together. A wide range of forms of communication were seen as strengths by families. A more pertinent question to ask when a young person is at risk of suicide may be what patterns of communication serve as protective factors, and facilitate resilience? For one family where their young person had been overlooked, shared conversation and affective expression were deemed important. This family had developed shared problem-solving skills based on their previous experiences of having a child with a significant disability. For the family who could not reach agreements, the use of contracts to structure problem-solving conversations led to resolution within the family. For the family whose daughter had suffered a traumatic experience, a conversation with her family about that event moved therapy forward. For the family whose son was depressed, the persistent attempts of his mother to elicit conversation from him led to shared conversation about his difficulties and a solution was found. It was clear that one size did not fit all, and that different interactive approaches were working for different families at different times.
Often families cited lack of communication as being problematic in the time leading up to a suicide attempt or a completed suicide. Families were often shocked by the event, and could not immediately identify what their young family member had been thinking or feeling that could have led to such an extreme action. Some families had been in close contact, but had not talked about problems with their young person. Some had simply been unable to talk with their young person because that person had withdrawn from contact with the family in the midst of problems.

Many families in the group where a family member had attempted suicide were able to reconnect with their loved ones, and able to resolve the issues that had been significant leading up to the attempt. The suicide attempt itself was the prompt for a change in communication patterns to occur within the family. These families found that having such an extreme event occur highlighted that even though it was difficult, putting even more time and effort into talking to each other was important. Two of the three families in the suicide attempt group had managed to do this even though they both had ongoing challenges in terms of mental health concerns for their family member and unresolved stressors. They stated that continuing to talk to each other, despite conflict, was part of successfully managing these. Compromise, which may involve coming to terms with personal disappointment, requires clear communication if the compromise is to be accepted by all family members. This domain appears to touch most closely on Walsh’s notion of “bouncing forward” (Walsh, 2003). A key piece of advice given by two mothers who had lost their sons to suicide was to keep talking.

7.3.3 Accessing external support

Many families accessed support external to the family specifically in response to their young person’s suicide attempt. Some had also accessed external support following the loss of their young person to suicide. Suicidal behaviour was mostly seen as a problem about which professionals, such as service providers in the mental health system, had knowledge and resources that were needed to help the at-risk young person. The experience of families accessing service providers was varied, with some finding it to be a useful process and others not. Either way, the families themselves took an active role in the process. They were often the ones making referrals, organising appointments, and making decisions about what kind of care was going to be useful for their loved one.

The information put forward by practitioners also highlighted the importance of family process in directing the care they provided to their young clients. Families that were connected, had already established helping relationships, and had a positive attitude toward change were described as using these strengths to engage with external support and to trial new ways of interacting as a family.

The nature of coping can be expected to change over time as the family progresses through the family life cycle and faces new challenges that shape its response to problems. Walsh (2003) placed emphasis on families “bouncing forward” rather than “bouncing back” as a sign of resiliency development. This implies adaptation and change over the family life cycle, rather than retrenchment. Family resilience is characterised by flexible views on what being a family is and how a family responds to the needs of individual members. For every developmental step forward that a young person takes, the family will need to discover a new equilibrium point, constantly adjusting to the changing individual, family and social environment. When families become entrenched and fixed in their ways they are moribund and may be of little assistance to an individual in distress.
7.4 Family strengths and family patterns of managing challenges at the time the young person was at risk of suicide

Most of the families did not appear to find the second interview any more distressing than the first. That is, when the focus of the interview was more explicitly on their experience of suicide they were able to manage any distress they were experiencing and remain focussed on the interview tasks. This may have been because of the highly self-selected nature of the sample we recruited, that is, families or individuals who would have become highly distressed by the interview process may not have volunteered to participate in the project. An alternative explanation is that those families that were able to think about and elucidate their own strengths and coping mechanisms were more likely to have the capacity to put these same strengths and coping skills into practice, including during the interviews. Some corroboration for this may be seen in the range of comments that supported the positive role of communication as an important family dynamic that facilitated coping.

Family strengths and typical patterns of family dynamics, such as those featured in the FAM-III, may be judged as positive characteristics if they support families to manage the challenges of daily living. However, it would be a mistake to assume that what has worked for a family under ordinary circumstances is going to facilitate resilience under adverse conditions. A protective factor, one that mitigates the potentially negative impact of adversity on the family and its members, is best determined based on the role it has in helping that particular family, at that particular time, and with that particular stressor (Fergusson et al. 2003; Patterson, 2002). The existence of more generic or universal protective factors that help any family under any circumstances remains an area to be investigated.

Themes derived from the question “How does your family react to challenging situations?” had already started to indicate that dynamics that were strengths in everyday life were harder to enact under adversity. This trend was also evident during the period of time leading up to suicidal behaviour, particularly regarding communication between family members. Families in this study were asked to comment on how their strengths were or were not relevant at the time that their young person was at risk of suicide. Overall the information provided by families demonstrated that not all family strengths evident prior to the young person being at risk had a protective role in the period leading up to the suicide attempt or completion. Many families simply did not know that their young person was contemplating suicide, and looking back there were no clear indicators of risk that they could identify. The Adolescent Health and Well-being Research Group found that 25 per cent of students who reported making a suicide attempt had done so without prior suicidal ideation or a suicide plan (Fortune, 2010). For those who did recognise there was a problem, the nature of the problem and possible solutions were difficult to discern.

Most of the participants who had lost a young person to suicide highlighted the importance of family dynamics in the period following the death. Expressions of caring, both emotional and practical, from friends and family, enabled the family to cope with the processes that immediately followed a death. At this time, family values and strengths were put into action in many ways, from making food to monitoring other family members at risk of suicide themselves.

Consistent with models of family resilience (Walsh, 2003), the experience of suicide or suicidal behaviour can be a trigger for family re-evaluation and change, confirming those things that have been helpful, and working to change those things that are perceived to have contributed to the difficulties or that were unhelpful in supporting coping. Discussion with families who had experienced a completed or attempted suicide indicated that they had developed some of their current strengths (e.g., Theme B: achieving a balance between individual and shared coping) as a result of those experiences.

Withdrawal to engage in individual coping strategies, such as taking time by oneself to reduce tension, plan and problem solve, has the potential to place additional pressures on relationships at a time when these are a most crucial resource.
This general dynamic is well-documented in the literature and would be evident in a family responding to the depression, substance use and anti-social behaviour that can be precursors to suicidal behaviour. While these behaviours may be useful in creating space, they also run the risk of alienating the young person from a valuable source of support. Therefore, it will be important that these manifestations are not misunderstood. As well as enhancing family dynamics, participants indicated that they developed a new skill set that helped them to recognise when a family member could be at risk of suicide (Theme E).

Participants emphasised the value of being able to talk openly about what had happened for their loved one. This is reflected in Theme E: skills to identify when a family member is at risk of suicide, and Theme F: acknowledging the reality of depression and suicide. This was an interesting observation as it may suggest that the taboo often associated with communication over a death by suicide may not be an issue of a reluctance to express the loss on the part of the family, but a difficulty on the part of those approached and society in general. Talking about suicide, and the circumstances in which it had happened, tended to happen for participants who had established patterns of communication within the family already. For participants who did not, this had proved more difficult to achieve.

While the focus of this project is on families, and much has been made in this report about the importance of the integrity of the family unit, young people inevitably pursue a developmental trajectory that takes them outside the family. Our emphasis here is on outside, rather than necessarily away from the family. Those interviewed made reference to issues that we have categorised as highlighting the growing importance of a young person’s peer group in increasing or mitigating suicide risk (Theme D).

It was not only from within the family that support is garnered, but also from external agencies, informal community supports, and from wider family networks. Most participants who had recognised that their young person was having significant difficulties had tried to engage services for support in the period leading up to the person’s suicide. Participants recognised that the young person needed something in addition to the support the family could provide, for example, treatment for depression. Some participants also perceived suicide as being “out of your hands” once a family member became an adult (Theme C: use your strengths, but acknowledge your limits). They were doubtful that any action they could take would prevent a future suicide attempt. One person indicated that their young person would always be vulnerable to depression and take extreme actions under stress. Another indicated that suicide was inevitable if the person really wanted to take their own life. These participants had both sought help outside the family, which had not been successful for them or their young person. In the face of such resignation and apparent hopelessness it is important that such families receive support to keep trying. Practitioners will need to consider what the beliefs and attitudes are about mental illness and suicide, and the role of helping professions. The focus needs to be on empowering families to use what strengths and resources they have, rather than contributing to an iatrogenic helplessness that may result in families stepping back from their young person in a time of need.

7.5 Recommendations

The recommendations provided below are drawn from those things that the participants felt that they did well, were important, or had value when dealing with the challenges posed by a young family member who was either considering or who had completed a suicide. In addition, we have also drawn on the observations made by the practitioners, who had experience working with families of at-risk youth. It is important to note that while we had requested practitioners to provide data relating to a single family, most had many years’ experience working with young people and their families.

We are aware that the data on which we are basing our recommendations is numerically limited. However, mixed methodology studies such as the one reported here draw validity from the depth and richness of the data, rather than being solely reliant on high participant numbers. While we would have preferred to have a larger data pool to draw on, we are confident that the comments and observations of our participants are sincere, based on their own experience, and capture the essence of the struggles that many families face under similar circumstances.
We have attempted to explore these in good faith and draw out what lessons can be learned. Where possible, we have attempted to indicate the lessons that may apply to families, service providers and service planners.

Within each area we offer an opening comment, followed by the general data on which our recommendations are based. This data is presented in bullet-point format. Finally, we present the recommendations themselves.

### 7.5.1 What is a family?

While a single idealised family format will not suit all families, there were some common observations made by a number of the participants about what makes a family. To some extent these were ideal characteristics that were attained only occasionally. There is, of course, no guarantee that their attainment would ensure perfect functioning and a problem-free family life. The point here is that there was some agreement about the desirability of these characteristics, and it seems reasonable that families be encouraged and supported in their attainment.

- When family members talk to each other it is generally a good thing, whether it is about issues towards which they are positive, or issues that they are struggling with (problem solving).
- Families are more united when they share interests, or at least share activities and take an interest in what other family members are doing. This means that they spend time together.
- There is a perception that a consistent feature of functional families is that they care about each other, and demonstrate this care via mutual support. They are able to negotiate and share goals, and work together to achieve these, even if they do not always benefit from them as individuals.
- Well-functioning families show their love and positive regard for each other.
- Good family relationships are more important than a tidy house. That is, the emotional and social relationships within the family are more critical to ongoing family cohesion than are the mundane tasks of everyday life.
- Functional families nurture and support the independence of family members. They are respectful of individual privacy, and value each individual. They demonstrate a capacity for unconditional acceptance and take a generally non-judgemental stance.

#### 7.5.1(a) Recommendation 1

**A proactive stance could be taken to further enhance the functioning of families, not just those that are experiencing stressful situations.** This would include the community provision of resources and materials drawing attention to the positive value of the points raised above. Agencies and organisations working within primary care settings could be encouraged to assist in the provision of healthy family resources and programmes. More critically, families who are assessed as being at-risk may benefit from early family interventions to assist them with, (a) communication skills within the family, (b) time management and task prioritisation, (c) understanding family relationships and emotional expression, and (d) child and youth development. These four elements address the issues raised in the preceding bullet points.

### 7.5.2 Family strengths

The second area of interest relates to those observations made by families about what makes families in general, and their family in particular, strong. Again, these observations may have been aspirational to a large extent, with no certainty that the identified strengths would actually enable them to deal more effectively with challenges in the future.
However, most of the families who participated in this research had experienced adversity, and the practitioners were reporting on the perceived strengths of families who had accessed assistance under similar circumstances. If it is possible to understand what helps families to be strong, to support each other and to meet challenges, then resources may be used to support the enhancement of these.

- Acknowledgement that each family member has strengths. The important thing is to recognise and utilise them in support of the family.
- Strong families show that they care for each other, and families that demonstrate mutual care are generally strengthened by these actions.
- Families need to be aware of the extrinsic and intrinsic rules that restrict and facilitate thought, action and emotional expression.
- Families are strengthened by clear communication.
- The ability to forgive, or at least move on regardless, is vital in the enduring relationships that usually exist within families.
- Families are strengthened by sharing interests and activities.
- (Practitioner theme) Strong families have an emotional connectedness.
- (Practitioner theme) It is important to build helping bonds, a reliable capacity and willingness to assist each other.

7.5.2(a) Recommendation 2

Families may benefit from support in the development and maintenance of good communication skills. These change over time. Young people may also benefit from special attention in this domain as the most potent influence on their developing communication skills can be their peers and not their family or parents. That is, young people may focus attention on developing peer interaction rather than family interaction skills. Communication is a complex skill, and effective communication can be context and person specific. At-risk families may be supported by assistance to develop and use a range of communication strategies that can be flexibly applied. Community and specialist family communication resources and programmes could assist in the proactive development of necessary skills. Family postvention programmes may need to specifically target communication behaviour.

7.5.2(b) Recommendation 3

Families may need reminding about the importance of being involved in each other’s lives, even if they do not receive significant personal benefit from the activity. As well as communicating interest, shared activities also provide both the time and focus for communication. A range of supporting initiatives may extend from public health campaigns such as Push Play, which often emphasise families doing things together, through to highly structured and facilitated activity programmes for families that are at-risk.

7.5.3 Coping with challenges

If a family operates solely on the basis of rigid structures, or highly specific strategies that are unlikely to be generalisable, then that family may not possess the flexibility to respond effectively in the face of a new challenge. On reviewing the comments of our participants it appears that they were fully aware of these considerations. There was broad reference to the importance of tolerance, compromise and seeking input from others in the face of challenge, indicating an openness to change.

- It is important to be tolerant of difference, both between individuals and within the same person at different times.
• Some ways of coping with challenges are unlikely to be useful, in particular ignoring the problem and hoping that it will go away, or being too focussed on a single solution.

• Play to your strengths.

• Compromise is important.

• When you are stuck, seek help. This can often be found elsewhere within the family, but don’t be afraid to look into wider social networks or helping agencies.

• (Practitioner theme) Challenges are more easily met when a response is initiated early. So it is important to recognise the signs that a problem is being generated.

• (Practitioner theme) Suicide is often not the only challenge faced by the family. This was not stated as an indication of family dysfunction, but to emphasise that these families may already be under stress when the suicidal behaviour is exhibited.

7.5.3(a) Recommendation 4

Some families need more help in solving problems as their learning history and perceived strengths do not adequately prepare them to face a crisis. It is likely that many challenges are initially met from within the repertoire of responses already possessed by individuals and families. People repeat what has worked previously, what has worked in a similar situation, or by applying a solution that they have heard about or found on the internet. In many cases these responses may suffice, but if they are not, then a response is required that is based on sound principles applied flexibly to a new situation. While many families will have the capacity and resources to do this, a number will not. Problem-solving resources and courses may assist, as these may help families make the minor adjustments which are often all that is required. Such materials could be made available through primary care and community providers. Further, greater emphasis on family coping, rather than individual coping, may shift thinking away from individual notions of failure and stigma, and towards a greater acceptance of sharing problems and solutions, transparency, and help seeking.

7.5.3(b) Recommendation 5

Families at risk, or those that are dysfunctional or in a chronic state of challenge and stress, may require extended and specific family support. For example, based on the comments of our participants some families may benefit from support in: identifying and utilising their strengths in a flexible way; exploring barriers to compromise; accepting diversity and change; and avoiding common (and less common) problem-solving dead ends. Specialist mental health family interventions will only be triggered by the presence of a diagnosable mental health problem. The type of intervention envisioned here would have wider application, would be better if deployed pro-actively, and would focus primarily on prevention.

7.5.4 Coping with suicidal risk

The final area for consideration, and the area that is the main focus of this project, relates to those aspects of family life and functioning that have particular relevance to the issue of suicide risk and behaviour of young people. There is ample research to suggest that in all ways there is nothing different and unique about the families of those who attempt and complete suicide. There is no single identifying or mitigating characteristic about families that have experienced the death of a young family member to suicide and those that have not. Also, while suicidal individuals may be statistically more likely to exhibit certain behaviours, thoughts or emotions, there is no single pattern or constellation of factors that identifies these individuals with a high degree of certainty or reliability.
This leaves the need to bridge a gap between the risk factors associated with an individual and the capacity of the family (in this case) to address those needs and challenges. Our participating families generated a number of comments and considerations in relation to this.

- Effective communication within the family is essential. This does not simply mean talking, it means communicating in a way that brings people together, agrees plans of action and facilitates change. In this, it is important that individual differences are understood and accepted. It is also important that individuals do not get isolated during this process.

- Both practical and emotional caring are important.

- The needs of each individual must be considered, as these are likely to vary. Under some circumstances a family member may see no alternative to suicide, and thus see it as inevitable. This suggests that individual needs may be emotional and psychological, as well as practical.

- Despite possible accusations of being nosey, participants recommended that it is important to know about their young people. That is, know where they are going, who they are spending their time with, and what they are doing. It is a logical extension to include knowledge of what they are thinking and feeling.

- Families wanted more information about the things that they could have been looking out for, specifically depression, signs of suicide, and the effects of trauma.

- Don’t stick your head in the sand. Confront your preconceptions, prejudices and affective responses regarding mental health issues, particularly depression and suicide. Don’t put it into the too hard basket, or ignore it and hope it will go away.

- (Practitioner theme) Families achieve better outcomes if their response to challenge is characterised by increased family involvement, increased or improved communication, enhanced emotional connections, and a non-judgemental stance.

- (Practitioner theme) Families cope better if they have a positive and hopeful attitude to change.

- (Practitioner theme) Families can be assisted by a formal mental health intervention if they are able to make a commitment to the intervention.

7.5.4(a) Recommendation 6

Communication is a critical component of effective coping. This message is not only aspirational, or generated within the context of applicability to all families, but by families who have experienced the death by suicide of a young family member or the suicidal behaviour of a young person. These families highlight the importance of communication, and it seems reasonable that in response, other family members, social networks and service providers could seek ways to support engagement with families in these circumstances.

Participants indicated that they had been keen to talk about their experiences, but had often struggled to find an appropriate forum. They also commented that it would have been helpful to have more social acceptance and openness around suicide and suicidal risk. It seems reasonable to review the arrangements for both prevention and postvention family support, whether this be proactively delivered within the community, or via specialist services at the postvention stage. The bottom line is that some families may need assistance to know when, where and how to talk about suicide, and to be provided with an appropriate venue and support for this.
7.5.4(b) Recommendation 7

Families and parents questioned the decisions that they had made regarding the balance of individual autonomy versus accountability. Clearer advice and support on raising young people may be beneficial for some families. They believed that they had allowed their young person too much freedom without demanding more transparency, and were advocating that more care needs to be taken to be aware of the choices and movements of their young person. While this may be difficult to institute at a later point in time, progress may be made if autonomy is supported gradually, and parents and young people may benefit from assistance in identifying effective strategies for managing this stage in the family life cycle. Perhaps adolescents could be advised that increased individuality does not have to cost them their family relationships. It is not growing away from their family, but growing up with their family. Obviously, many parents will also need help to receive, understand and work within the same framework.

7.5.4(c) Recommendation 8

Families wanted more information about mental health. They stated that they may have been able to cope more effectively if they knew what to look out for. That is, if they knew the signs and symptoms of depression, if they knew what the most common warning signs of suicidal thoughts and behaviour were, and if they knew how to recognise trauma. Despite public awareness campaigns about the management of depression, our families still believed that this is something better left to the experts. However, its high incidence may suggest that the provision of more information about depression and when to seek help, could aid families in recognising the signs and responding appropriately.

7.5.4(d) Recommendation 9

Families wanted more information about suicide risk. While related to recommendation 8, it seems important to isolate the request of our participants for more information about suicide. Practitioners may restrict access to general information about suicide in the belief that talking about suicide is likely to increase risk. However, this policy cannot ignore the informational vacuum that this may create, leaving space for potentially unreliable data to be sought from the internet or other sources, or for myth and folklore to go unchallenged. It is important that families have access to authoritative and current information on which to base decisions.

In addition to the above recommendations, it is useful to observe that little research has been conducted on families and suicide. There is some useful data available from international research, but it is unclear how much of this is applicable to Aotearoa New Zealand. Within New Zealand, there is virtually no research on Māori in this area. There is an additional problem with the studies that have been conducted, whether in New Zealand or overseas, and this relates to their focus. Many studies have been heavily influenced by Western empirical theorising and methods, which have allowed suicide to be reduced to an individual disorder or a sign of a psychiatric illness. Where context has been considered, it is often focussed on family or peer group pathology and dysfunction, not on strengths and coping. There is little research that appears to really address the struggles of the ordinary family in dealing with suicidal risk or suicidal acts leading to death. While some of the families who participated in this study had experienced a range of life stressors, they were generally families that functioned well in many aspects of their lives, had good general coping skills, and were committed to each other. There is a challenge to understand the suicide experience for these families, and to help families like this to cope effectively at the time of crisis.

7.5.4(e) Recommendation 10

There is a need for further resources to be allocated to research and evaluated service provision in order to understand the best methods of developing and enhancing family resilience when challenged by suicide.
Appendix A: recruitment materials

Recruitment poster

Understanding Families & Suicide Risk

The Psychology Centre is looking for families of young people aged 16 to 24 years to be part of a research project. Our goal is to understand what family strengths are relevant when facing a challenge. In particular, we would like to explore what helps people to cope when a young family member is “at risk” of suicide.

If you are willing to talk with us as a family, we would like to hear from you. All kinds of families are welcome to participate.

We would like to talk with families where no concerns about mental health or risk of suicide are present, as well as families where there are mental health concerns for a young person or where a young person has attempted suicide, and families where a young person has been lost to suicide.

If you are unsure whether or not this project is okay for your family, or you would like more information about the project, please:
- ask for an information sheet from your healthcare provider, or
- contact Lyn at The Psychology Centre on 07 834 1520, or
- visit our website www.tpc.org.nz

For more information from your local healthcare provider please contact:
Researchers: John Fitzgerald, Karma Galyer, Philippa Thomas & Gavin Whiu

Administrator: Lyn Walsh

The Psychology Centre
1st Floor
2 Von Tempsky Street, Hamilton

Location: 1st Floor
2 Von Tempsky Street, Hamilton

Post: P.O. Box 4423, Hamilton East, Hamilton, 3247.

Phone: (07) 834 1520
Fax: (07) 834 1519

We are open 8.30am till 5.00pm, Monday to Friday.

This project has been reviewed and approved by the Northern-Y Regional Health and Disability Ethics Committee (NTY/08/03/078).

This process includes review and approval by the Waikato DHB Kaumatua Kaunihera Committee.

You can obtain independent advice and support from the local Health & Disability Advocacy Service on 0800 4 ADNET (0800 42 36 38).
UNDERSTANDING FAMILIES

The Psychology Centre is looking for families of youth aged 16-24 years to be part of a research project.

Our goal is to understand what family strengths are relevant when facing this challenge.

We would like to understand what helps families to cope when a young person is at risk of suicide.

To get a good understanding of what is important, we need to talk to families themselves.

All kinds of families are welcome to participate.

If you are willing to talk with us as a family, we would like to hear from you.

We would like to hear from families with four different types of experiences.

- Families where a young person has been lost to suicide
- Families where a young person has attempted suicide
- Families where there are mental health concerns (any kind) for a young person, but no suicide attempt
- Families where there are no concerns for a young person

If you are unsure whether or not this project is okay for your family, please talk to your health care provider.

If you would like more information about the project you can:

- Ask your health care provider
- Call Lyn at The Psychology Centre on 07 834 1520
- Visit our web site: www.tpc.org.nz

This is not a counselling or crisis project. If you require urgent help, please talk to your health care provider, a GP, or phone the crisis service on 0800 50 50 50.
Appendix B: cover letter and information sheet for families

Thank you for your interest in our “understanding families and suicide risk” project. We want to find out what makes families strong in the face of challenges; we want to know what helps them to be resilient. To achieve this we need to talk to a wide range of families.

This project is funded by the Suicide Prevention Research Fund. Past research in this area has mainly looked at individuals and suicide risk, but not much known about how families cope. This information collected in this project will hopefully be used to develop supports for families when a young family member is at risk of suicide.

We have enclosed some short leaflets about the project for you to give to other family members if you want to. We have also included a full information sheet for you to look at and talk about with each other.

If any of this information is unclear, or you have any questions please don’t hesitate to contact The Psychology Centre. If you are unsure if this project is okay for your family, you can also ask your support people, your doctor, or anyone who is providing care for your family.

If you would like to take part, please give Lyn at The Psychology Centre a call on 07-834-1520. She will be able to make a time for us to meet.

Thanks again

John Fitzgerald

*Principal Investigator*

The Psychology Centre
Information Sheet (16 October 2008)

Principal Investigator: Dr John Fitzgerald, Director/Consultant Clinical Psychologist
The Psychology Centre, Hamilton

You are invited to take part in a research study exploring what helps families to cope when suicide becomes an issue for a young family member. You do not have to have had this experience yourself to participate. We are also interested in talking with families who have no concerns for their young persons, or have mental health concerns but no suicidal behaviour.

Participation in this project is entirely voluntary and confidential. Your participation (or not) will have no impact on the health services you receive now and in the future. If you decide to participate, you (as an individual or a family), can withdraw at anytime without any need to provide an explanation.

Background

Suicide is one of the leading causes of death for New Zealand youth and young adults. The New Zealand Suicide Prevention Strategy 2006-2016 aims to reduce the rate of suicide and suicide attempts. The strategy also aims to reduce any associated negative impact on a young person’s family/whānau. It would be useful to know what could protect youth from suicide, and one important factor is the family/whānau that are caring for them.

Unfortunately little is known about the experience of families at the point at which they are faced with suicidal behaviour of a young family member. Only a few studies to date have looked at what makes families resilient, or what helps them to cope well. This is the area of research that you and your family are being invited to take part in. The aim of this project is to identify processes within families that could lead to better outcomes for all involved. We would like to look at similarities and differences in across families who have experienced any such concerns.

What is involved for families?

Remember: Yours and your family’s participation in this study is completely voluntary. That is, you do not have to take part in the research. If you or your family chose not to be involved it will in no way affect your relationship with your health service provider.

There is no set definition of a “family”. Whoever you identify as your family is welcome to be included in the study. There will be no cost to you as a result of participation in this research. The Psychology Centre will cover petrol costs for travel. The study materials will be in English, so it is important that you can understand, read, and speak English. There are no translator services available. There are three main parts to the study.

Part one – Describing Your Family. A meeting will be arranged for the research team to meet with your family. All family members will be involved in this part. This will be at a time and place that is acceptable to you. If you agree to take part after meeting with the research team, we will ask each family member to sign a consent form. There will be time for a break between tasks with refreshments provided by the research team. To ensure information is recorded accurately, the interviews will be audio-taped using a digital recorder and then typed out by one of the research team. The following tasks are planned for the first meeting. These are expected to take up to 2 hours in total.
**Family Group Interview.** The interview will start with a very brief history of your immediate family. Who is in your family and any family significant events you identify will be drawn on a time-line. To help get a fuller description of your family, the interview will then move into broad questions. For example, we would like to know what being a “family” means to you, the key signs that you are doing well as a family, your strengths as a family, and how people might know they’re a valued part of your family. We would also like to understand how your family cope with stressful times. These questions ask about how your family reacts to stress, and what makes it easier or harder to cope with stress. There are no right or wrong answers to these questions. The aim is to find out your family’s own ideas about what is important. You choose what information you would like to share.

**Individual Family Members Questionnaire.** After the interview we will ask each family member to complete two questionnaires. One is about current psychological wellbeing. The other is a commonly used measure describing everyday aspects of being in a family.

**Part Two – Checking Family Descriptions.** A second meeting will be arranged for the research team to again meet with your family. All families will be involved in this part. The researchers will feed back the summary of your “describing your family” information. You are welcome to add to the summary so that it accurately reflects your family. A full typed out version of the family interview will be made available at your request. This is expected to take 30 to 60 minutes.

*Only those families who have lost a young family member to suicide or had a young family member make a suicide attempt will be asked to do Part Three.*

**Part Three – Family Descriptions and Suicidal Behaviour.** In this part the interview will move on to what was happening for your family during the time that suicidal behaviour was occurring. Young people and parents/caregivers have the option to be interviewed separately at this point to allow each person to share private information. Young children in the family will not be included in this interview due to the potentially sensitive nature of the information shared.

The focus of this interview is on what helps people to cope at this very difficult time. It is not about blaming families for what happened. The interviewer will ask for a brief description of what was happening for the young person and the family at the time that the suicidal behaviour occurred. They will then ask you to think about the features of your family that you have described, and consider the relevance of these during that time. This is expected to take 30 to 60 minutes.

**What are the benefits/risks of taking part in the research?**

**Benefits** - It is unlikely that you or your family will gain any additional benefit from taking part in the study. The real value of the study is the analysis of information from several families. Our research is being funded by Te Pou, New Zealand's National Centre of Mental Health Research, Information and Workforce Development. We are required to provide them with a summary report and recommendations at the end of the research. We hope that we will be in a position to make recommendations about programme development that will help families in the future.

**Risks** – Families who have lost a young person to suicide, or have a young person who has made a suicide attempt will be asked questions about their family’s experience during that time. We would like to know if the features that each family describe about themselves in first part of the project were relevant to that time. Detailed information about the suicide or suicide attempt is not required.
It is reasonable to expect that when people talk about suicide they may experience distress. If you are in this situation please consider whether or not participating in this project is a reasonable risk for you to take. You may want to talk with your health service provider or another support person before deciding to take part. All of the questions asked in the interview are open-ended, which means the degree of personal information discussed is up to you and your family. If as a result of participating, you or others in your family decide more help is needed, the research team can talk to you about what is available.

What will happen to information that we have about you and your family?

The research team who meets with you is obligated to keep all the information you share confidential. Quotes from your interview may be published just as you say them, so that the final report for the study will reflect your views. But we will ensure that you cannot be identified from any quotes. All the recorded information you provide for us will be kept anonymous, that is no information that could uniquely identify you or your family, such as names and addresses, will be linked. Every person who participates will be given a unique identification number for their questionnaire. No identifying information will be included when the interviews are typed out.

All information is kept in a computer database at The Psychology Centre. The database is accessible only to members of the research team, and is password protected. Any paper copies of forms will be stored in a locked filing cabinet at the Centre until the study is completed and then destroyed.

No data that we hold will be individually reported, that is, any reports or presentation of our findings will use only results from everyone who participates in the study. There will be no way to identify individuals within this data.

Can families change their mind about being on the study?

Yes. Any family member is free to stop the study tasks at any time during the meeting without any explanation. You can withdraw any information that we have already collected, at any time.

Has this project be reviewed by an ethics committee?

Yes. This project has been reviewed and approved by the Northern-Y Regional Health and Disability Ethics Committee (NTY/08/08/078). This process includes review and approval by the Waikato DHB Kaumatua Kaunihera Committee.

What should I do if I have concerns about the project?

If you have any questions or concerns about the project please speak to your support service provider or to one of the research team (John Fitzgerald, Philippa Thomas, Karma Galyer, or Gavin Whiu). Our contact phone number is 07-846 6907. Our mailing address is The Psychology Centre, PO Box 5556, Frankton, Hamilton 3242. Our website is www.tpc.org.nz. We are open from 8.30am to 5.00pm, Monday to Friday. You can also obtain independent advice and support from the local Health & Disability Advocacy Service on 0800 4 ADNET (0800 42 36 38).

What should I do if I want to find out more, or if I’m willing to participate?

If you are interested in the project please contact one of the research team (Dr John Fitzgerald, Philippa Thomas, Dr Karma Galyer, or Gavin Whiu) at The Psychology Centre. You can call on 07-846 6907 or 0276-308-708.

Thank you for taking the time to read this information sheet.

John Fitzgerald, PhD
Principal Investigator
If you and your family are interested in the project please tear off this form and post it to the address below. This is a Freepost address so you do not need to use a stamp.

Please keep the rest of the information sheet for yourself.

The Psychology Centre, Freepost No. 205165, P. O. Box 5556, Frankton Hamilton 3242

We will contact you with further information.

Name of Contact Person for Family: _________________________________________

Phone Numbers:
Home: _____________  Work: _____________  Mobile: __________

The Psychology Centre
ahead for health
Appendix C: sample questions for the Outcome Questionnaire-30.2

Responses are rated on a five-point scale (never – almost always)

Q1. I have trouble falling asleep or staying asleep.
Q5. I am satisfied with my life.
Q11. I use alcohol or a drug to get going in the morning.
Q15. I have frequent arguments.
Q21. I have an upset stomach.
Q25. I feel that something bad is going to happen.
Appendix D: sample questions from the Family Assessment Measure-III (FAM-III)

Responses are rated on a four-point scale (strongly agree – strongly disagree)

Q1. We spend too much time arguing about what our problems are.
Q5. We are as well-adjusted as any family could possibly be.
Q11. When problems come up, we try different ways of solving them.
Q15. My family could be happier than it is.
Q21. We never let things pile up until they are more than we can handle.
Q25. We never get angry in our family.
Appendix E: consent form for families

Participant Consent Form

I have looked at and understand the contents of the participant information sheet dated ______________ for volunteers taking part in the study investigating what helps families to cope when a young person is at risk of suicide. I have had the opportunity to use whānau support or a friend to help me ask questions and understand the study. Any questions that have arisen in regard to this study have been satisfactorily answered and it is my understanding that should any further queries arise I can contact the researchers named on the information sheet.

I understand that taking part in the study is my choice (voluntary). I understand I have the right to withdraw from this study at any time, and to decline to answer questions should I so wish without it affecting my future health care. I do not need to provide an explanation if I wish to withdraw from the study.

I understand that the interview information I give will be audio-recorded and typed out. No material that could identify me will be included in that transcript.

It is my understanding that the information gathered will only be used for this research and publications arising from this research project. No material that could identify me will be used in any reports on the project.

I, ______________________________ (participant’s name) agree to participate in this study under the conditions set out in the information sheet.

Signed: ________________________ Date: ________________________

Would you like to receive a summary of the results of this study? Yes/No

If yes, please send to the following address:

___________________________________________________________________________
___________________________________________________________________________
Appendix F: information sheet for the practitioner arm of the study

“The National Centre of Mental Health Research, Information and Workforce Development

Appendix F: information sheet for the practitioner arm of the study

“Understanding Families and Suicidal Risk.”
Participant Information Sheet – Practitioner Arm
(24 September 2009, v.1)

Principal Investigator: Dr John Fitzgerald, Director/Consultant Clinical Psychologist
The Psychology Centre, Hamilton

You are invited to take part in a research study exploring what helps families to cope when suicide becomes an issue for a young family member.

Participation in this project is entirely voluntary and confidential. The only criteria for inclusion in the ‘practitioner arm’ of the project, is that you have worked with a young person/family within the last year where suicide or suicidal behaviour has been an issue.

Background

Suicide is one of the leading causes of death for New Zealand youth and young adults (16-24 years old). The New Zealand Suicide Prevention Strategy 2006-2016 aims to reduce the rate of suicide and suicide attempts. The strategy also aims to reduce any associated negative impact on a young person’s family/whānau.

Unfortunately little is known about the experience of families at the point at which they are faced with suicidal behaviour of a young family member. Only a few studies to date have looked at what makes families resilient, or what helps them to cope well. This is the area of research that you and our ‘family participants’ are being invited to take part in. The aim of this project is to identify characteristics and processes within families that could lead to better outcomes for all involved.

What is involved for practitioners?

Our focus in this study is on what is useful for families and what is not. While we are talking to families about this, we would also like to collect the views of those who have been working with them. Therefore, we are keen to talk to practitioners who have either worked with families/whānau facing the challenge of suicidal behaviour, or who have worked with a suicidal individual and feel that they have some understanding of the individual’s family. There is no set definition of a “family” that we have been working to.
If you are able to help us with this project then we would like to meet with you, at a location/time convenient for you, for a single semi-structured interview lasting no more than one hour. During the interview we will ask you to,

a) provide brief and anonymous background information about the family being considered, so that we have a context for the interview,

b) comment on your own role and contact with the family, and

c) comment on your perception/assessment of the family’s strengths, struggles, coping strategies and resilience factors.

To ensure information is noted accurately the interviews will be audio-taped using a digital recorder. However, we will not be asking you to provide any information which could be used to identify your client or their family. No clinical details, or information which could be used to identify you, will be included in any research reports.

What are the benefits/risks of taking part in the research?

Benefits – Our research is being funded by Te Pou, New Zealand's National Centre of Mental Health Research, Information and Workforce Development. We are required to provide them with a summary report and recommendations at the end of the research. While there are unlikely to be any benefits to you from taking part in this research we hope that we will be in a position to make recommendations about programme development that will help families in the future.

Risks – We do not foresee any risks to you as a result of taking part in this research.

What will happen to information that we collect?

The research team is obligated to keep all the information you share confidential. Every person who participates will be given a unique identification code. We do not intend to transcribe the interviews, but simply identify the themes based on reviewing notes made at the time of the interview and the audio recording. When this has been done the recording will be erased.

All computer files will be maintained on the password secured servers at The Psychology Centre. Any paper copies of forms will be stored in a locked filing cabinet at the Centre until the study is completed and then placed in long-term secure storage or destroyed.

No data that we hold will be individually reported, that is, any reports or presentation of our findings will use only aggregated results from everyone who participates in the study. There will be no way to identify individuals within these data.

Can participants change their mind about being in the study?

Any participant is free to stop their interview at any time, or decline to answer any particular question, without any explanation. You can withdraw any information that we have already collected at any time prior to completion of the final report.

Has this project be reviewed by an ethics committee?

This project has been reviewed and approved by the Northern-Y Regional Health and Disability Ethics Committee (NTY/08/08/078). This process includes review and approval by the Waikato DHB Kaumutua Kaunihera Committee.
What should I do if I have concerns about the project?

If you have any questions or concerns about the project please speak to one of the research team (John Fitzgerald, Karma Galyer, or Gavin Whiu). Our contact phone numbers are 07 846 6907 or 0276 308 708. Our mailing address is The Psychology Centre, PO Box 5556, Frankton, Hamilton 3242. Our website is www.tpc.org.nz

What should I do if I want to find out more, or if I’m willing to participate?

If you are interested in the project please contact one of the research team (Dr John Fitzgerald, Dr Karma Galyer, or Gavin Whiu) at The Psychology Centre. You can call on 07 846 6907 or 0276 308 708. Alternatively you can send us the expression of interest form attached to the back of this information sheet and we will contact you. Please use the free post number on your envelope. No stamp is required.

Thank you for taking the time to read this information sheet.
Understanding Families and Suicide Risk

**EXPRESSION OF INTEREST**

If you are interested in the project please complete this form and post it to the address below. This is a Freepost address so you do not need to use a stamp.

Please keep the rest of the information sheet for yourself.

The Psychology Centre, Freepost No. 205165,
P. O. Box 5556, Frankton, Hamilton 3242

We will contact you with further information/arrange an interview time.

Name: _________________________________________

Phone Numbers:

Work: _____________ Mobile: _____________

Email: _____________
Appendix G: consent form for practitioner arm of the study

Practitioner Consent Form (24 September 2009, v.1)

“Understanding Families and Suicidal Risk.”

I have looked at and understand the contents of the Participant Information Sheet – Practitioner Arm (dated 24 September 2009, v.1) for practitioners taking part in the study investigating what helps families to cope when suicidal behaviour becomes an issue for a young family member. I have had the opportunity to ask questions and understand the study. Any questions that have arisen in regard to this study have been satisfactorily answered and it is my understanding that should any further queries arise I can contact the researchers named on the information sheet.

I understand that taking part in the study is my choice (voluntary). I understand I have the right to withdraw from this study at any time, and to decline to answer questions should I so wish. I do not need to provide an explanation if I wish to withdraw from the study.

I understand that the interview information I give will be audio-recorded.

It is my understanding that the information gathered will only be used for this research and publications arising from this research project. No material that could identify me, or the family/individuals that are the focus of my interview, will be used in any reports on the project.

I, ________________________________ (practitioner’s name) agree to participate in this study under the conditions set out in the information sheet.

Signed: __________________________ Date: ________________________

Would you like to receive a summary of the results of this study?  Yes/No
If yes, please send to the following address:
References


