

Parents Caring for a Young Person at Risk of Suicide

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Abstract

Parents can have a key role in supporting youth at risk of suicide and may be able to help reduce their child's future suicide risk. There is little research exploring parents' experiences of caring for a young person at risk of suicide in New Zealand. This exploratory study reports on parents' experiences of caring for a young person at risk of suicide and their experiences with the services supporting their child. Semi-structured interviews were conducted with 13 New Zealand parents of suicidal young people. The interviews were transcribed and analysed using thematic analysis. Parents described feeling emotionally overwhelmed, powerless and responsible. They described not taking time for themselves, walking on tiptoes, and finding it difficult to talk about if people had not been through similar experiences. They also spoke about building strengths growing and learning. The second part of the analysis focused on parents' discussions of the services supporting their child. Parents found it difficult to get the help they wanted for their child and felt they were on the outside. They wanted professionals to give greater recognition to their role in their child's recovery. These findings suggest ways in which mental health professionals could more effectively relate to parents of young people at risk of suicide. The findings emphasize the need for compassion and sensitivity to parents' emotional needs, and the importance of collaboration between all of those supporting the young person's wellbeing.

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THESIS OVERVIEW

‘Tis a fearful thing to love what death can touch’

Judah Halevi, from the 12th Century

Youth suicide is one of the major health issues in New Zealand (Ministry of Health, 2019a).

Suicidal behaviour is often recurrent, with risk of completed suicide being significantly increased in young people who have attempted suicide (Turecki & Brent, 2016). Therapeutic intervention with youth who have engaged in self-harm has the potential to save lives. Youth are often reluctant to seek help from formal services (Mariu, Merry, Robinson & Watson, 2011), and there are high drop-out rates from services (Block & Greeno, 2011). This means that the young person’s informal support network is crucially important, and engagement of families offers another possibility of effective intervention. Focus on family interactions has been identified as an important element of treatment interventions with some evidence of effectiveness (Brent, McMakin, Kennard, Goldstein, Mayes & Douaihy, 2013).

Parents and caregivers play crucial roles in young people’s lives and can be sources of risk and sources of support. Past studies tell us that parents caring for a young person at risk of suicide are likely to experience a range of difficult emotions, lose confidence, and feel isolated (Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a).

Parenting a child with suicidal behaviour is clearly a challenging experience. We need to understand better what these challenges are for parents in the New Zealand context. Further, we need to understand what the support needs are for parents in this situation in order to inform the development of services and resources in this area. I had three research questions guiding my study 1) What are the challenges that parents face in caring for a suicidal young person? 2) How

do they deal with these challenges? And 3) How do parents experience their engagement with services aimed at supporting them and their child? This research was intended as a basis to make recommendations to parents for how to cope with the experience of having a suicidal child and to make suggestions for the services intended to support them.

This study involved interviews with 13 parents who had cared for a young person at risk of suicide. The interview transcripts were analysed using a thematic analysis approach. This approach allowed for the parents' voices to be heard and similarities and difference identified across transcripts (Braun & Clarke, 2006).

This analysis, and the project in general, has been influenced me as the researcher (Mauthner & Doucet, 2003). My personal and professional experiences sparked my interest in the research topic and influenced how I have understood the participants' stories. I am not a parent myself and have not lived in a household with a young person at risk of suicide. I am a Pākehā New Zealand woman and, along with many New Zealanders, suicidal behaviours have been present in my social world. I have also worked in mental health settings with people at risk of suicide and their families. This project was completed as part of my clinical psychology training while I was working as a trainee psychologist.

This thesis is comprised of four chapters. Chapter one discusses the literature which is relevant to this study and is divided into two parts. The first part explores youth suicidal behaviour and the second part explores parenting and the emerging literature parenting in the context of suicide risk. Chapter two outlines the theoretical and methodological approaches taken in this study. Chapter three then presents the findings of the analysis. Lastly, chapter four discusses the findings, their implications and the strengths and weaknesses of this research.

CHAPTER ONE: LITERATURE REVIEW

In the first part of this literature review, I provide a background to understanding suicidal behaviour and youth suicide. I begin by defining suicidal behaviour and then outline the prevalence and incidence of youth suicide. I also review research literature that examines the risk factors associated with suicidal behaviour and discuss interventions targeting suicidal behaviour of young people. In the second half of the review, I discuss parenting and the emerging literature on parents' experiences of caring for a suicidal young person.

Youth Suicidal Behaviour

To understand parents' responses to a child's suicidal behaviour, it is necessary to explore the definition of suicidal behaviour, and to examine risk factors associated with youth suicide and interventions aimed at addressing this problem. This body of literature discusses research and professional ideas about suicide, it provides an important context for making sense of parents' responses.

Definitions of Suicidal Behaviour

In suicide literature a wide range of terms are used, and definitions remain an area of much debate (Berman, Silverman, & Bongar, 2000; De Leo, Burgis, Bertolote, Kerkhof, & Bille-Brahe, 2006; Linehan, Comtois, Brown, Heard, & Wagner, 2006; Silverman, Berman, Sanddal, O'Carroll, & Joiner, 2007). While some argue that there is a dichotomy between suicide attempts and non-suicidal self-injury (e.g., Brausch & Gutierrez, 2010), it appears that it could be more complex than this (Hawton, Saunders, & O'Connor, 2012). Intent to die is difficult to establish and often requires some degree of interpretation by others. The parents', the clinicians' and the young person's views may all differ regarding what the intent or motive was for the self-harm or suicidal disclosures. For example, an individual may either want to give the appearance of

intending to die or may genuinely intend to die, and it is difficult to decipher the difference between these two (Silverman et al., 2007). Similarly, the individual may want to escape distress but not intend to die (e.g., Rodham, Hawton, & Evans, 2004).

The terms ‘self-harm’ or ‘deliberate self-harm’ have been used to describe a range of self-injury behaviours irrespective of motive. The influential National Institute for Health and Care Excellence (NICE) guidelines adopted this approach (National Collaborating Centre for Mental Health, 2012). However, the term self-harm can also be seen as minimising serious or almost lethal attempts by some people on their own lives (Linehan et al., 2006). For parents, low-risk self-harm may be greatly distressing, and thus it seems inappropriate to use terms in this study that may minimise their experience.

Since this research focuses on the experience of parents, it could be that the parents’ subjective perception of the level of suicide risk of their child is more relevant in this situation than the child’s intention or behaviour. In addition, because parents were interviewed (rather than the young people about their own experience), it seemed important to define the behaviour in terms of what the parents could observe. Thus, in this thesis, I have chosen to focus on self-harm and suicide-related behaviour (which could be intended by the young person or not), rather than the more intangible notion of suicidal ideation.

In this thesis, I have chosen to use the term ‘suicidal behaviour’ to refer broadly to any suicide-related communication or action, as described by Silverman and colleagues (2007). Suicidal behaviour includes cutting, burning, overdosing, attempted hanging, disclosures of suicide plans or suicide threats. The suicidal disclosures can be implicit or explicit. This includes deliberate self-harm or suicide attempt regardless of whether there is an explicit intent to die.

Prevalence of Suicide and Suicidal Behaviour

It is estimated that around 800,000 people die by suicide worldwide each year (World Health Organization, 2019). It is likely that suicide is under-reported in many places given that suicide remains a sensitive issue and is still illegal in some countries. In New Zealand, however, a coroner's inquest is undertaken for each suspected suicide, meaning that misclassification is unlikely (Beautrais & Fergusson, 2006). About 500 deaths by suicide occur each year in New Zealand (Ministry of Health, 2019b). For many years, youth suicide rates have been high in New Zealand. Suicide was the most common cause of death for youth in 2011 and 2012, and those aged 15–24 had the highest rates of hospitalisations for deliberate self-harm (Ministry of Health, 2014, 2015). In New Zealand, youth suicide has been decreasing; however, youth (aged 16–24) still tended to have the highest rate of suicide out of all the life-stage groups between 1996 and 2016 (Ministry of Health, 2019b).

For each fatal suicide there are many times the number of attempted suicides. Many young people experience thoughts about suicide at some time; however, very few of these young people make an attempt, and of those that do attempt, even fewer go on to die as a result (Fortune, Seymour, & Lambie, 2005). Cutler and colleagues (2001) estimated that for one completed suicide there are 400 teenagers who report an attempted suicide. The World Health Organization (2014) had a more conservative estimate of over 20 attempted suicides for each fatal one.

Suicidal behaviour is a common occurrence, and the suicidal individual is not the only one who is affected by it. It is suggested that for each suicidal person around six others are intimately affected by that person's behaviour (Andriessen, 2009; Shneidman, 1969). Each

suicidal behaviour is a signal of intense emotional distress. The impacts can be devastating and long-lasting for those around them.

Risk Factors Associated with Suicidal Behaviours

Identifying and understanding risk for completed suicide and self-harm is challenging. Like any human behaviour, it is likely that suicide and self-harm come about because of a complex range of biological, psychological, social learning and cultural factors. Suicide can result from a gradual and increasing build-up of vulnerability factors, it is rarely the outcome of a single risk factor (Bilsen, 2018; Overholser, Braden, & Dieter, 2012). There is a considerable literature on the risk factors associated with suicidal behaviour, and while a full exploration of risk factors is beyond the scope of this thesis, some of the factors that are thought most relevant for this research are discussed below. There are several reviews that summarise the full range of risk factors (e.g., Bilsen, 2018; Hawton, Saunders, & O'Connor, 2012)

Previous suicidal behaviour is recognised as one of the most significant risks for completed suicide. Individuals who engage in self-harming behaviours make up one of the highest risk groups for a subsequent fatal suicide (Beckman et al., 2018; Hawton et al., 2020; Rhodes et al., 2019). Attempted suicide is the single strongest predictor for an eventual fatal suicide (Beghi, Rosenbaum, Cerri, & Cornaggia, 2013; World Health Organization, 2014). Some research supports the idea that individuals who self-harm habituate to the accompanying fear and pain, and build up the capacity to be able to perform fatal self-injury (Nock, Joiner, Gordon, Lloyd-Richardson, & Prinstein, 2006). Suicide risk of individuals who self-harm are hundreds of times higher than it is for those in the general population (Jenkins, Hale, Papanastassiou, Crawford, & Tyrer, 2002; Owens et al., 2002).

Given the increased risk of completed suicide for people who self-harm in comparison with the general population, there is a statistical basis to concerns that parents might have that their child's suicidal or self-harm behaviour suggests a threat to the life of their child (Bilsen, 2018; Hawton et al., 2015). However, completed suicide remains a rare event. This contrasts with self-harm, which is a common event. This means that despite the increased risk associated with self-harm, it is still very uncommon for people who self-harm to go on to die by suicide. Studies show that the likelihood of someone dying by suicide following a self-harm incident is around 0.5%–2% after one year and over 5% after nine years (Owens et al., 2002). So although self-harm remains a significant risk factor for suicide, the association is less strong than is often thought.

The majority of youth who report suicidal behaviours meet the criteria for a pre-existing mental health diagnosis (Nock et al., 2013). The public has come to see suicidal behaviour as an indicator of mental health difficulty (Marsh, 2015) and it is generally treated by mental health professionals as such. Fergusson and Lynskey (1995) found that 90% of adolescents who attempted suicide and 70% of those who disclosed suicidal ideation met the criteria for psychiatric disorder (compared with only 30% of non-suicidal adolescents). The most common disorder associated with suicidal behaviours is depression (Bridge, Goldstein, & Brent, 2006). However, this is not necessarily best understood as an individual risk factor. It could be that many adolescents experience the family-related risk factors and then go on to develop psychological difficulties (Fergusson & Lynskey, 1995). It is likely that the same factors that make young people vulnerable to mental health diagnoses also make them more likely to engage in suicidal behaviours. Therefore, the concerns that parents have about a child's suicidal

behaviour are likely to be overlaid with more general concerns about his or her mental health and well-being.

Beyond the individual, a range of family- and parent-related factors are also thought to increase the risk of suicidal behaviour. Parental abuse and neglect are consistently found to be a risk factor for suicidal behaviour among adolescents and adults (Buckmaster et al., 2019; Fortune et al., 2016).

Poor attachment between parents and children is also associated with increased risk of suicidal behaviour (Buckmaster et al., 2019; Fortune 2016). One of the studies demonstrating this association is a longitudinal New Zealand study (Fergusson, Woodward, & Horwood, 2000). In this study, attachment had an association independent of childhood sexual abuse and socio-economic adversity, both of which were also shown to predict suicidal behaviour. These variables were mediated by mental health problems and exposure to stressful life events. Internationally, multiple studies of online surveys with university students have found that parent–child attachment relates to self-harm (Fung, 2006; Irvin, 2003). This relationship may be mediated by other factors, such as stress (Hallab & Covic, 2010) or the young person’s perception of his or her problem-solving abilities (Glazebrook, Townsend, & Sayal, 2015). Either way, studies tend to demonstrate that parent–child attachment could play a role in the development of suicidal behaviour.

Parenting style has been researched to better understand the development of suicidal behaviours. Significant roles have been identified for a range of styles. Research in Germany showed that parenting styles that have low levels of warmth, such as authoritarian or neglectful styles, are linked with the development of a variety of risky behaviours and personality traits, including suicidal behaviour (Donath, Graessel, Baier, Bleich, & Hillemacher, 2014). The

authoritative parenting style, with high levels of both control and warmth, was a protective factor (Donath et al., 2014). One might expect this to differ across cultures but these effects are surprisingly consistent around the world. Lai and McBride-Chang (2001) found similar results in Hong Kong. Li, Li, Wang, and Bo (2015) found similar results in China. In an Australian study, Martin and Waite (1994) found that adolescents had double the risk of suicidal ideation and three times the risk of engaging in self-harm if the parents had an authoritarian parenting style (i.e., low in affection and high in control).

The level of parental involvement is another factor that has been identified as significant in relation to suicidal behaviours. In a large survey study with adolescents in the United Kingdom, Flouri and Buchannon (2002) found that adolescents who reported a suicide attempt also reported lower levels of parental involvement (i.e., listen to their views, take notice of them) than adolescents who had not made a suicide attempt. Randell, Wang, Herting, & Eggert (2006) conducted a survey study with American adolescents aged between 14 and 19. The participants in the study with higher level of suicide risk perceived less parental involvement and less support within the family than those classified in the 'non-risk' group. Johnstone and colleagues (2016) found that low parental care may account for the association of abuse with suicidal behaviour. After removing the effect associated with low parental care, parental abuse ceased to have a significant association with suicidal behaviour among adults experiencing depression. Measurement of parental involvement may be confounded by a tendency for families who usually operate with a disengaged parenting style to often take action and become more involved during a time of crisis (Bush & Pargament, 1994). Wedig and Nock (2007) found that parental criticism was strongly associated with suicidal thoughts and behaviour (suicide ideation, suicide plans, suicide attempts and self-harm). The complexity of research in this area is demonstrated

by the finding that the link between parental criticism and suicidal behaviours was particularly strong for adolescents with a self-critical thinking pattern (Wedig & Nock, 2007).

It is common for adolescence to be a time of greater parent–child conflict than usual because of changing boundaries as young people strive for more independence. Family conflict is one of the more studied areas relating to family and suicide risk (Brent, Baugher, Bridge, Chen, & Chiappetta, 1999; Hawton, Fagg, & Simkin, 1996; Hollis, 1996; Randell et al., 2006). Youth who have made a suicide attempt are more likely to report family conflict. Randell, Wang, Herting, and Eggert (2006) conducted a study with 1,083 teenagers who had dropped out of high school. They found that teenagers reporting a higher level of conflict with parents, was correlated with a higher level of suicide risk. Brent and colleagues (1999), in an study of completed suicide, reported that for younger teenagers conflict with parents was more common among suicide victims, whereas among older suicide victims conflict with intimate partners was a more common factor. This could reflect the more important roles parents play in younger adolescents' lives. However, parent or partner conflict did not persist as a significant predictor of suicide risk in the multivariate analysis. This indicates that its apparent effect is mediated by a more significant variable. Brent et al. (1999) suggested that relationship conflict could be secondary to parent and/or child psychopathology. However, the researchers also acknowledged that conflict can be a catalyst for suicidal behaviour and thus is an important area to address in interventions. It could be that for conflict to be associated with suicide it may need to be chronic and more serious. For example, in a study of 755 adolescents admitted to hospital for self-harm, almost all participants reported chronic conflict in the parent–child relationship (Hawton et al., 1996). The conflict also often included violence (Hawton et al., 1996). A cross-sectional study of 9,500

adolescents in New Zealand (7.8% had suicide attempts) found that family violence and suicide attempt by a family member was associated with suicide attempts (Fleming et al., 2007).

Parents appear to play an important role in suicide risk. Even the factors that have been identified by research and presented here as individual risk factors, such as previous suicidal behaviour and mental health difficulties, may be significantly influenced by family function, parenting style, parental involvement and level of care. While there is potential here for parental blame, by parents themselves, the community and professionals, this also indicates a possibility for positive intervention. This further highlights the importance of understanding parents' experiences and perspectives of parenting and engaging with services with their suicidal children.

Interventions for Suicidal Behaviour

There are multiple promising treatments aimed at reducing young people's suicidal behaviour (Robinson, 2018). However, none of the interventions yet meets the *Journal of Clinical Child and Adolescent Psychology* classification of a 'well-established treatment' (Glenn, Franklin, & Nock, 2015). Unfortunately, drop-out rates are high, and it is difficult to keep young people engaged in treatment. Moreover, even if they are engaged in services, it does not safeguard against subsequent suicidal behaviour (Luoma, Martin, & Pearson, 2014). Even if a suicidal young person is willing to engage with a formal service and is able to receive best practice care, research indicates that subsequent suicidal episodes are not prevented through mental health service involvement (Brent et al., 2013; Nock et al., 2013). Even though some interventions show effectiveness for reducing young people's distress, most young people are likely to have some residual suicidal thoughts and self-harm (Brent et al., 2013). Thus, professionals are not able to say to families with confidence that they can offer the needed

interventions to protect the young person. They are not able to take the burden of care and responsibility for ‘managing’ suicide risk from the parents.

Characteristics of parenting have been identified as risk factors for self-harm and research indicates that the best interventions involve parents (Brent et al., 2013). This also suggests the importance of support for parents so that they are able, in turn, to contribute to supporting their child.

While no interventions have become well-established treatments, there are some promising studies of psychological interventions, many of which include the involvement of parents. Increased effectiveness of interventions for suicidal youth may be mediated by a positive effect on characteristics of parenting that have been identified as risk factors for youth self-harm. For example, therapy addressing attachment has been found to be helpful (e.g., Diamond et al., 2010).

The randomised controlled trial intervention studies focusing on reducing suicidal behaviour in young people that are currently available (Brent et al., 2013; Glenn et al., 2015; Robinson et al., 2018) do not give evidence of the superiority of a particular modality but do support the involvement of family. Theoretical orientations with some support from trials include cognitive behavioural therapy (CBT), dialectical behaviour therapy (DBT), interpersonal therapy (IPT), psychodynamic therapy and family-based therapy (Glenn et al., 2015). The efficacious trials of CBT and psychodynamic therapy involved both individual and parent involvement. There was only one treatment (IPT) that showed effectiveness without including family. IPT does, however, include a strong focus on interpersonal functioning in the individual sessions (Mufson, Dorta, Moreau, & Weissman, 2011). Pineda and Dadds (2013) identified further support for involving family. They found that adding a four-session parent programme alongside

treatment as usual improved outcomes for youth suicidal behaviour. Improvements in the parent-reported family functioning mediated the reduction in suicidal behaviour. This finding highlights the protective impact family functioning can have.

Involving families in treatment of young people generally increases chances of successful changes (Brent et al., 2013; Glenn et al., 2015). The positive effect of involving families in treatment of young people has now become standard practice, and most recent interventions with youth that have been studied include a family approach (Robinson et al., 2018). This means that the differential effect of having parents involved is no longer being investigated. However, there is much to learn about the mechanism by which involvement of families contributes to better outcomes. Pineda and Dadds's (2011) study indicates that the mechanism may be improvement of family functioning. Another possibility is in increasing support to youth to continue therapy. This could be practical in terms of transport or in supporting commitment. The most effective therapies generally provide the most sessions (Brent et al., 2013), which means that the young person needs to remain committed to continuing therapy and some may require parental support to get there.

Research into effective treatments for suicidal adults has identified positive gains for DBT (Linehan, et al., 2006). DBT is commonly used with adults who engage in suicidal behaviour. However, the evidence base for DBT in treating adolescents is less clear (Groves, Backer, van den Bosch, & Miller, 2012).

Barriers to Effective Intervention with Youth Who Engage in Suicidal Behaviours

Young people are generally reluctant to seek help from formal services (Mariu, Merry, Robinson, & Watson, 2012). Rates of mental health problems affecting young people has been estimated at 13.4% of the general population (Polanczyk, Salum, Sugaya, Caye, & Rohde, 2015);

however, it is estimated that only a small portion of those have access to or are willing to use formal mental health services (Siti Fatimah, Nor Afiah, Anisah, & Minhat, 2015). Adolescence is a time of forming identity and finding autonomy (Eriskon, 1968); therefore, simply the act of attending therapy sessions can seem to adolescents like a threat to independence because it means they require outside help (Chu, Suveg, Creed, & Kendall, 2010)

Young people dropping out of treatment is a major challenge in youth mental health services. When young people do engage in treatment, not all benefit; however, their psychological problems are more likely to be resolved if they continue to engage (de Haan, Boon, de Jong, Hoeve, & Vermeiren, 2013). Drop-out rates in community child and adolescent mental health settings range from around 15% to 85% (de Haan et al., 2013; Wergeland et al., 2015). Adherence to treatment and aftercare is particularly low in young people who are suicidal (Robinson et al., 2018). The high level of treatment drop-out could indicate that treatment is not meeting young people's needs. This underlines the possible importance of the role of the family in supporting a young person's engagement with treatment.

Parents can be an important factor in treatment engagement and treatment outcomes for young people (Hazell, 2000). Parents often initiate referrals for mental health support (Rickwood Deane, & Wilson, 2007). Teenagers could be reliant on parents for transport to appointments and for money to buy medications. Parents may not mention practical barriers, such as taking time off or financial pressure, because this can be added shame (Mendiola, 2011). It is crucial to support parents' involvement and consider their views and needs in effective intervention.

There is also potential for parents to be unhelpful in treatment. Frey and Cerel (2015) suggested that it is important to consider whether the family is too volatile and whether they might distract from the treatment rather than be helpful. However, features of these families may

also be associated with increased risk factors for youth suicide. This might mean that finding a way to engage these families successfully in an intervention could reduce risk. Parental involvement detracting from treatment is likely to be only a small minority of cases, because the current research has found that treatments that focus on augmenting parental support can be effective in reducing further suicide attempts, ideation and self-harm (Brent et al., 2013).

Even when young people are willing to access interventions and parents are able to support them to do this, best practice interventions may not be available. Staff and resources are limited in Child and Adolescent Mental Health Services (CAMHS). New Zealand research has found that mental health services have been inadvertently deviating from best clinical practice because of excess pressures on staff (Elliott, 2017; New Zealand Government, 2018). In 2006, Fortune and Clarkson found similar pressures on CAMHS services. In their study they described how the practitioners were focused on risk assessment and risk management rather than ongoing non-crisis interventions that would have a better chance of meeting the needs of young people and their families. Risk assessment is not identified as the most effective practice in this context. Despite decades of research on risk factors, we are no better at predicting risk of suicide now than we were 50 years ago (Franklin et al., 2017). Even experienced clinicians are not very accurate at assessing suicide risk (Berman & Silverman, 2014). This raises concerns that a focus on risk assessment is directing scarce clinical resources into an area with limited effectiveness. In fact, some argue that overusing structured risk assessment processes can reduce real engagement with clients and be more about the clinician's own anxieties (Chan et al., 2016). There is a possibility that engaging in repeated risk assessments can undermine the ability of the young person to receive the most effective care.

The difficulties of engaging suicidal young people with effective treatment means that their informal support networks are crucially important. In a large representative study of youth in England, participants viewed informal social support (i.e., friends and family) as the key sources of support for reducing suicidal behaviour, rather than professional agencies (Fortune, Sinclair, & Hawton, 2008). Parents can be the first to identify when young people self-harm if they are unknown to mental health services (Oldershaw, Richards, Simic, & Schmidt, 2008), and in some cases parents may be the only ones who know about the suicide risk (Luoma et al., 2014; Owen et al., 2012). Disclosure of self-harm to parents can lead to more support and reduction in suicidal thinking (Hasking, Rees, Martin, & Quigley, 2015). Intervention studies typically focus on relatively short-term clinician involvement, whereas parental caregivers are involved in a young person's life on a daily basis and are likely to have an enduring relationship.

Though the research on therapeutic interventions for suicidal adolescents can provide only tentative guidance, a number of lines of research support the potential role of parents in recovery for these young people. Programmes involving parents across a range of treatment models are more effective than the programmes that did not involve family (Brent et al., 2013). Engagement and retention of young people in care is challenging, and parents may have an important role to play in enabling young people to begin and sustain engagement in treatment. Parents may also play an important role in supporting youth who do not engage with treatment or who do not receive the kind of support they need. To engage parents most effectively in providing support to a young person who engages in suicidal behaviour, it is important to understand their experience and needs.

Parenting and Youth Suicidal Behaviour

In this section of the review I explore research that is specifically relevant to the role of parents in dealing with a child with suicidal behaviour. First, I discuss parents' roles more generally, then I explore the emerging literature on parenting a young person at risk of suicide. This review is intended to provide a framework for understanding the parents' perspectives, which is central to this study.

Parenting Challenges with a Young Person

To understand the experience of parenting a suicidal young person, it is important to look at the broader context of parenting in general. Parenting is considered important in relation to a wide variety of long-term outcomes for children, such as educational achievement (Steinberg, Lamborn, Dornbusch, & Darling, 1992; Turner, Chandler, & Heffer, 2009), behaviour problems (Oliver, Guerin, & Coffman, 2009) and an ability to show empathy (Farrant, Devine, Maybery, & Fletcher, 2012). Many argue that parents face unrealistic expectations in today's society (Fox, 2009; Hays, 1998; Hoffman, 2010). Hays (1998) introduced the idea of an 'intensive parenting' culture, in which parents are expected to care for their children in an expert-guided and fully child-centred way. This intensive parenting ideology supports the idea that good parenting requires investing a large amount of time, energy and material resources in the child. The parent role is also viewed as more important than other roles held, such as paid employment (Hays, 1998). This approach to parenting is both emotionally demanding and time intensive (Lee, Macvarish, & Bristow, 2010). Intensive parenting may exist more strongly in certain demographics, but it remains the most powerful, visible and consciously articulated ideology of parenthood (Hays, 1998; Hoffman, 2010).

While parenting is important, just being a loving parent cannot ensure a child's happiness. Mother's love has been considered fundamental for a child's mental health development for a long time (Bowlby, 1952), and effective parenting strategies are seen to have a powerful influence on children's positive development, as mentioned above. Unfortunately, however, there can be pressure on parents to provide 'good parenting' in order to raise children who are happy and able to manage emotional challenges. Some self-help book titles, such as *Raising Resilient Children: Fostering Strength, Hope and Optimism in Your Child* (Brooks & Goldstein, 2002) and *The Optimistic Child: A Proven Program to Safeguard Children Against Depression and Build Lifelong Resilience* (Seligman, 2007), can give the impression that parents have the ability and responsibility to raise emotionally resilient children. While these books can be great tools and useful for many parents, they can also lead to an implied logic that when something goes wrong the parents have not done enough. These intensive parenting expectations can lead to an exaggerated sense of responsibility and blame for when their child is unhappy (Hoffman, 2010). Mothers, in particular, seem to still be scrutinised when something goes wrong with their child. Mother-blaming, both by themselves and by others, is tied to dominant cultural narratives about what it means to be a 'good' mother (Moses, 2010).

There are particular demands in parenting an adolescent and young adult. Parenting books for adolescents prepare parents for this to be a tough period. When children move into adolescence, parents often experience many fears (Steinberg & Silk, 2002), and the developmental changes through adolescence can create stress in the relationship between parents and their children (Mc Cubbin & Patterson, 1983).

Erikson (1968) proposed that humans face challenges at different points in their life, and during adolescence the key challenge is negotiating identity. As adolescents begin to negotiate

their personal identity separately from the family, the relationship with parents becomes more complex. Some conflict of ideas can be considered normal and healthy, especially as teenagers are finding their own set of beliefs and values separately from their parents. As adolescents develop their own identity, they can begin to challenge the authority of their parents. Studies indicate that there is increased hostility between parents and their children during adolescence (De Goede, Branje, Delsing, & Meeus, 2009).

Increased importance of peers is a hallmark of the adolescent phase of life (Brown, 2004; Steinberg & Monahan, 2007). With this increase in peer influence, the influence parents have on their adolescent children decreases (De Goede, Branje, Delsing, & Meeus, 2009). This situation can be challenging for parents to negotiate.

Adolescents care deeply about having privacy (Marwick, Diaz, & Palfrey, 2010). Parents may find that their once open and confiding child becomes much more attached to his or her own privacy. The amount of information adolescents share with their parents depends heavily on the quality of the parent–child relationship (Smetana, 2008).

Parents generally tend to monitor their children less as they move through the teenage years and to give them more freedom (Smetana, Crean, & Campione-Barr, 2005). Parents vary in their ideas about the rights of children to privacy and in how much they monitor them (Cranor, Durity, Marsh, & Ur, 2014; Metzger, Ice, & Cottrell, 2012). Greater parental monitoring can lead to increased conflict between teenagers and their parents (Hawk, Keijsers, Hale, & Meeus, 2009), which may then make teenagers less likely to disclose information. So, while the transition from childhood to adulthood is not necessarily a difficult time, there can be many challenges for families to work through.

When the young person has mental health problems, the transition to adulthood can be more complicated and difficult (Hausser-Cram, Krauss, & Kersh, 2009). One area of struggle is managing the boundary between encouraging the young person's autonomy versus providing extra support (Gerten & Hensley, 2014; Jivanjee, Kruzich, & Gordon, 2009; Lindgren, Söderberg, & Skär, 2016). The extra stress of caring for a young person with a mental illness can lead to negative consequences for the caregiver's well-being, such as depressive symptoms, poor physical health and reduced quality of life (Gerkenmeyer et al., 2011; Vaughan, Feinn, Bernard, Brereton, & Kaufman, 2013). There may also be added pressure on parents who feel responsible for their child's difficulties. In a qualitative study of parents of young people with mental disorders, all 68 parents described self-blame in their narratives (Moses, 2010). When children experience difficulties such as mental illness and behaviour problems, parents often feel some liability (Hoffman, 2010).

If caregivers are not functioning well, it can have flow-on effects for young people with mental health difficulties (Shah, Wadoo, & Latoo, 2010). When family caregivers are supported, they are able to better support the young people's recovery goals, and better cope with the difficulty of living with mental health difficulties. Support can relieve some of the parents' sense of burden and can improve caregivers' sense of empowerment and decisions to use self-care (Yesufu-Udechuku, 2015). Thus, research tells us that parenting a young person with mental health difficulties can have major impacts on parents and lead to a vicious cycle.

Experiences of Parenting a Young Person with Suicidal Behaviour

Parents' experiences of parenting a suicidal young person is an emerging field of study based largely on qualitative research. Some of the results are apparently contradictory. Some studies have reported parents' descriptions of intense emotional response to finding their child

self-harming (Ferrey et al. 2016a; Raphael, Clarke, & Kumar, 2006). In contrast, Oldershaw et al. (2008) reported parents describing a gradual process of discovery, often underestimating the significance of self-harming. Anxiety was a common response (Buus et al., 2013; Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a; Raphael et al., 2006). Buus et al. (2013) reported some parents describing a sense of relief when their child attempted suicide because they had been living with fear for so long.

A common finding across studies was that of parent participants talking about losing confidence in their parenting ability (Byrne et al., 2008; Daly, 2005; Raphael et al., 2006). Byrne and colleagues (2008) reported that some parents felt uncertainty concerning parenting adolescents in general. Some concerns parents carried were about things outside their control, such as the detrimental influence of the internet, peer pressure, bullying and contagion of suicidal behaviours. A particular concern of parents was doubting their ability to use discipline, set boundaries and establish healthy relationships with their children (Byrne et al., 2008; Raphael et al., 2006).

Parents' fear of upsetting their child and precipitating self-harm can serve to give the child an inappropriate amount of power in the family, and setting boundaries can be extremely difficult. Parents may become more lenient to avoid conflict (Daly, 2005). Parents could also find it difficult to set limits or end up giving the child special privileges (Buus et al., 2013; Mendiola, 2011; Raphael et al., 2006). A common reaction to suicide threats is for parents to 'give in' (Buus et al., 2013; Omer & Dolberger, 2015). The child attaining this position of power could lead to parents feeling disempowered (Buus et al., 2013; Byrne et al., 2008). This has further potential for creating a vicious cycle of exacerbating the parents' loss of confidence in their parenting. Giving in to the suicidal threats could also serve to reinforce the suicidal behaviour by giving the

child what he or she wants and lead to a coercive cycle. Some parents described being manipulated by their child, because of their sense of guilt and fear (Buus et al., 2013). Many parents described being extremely careful to avoid upsetting the young person, out of fear that upsetting them could lead to further suicidal incidents. Wagner and colleagues (2000) reported that both mothers and fathers were careful about what they said to their child following a suicide attempt.

Uncertainty in parenting can cause parents to withdraw from their child (Omer & Dolberger, 2015) or try to exert greater control in order to prevent their child's self-harming behaviours (Byrne et al., 2008). These responses can lead to damaging the parent–child communication, increasing conflict and potentially an escalation of self-harm and increased risk of suicide (Omer & Dolberger, 2015; Yip, 2005). Low warmth and high control in parenting style have been identified as risk factors for adolescent self-harm (Donath et al., 2014) that can contribute to a vicious cycle in effect.

It can be difficult to sustain stable and generous parent–child relationships in the context of suicidal behaviours (Buus et al., 2013). Guilt, fear and difficulties with limit setting and good intentions could all lead to conflict in the parent–child relationship. Parents are much more likely to verbalise messages of support while also trying to give messages that the suicidal behaviour is unacceptable. Communicating with a suicidal person can be like ‘walking on eggshells’ (Daly, 2005), a situation in which parents fear that if they do something wrong or say the wrong thing this could have devastating effects. Other parents may withdraw from the relationship (Byrne et al., 2008). Daly et al. (2005) suggested that withdrawing could be a way of pre-emptively preparing for the possibility that their child goes on to complete a fatal suicide attempt.

Distancing from the suicidal young person could also be a way of avoiding the intense and painful emotions associated with the child.

While the majority of studies focus on the intense challenges and difficulties faced by parents caring for youth who are suicidal, one study identified positive effects on the parent–child relationship (Mendiola, 2011). In a small study conducted with New Zealand mothers and caregivers, participants reported feeling closer in their relationships with their children following deliberate self-harm (Mendiola, 2011). The suicidal behaviour led to them prioritising spending time together and improved communication. Maintaining a strong parent–child relationship is a protective factor; however, a strong family bond is not enough to mitigate suicide risk on its own (Fitzgerald et al., 2010).

Suicidal behaviour of a young person can also have major impacts on other relationships within the family. One parent described caring for a suicidal young person as a ‘double crisis’ because of the stress that was put on the wider family (Buus et al. 2013). In two-parent families, some reported conflict and arguments arising relating to the suicidal behaviour of the child. Mothers could feel isolated from other family members, including their partners (Daly, 2005). Buus et al. (2013) described that parents could be played off against each other by a suicidal young person. In one focus group study, parents described gendered differences in how mothers and fathers tried to cope (Buus et al., 2013). They described women wanting to talk more about what was happening and ending up feeling rejected, whereas men partners described feeling intruded upon and wanting time to process alone.

Siblings of a suicidal young person can be drawn into the changes in the family, and may experience some similar reactions to that of the parents (Buus et al. 2013). Siblings may feel protective and sensitive towards the young person. Across generations, family members

described taking on responsibility for keeping the suicidal person safe, and thus it was not only the parents who felt added stress (McLaughlin, McGowan, O'Neill, & Kernohan, 2014). The potential for suicide is likely to dominate the whole family for a period while each family member still has to deal with his or her own stressors. Some parents noticed that the brothers or sisters of suicidal youth felt neglected or resentful because of the extra attention on their sibling (Buus et al., 2013). Many parents feel guilt towards the other children in their family due to the suicidal child receiving or requiring so much of their attention. This also has the potential of being an added burden on suicidal young people if they feel they are causing harm to their siblings.

When parenting an adolescent at risk of suicide, the added stress and change in family dynamic can leave parents trying to cope with multiple difficulties on top of caring for a suicidal child. Bryne et al. (2008) found that deliberate self-harm could disempower parents and destabilise the family structure. As mentioned above, on top of parents' own complex emotional reactions, they may feel pressure to support both the suicidal child and his or her siblings, and possibly manage arguments arising in their partnership. For some families, new strategies and strengths can arise out of these times of crisis (Fitzgerald et al., 2010). Ferrey et al. (2016b) reported parents describing a range of parenting strategies, including increasing control, but also increasing support, developing coping strategies for their child and increasing their own self-care.

Through this literature review, the burden of parenting a suicidal child becomes clearer. The literature also shows the risk of a number of these factors interacting to exacerbate a vicious cycle whereby parents withdraw from their child or attempt to become more controlling, leading to increased conflict in the family which may contribute to suicidal behaviour. It would be useful

to gain a deeper understanding of the complex parent–child relationships as well as the strategies parents use to manage themselves, their families and their relationships with the young person.

Research suggests that parents suffer when their children are suicidal and that they are often an important part of the support network, but the opportunities for them to receive direct intervention from youth mental health services can be limited (Fortune, 2006). As previously noted, interventions for young people with suicidal behaviour tend to be more effective with parent involvement (Brent et al., 2013); however, these approaches are seldom implemented in practice. Mental health services are under significant pressure (Allen 2018, Elliott, 2017), which, as has been discussed, can lead to a potentially unhelpful focus on risk assessment rather than direct therapeutic intervention (Fortune, 2006). The services that are available are likely to focus on the engagement of the young person rather than on the parents. Parents are often treated solely as support for the child, rather than as going through their own distress that needs support (Omer & Dolberger, 2015). As adults, and in the context of youth suicide risk, they may be treated as if they should be able to manage their own distress.

Parents and practitioners may share the same goal of wanting the child to be safe; however, they are not always able to work together. Some practitioners have described how parents can ‘get in the way’, ‘ask too many questions’ or be a ‘nuisance’ (Piacentini, 1993). Practitioners holding these views illustrate how there could be a lack of understanding of parents’ distress. Even so, practitioners in New Zealand describe the struggle between involving the family and giving children space to talk freely without worrying about their family telling others (Mendiola, 2011). Parents can find clinicians insensitive to their own emotional state (Raphael et al., 2006). Not attending to the needs of parents could also risk parents disengaging from mental health services or therapeutic processes, which may increase the suicide risk of the young person.

When services do involve parents alongside the young person, it can increase parental well-being as a side effect of treatment targeting the young person. For example, Larssen, Andersson, Stern, and Zetterqvist (2019) found significant improvement for both parents' and adolescents' emotion regulation in an emotion regulation group skills training pilot study.

Direct therapeutic involvement with adolescent mental health services is not the only way parents can be supported. Other possibilities include providing education resources and information, parent counselling, parent support groups, family therapy, informal supports and online support groups (Krysinska et al., 2020).

Research suggests that parents would like to know more about suicidal behaviour and what to expect (Byrne et al., 2008; Mendiola, 2011; Wagner et al., 2000). Parents also described a need for support, information, skills for parenting and advice on further incidents (Byrne et al., 2008; Dempsey et al., 2019). Education interventions are designed to reduce stress, by validating and normalising parents' experiences.

It is common for parents to use the internet to find information about their children's health (Khoo, Bolt, Babl, Jury, & Goldman, 2008; Sim et al., 2007). Parents of suicidal young people are likely to search the internet for information. Many parents find the available information helpful, but a few find it distressing (Sim et al., 2007). As the information available increases, it is not necessarily becoming any more accurate or helpful. It is interesting to learn where parents look for support and advice following a young person's suicidal behaviour, especially with the changing times in terms of media reporting and the vast amount of information available on the internet.

Parent counselling after the attempt was described as wanted by a significant proportion of the participants of a Swedish study with families of an adolescent who attempted suicide,

(Magne-Ingvar & Öjehagen, 1999). Non-specific gains from this process, including helping the parents make sense of the experience and improving their coping skills, may increase the ability of parents to remain connected with their suicidal adolescents and reduce the potential for vicious cycles. New Zealand health services are too understaffed and under-resourced to be able to offer this (Beautrais, 2004), but it can be provided by other, less specialised services.

Parent support groups offer a chance for members to draw on others' experiences, learn, be supported and develop mutual understanding. A few studies have examined support groups for parents of children who have engaged in suicidal behaviour (Byrne et al., 2008; Rose, Cohen, & Kinney, 2011; Slowik, Willson, Loh, & Noronha, 2004). Each of these studies highlighted some positive aspects of being involved in support groups. Slowik et al. (2004) reviewed a support group for parents with children in in-patient care. The parents described the group as being helpful through allowing them to share their stories, making them feel not alone and providing mutual support. In another study, participants said that seeing other parents going through a similar experience was helpful (Byrne et al., 2008). Some preliminary findings indicate that parent support groups may have benefits for the psychological well-being of the parent as well as perceived improvements in their child (Power et al., 2009).

Informal support from family and friends can be important for parents in coping with caring for a suicidal young person. Social support has been found to be an important factor for parents' overall well-being and lowers the risk of parents feeling stigmatised (Corrigan, Watson, & Miller, 2006; Duchovic, Gerkenmeyer, & Wu, 2009; Johnson, 2000). Some parents may not want to engage in formal services for a variety of reasons, such as stigma or a preference for speaking with people they know. In a New Zealand study, some parents described feeling

concerned about engaging with mental health services because of bad connotations of the word ‘mental’ (Mendiola, 2011).

Online support groups offer the potential for parents from far and wide to connect with each other and make more frequent contact than in face-to-face groups. They also offer the opportunity for parents in rural areas or where there is no option for a face-to-face group to receive peer support. Some research indicates that online support groups can be useful for parents of children with disabilities (Ammari, Schoenebeck, & Morris, 2014) and for health-related caregivers (Hamm et al., 2013). Understanding the use of online platforms appears to be a gap in the current knowledge regarding supporting parents of young people who engage in suicidal behaviour.

Parenting Suicidal Young People in New Zealand

New Zealand has one of the highest youth suicide rates in the developed world (Shah, Rakhee, & Cheung, 2019). Suicide prevention has long been a focus of public and health service attention (Ministry of Health, 2019a). New Zealand is perceived as having some of the most extreme censorship laws on suicide reporting in the media (Hollings, 2013). Prominent New Zealand researchers have discouraged use of suicide awareness programmes in schools (Collings & Beautrais, 2005), and it seems there are very few avenues where people are able to speak about suicide. While some researchers recommend strict guidelines controlling the discussion of suicide, other researchers have criticised this approach. Hollings (2013) suggests that censorship means there is not an opportunity to have responsible reporting which can open helpful discussions about suicide. Without public dialogue on suicide people may rely on the beliefs of their peers, which can be stigmatising or unhelpful (Fullagar, Gilchrist, & Sullivan, 2007). The New Zealand reporting laws relaxed slightly in 2016; however, contagion remained a key focus

of the current plan (Ministry of Health, 2019a). Researchers have suggested that it could be important to reconsider suicide reporting guidelines with specific attention paid to ways that media can be used for suicide prevention (Collings et al., 2011).

New Zealand has a small population, about five million, with a low density and many people living in small centres and rural areas. New Zealand's population is of mixed ethnicity. The indigenous population, Māori people, are overrepresented in completed suicide and under-represented in people who access services (Ministry of Health, 2019a). Mental health services are mostly publicly funded. There is also a small private sector. The 20 district health boards which cover different geographical areas of the country all function independently. Availability and types of services vary significantly across district health boards, even within one city. There is a shortage of qualified clinical staff, particularly in the area of adolescent mental health clinicians. Non-governmental organisations (NGOs), schools and welfare services offer limited additions to the services provided by specialist CAMHS in the district health boards. A recent government inquiry into mental health and addiction identified suicide prevention as a major target (New Zealand Government, 2018). Involvement of families of people using mental health services was another priority.

Support available for parents of young people at risk of suicide varies greatly depending on the part of the country they reside in. Some support is provided by regional mental health services and some by NGOs. Mental health services' support of parents could include being consulted about treatment planning, family meetings, being kept up to date on progress and being given information about who to access in a crisis. In most areas, some respite care is available for young people who have made suicide attempts (Beautrais, 2004). Respite care is often requested immediately after a suicide attempt to give the family members an opportunity to

recover from some of the shock, before reassuming responsibility for the young person straight away.

Some mental health services offer parents participation in DBT skills groups, family therapy or, rarely, support groups specifically for parents. Kaupapa Māori mental health services are more family oriented with an awareness that the well-being of the whānau (family) and the well-being of the individual are interconnected (Te Rau Matatini, 2015); thus, they encourage whānau to attend appointments and become pivotal in the recovery of the young person at risk of suicide. Previous New Zealand research has found that because of staffing pressures, mental health services are unlikely to be able to meet the needs of families of suicidal young people, because their focus tends to be on risk management (Beautrais, 2004; Fortune & Clarkson, 2006). Services have increased since these studies were done but they have still not been able to keep pace with the demand. Lack of family involvement and support was also reflected in comments in the He Ara Oranga inquiry into mental health services (New Zealand Government, 2018).

There are also some NGOs that provide assistance to families of young people engaging in suicidal behaviour. Supporting Families is an NGO that was specifically set up to provide information and support to families of people who experience mental health difficulties (Supporting Families, 2020a).

There are also a few online support groups on social media specific to New Zealand. These are private Facebook groups in which members can share their experiences and support each other, but people who are not members cannot read the posts. There are also face-to-face groups in different areas (Supporting Families, 2020b).

Overall, it appears there are some support systems across New Zealand for parents; however, they are limited and not everyone has access to the support. It would be helpful to gain a better sense of the experiences and support needs of those parenting a child with suicidal behaviour in New Zealand to inform the development of appropriate services.

The Current Study

This chapter has outlined how parents play a crucial role in the lives of young people struggling with suicidal behaviour. Research tells us that parenting behaviour can contribute to development of suicidal behaviour (e.g., Donath, et al., 2014; Johnstone et al., 2016; Martin & Waite, 1994), but parents also play an important role in the support and recovery of the youth at risk of suicide (Brent et al., 2013). The emerging literature on parenting in the context of suicide risk tells us that it is a very difficult experience for parents (e.g., Buus et al., 2013; Byrne et al., 2008; Ferrey et al., 2016a).

The current study seeks to explore two key issues. Firstly, we need to understand better what these challenges are for parents in the New Zealand context. And secondly, we need to understand what the support needs are for parents in this situation in order to inform the development of services and resources in this area.

This research aimed to address three key questions: What are the challenges that parents face in caring for a suicidal young person? How do they deal with these challenges? and How do parents experience their engagement with services aimed at supporting their child? This research was intended as a basis to make recommendations to parents for how to cope with the experience of having a suicidal child and to make suggestions for the services intended to support them.

The following chapter describes the qualitative methodology used to address these research questions.

CHAPTER TWO: METHODOLOGY

In order to explore parents' experiences of dealing with a child with suicidal behaviour, I utilised a qualitative, interview-based research design. The aim of this was to elicit parents' own accounts of their experience and engagement with services. This data was analysed to address the key research questions identified in the previous chapter.

In this chapter, I outline the theoretical perspectives used to inform the research and the methods of collecting and analysing the data. This chapter also examines how I ensured the quality of the research and attended to ethical considerations.

Theoretical Framework

Qualitative research. Qualitative research is a term that covers a broad range of methods for conducting research. This research employed qualitative methods for a few reasons. First, qualitative research is better suited to exploratory studies in an area with a dearth of research data (Braun & Clarke, 2013). Second, it can examine the depth and complexities of participants' experiences (Guest, MacQueen, & Namey, 2011). In addition, qualitative approaches allow people's experiences to be considered within a specific context (Braun & Clarke, 2013; Coyle, 2007; Willig, 2013). Given that the aim of this study was to understand parents' experiences of caring for a young person at risk of suicide, a qualitative research methodology was considered most appropriate. Understanding the context of the families is essential to make recommendations that can work for people in their lives. Hjelmeland (2015) argued that much of suicide research currently being produced is repetitive and not easily translated into practice by those who need it most.

Psychology has typically prioritised the voices of professional, academic and medical knowledge (Sayre, 2000). However, understanding service users' perspectives is important in the

development of how the services operate (Tait & Lester, 2005). The suicidal young people are the primary focus of care in this context, but the involvement of parents is important for effective treatment. Thus, parents of suicidal youth are also service users in their role in supporting their children. The benefit of using a qualitative approach with this population is that it gives a voice to those who are not the dominant voices in literature on mental health services.

Critical realism. A common assumption in qualitative research methodology is that there is no clear ‘objective’ truth and that knowledge is influenced by the context (Coyle, 2007). There are many different epistemologies that researchers can adopt within a qualitative methodology. This thesis adopted a critical realist approach to the participants’ descriptions of their experiences. Critical realism affirms that there is a ‘reality’ that we interact with and acknowledges there is social interpretation of that reality (Archer, Bhaskar, Collier, Lawson, & Norrie, 2013; Danermark, Ekstrom, & Jakobsen, 2005). From this viewpoint, it is recognised that the meanings derived from the data have been influenced by participants, the researcher and the current political, historical and cultural contexts. This viewpoint reminds me to remain cautious of making claims to absolute truth. In this thesis, I have remained attentive to the possibility that the experiences described by parents contain both elements of truth and interpretations that could be seen differently by others, such as their own children or the mental health clinicians.

Strength-based approach. This research project adopted a strength-based approach (Maton, Schellenbach, Leadbeater, & Solarz, 2004; Saleeby, 1993), placing parents in a position of competence and as experts in their own experience. Research on family and suicide risk tends to be pathology or deficit focused. Deficit-focused approaches can represent individuals as deficient or as problems that need to be ‘fixed’, and unintentionally place the experts as the ‘solution’ (Maton et al., 2004). In this study, I was actively looking for strengths and ways that

parents coped. Exploring their experiences from a strength-based lens could help make practice more parent friendly and hopefully assist them to recognise their own strengths and skills.

Subjectivity and Reflexivity

Qualitative research is a personal process through which all researchers have their own unique way of seeing the world and their own biases (Morrow, 2007). The researcher influences each part of the process, from selecting the topic, to the collection, interpretation and presentation of the data. Personal, interpersonal, emotional, theoretical and institutional factors all influence researchers (Mauthner & Doucet, 2003). Thus, both before and during the research and reporting process, it is important for the researcher to use critical self-reflection to maintain trustworthiness of the analysis process. In this thesis, this was also done alongside peer review of the analysis to prevent reliance on individual interpretation.

I became interested in this topic through both my personal and my professional experience. In my social world, I have had conversations with people about their non-fatal suicide behaviour and also dealt with the aftermath of fatal suicide. I have also supported clients struggling with suicidal thoughts. Alongside the pain of the person, I recognised the impacts on family, and how it can be difficult for family members to support someone in that level of pain and emotional suffering. I wanted a project that would allow family members to give suggestions of what worked for them because family can be a key support and they can also feel isolated because of the stigma around suicide. I was hoping for findings that could be helpful in terms of general advice for other parents and for clinicians to better support families.

I am not a parent and have not been present in a family that included a teenager at risk of suicide. Thus, my understanding of the parents' experiences is limited to what the participants told me, in the absence of any assumptions that might arise from personal experience. My

limited personal experience enabled me to maintain an open-minded curiosity and to not overidentify with the parents' narratives.

I did approach the research with awareness of the relevant literature about parents supporting suicidal children. I also consulted with a parent who has cared for a suicidal teenager at the research planning stage to obtain feedback on the research plan, semi-structured interview schedule and participant information sheet.

As a trainee psychologist, I noticed a conflict between my role as a clinician and my role as a researcher. Initially, I was concerned that my tendency to prioritise validation and ensure the participants felt heard might interfere with obtaining a breadth of information. However, over time, I came to think that this approach of giving them space to share their story allowed them to talk about what was most important to them, and thus of interest in the research. My position as a trainee clinician may also have influenced how the parents spoke with me, seeing me more in the role of a service provider than as a pure researcher.

Ethical Considerations

This project was approved by the University of Auckland Human Participants and Ethics Committee (Reference Number: 016236).

Parents caring for suicidal young people can be considered a vulnerable population. Parenting a suicidal young person is a stressful time, and it is important that more stress is not added to their load, not only because of the direct effect on their well-being, but also because of a potentially indirect effect on the well-being of their child. While it was anticipated that the interviews could be distressing, previous studies have reported that for most participants, taking part in qualitative research about sensitive topics can be a positive experience and can have a cathartic effect (Biddle et al., 2013; Kavanaugh & Ayres, 1998). This appeared to be the case for

the participants in this study, several of whom shared that it felt like “letting go”, or a therapy session. In a previous study, of the few who experienced lower mood during sensitive interviews, most thought the discomfort would be transient, and that it was outweighed by the desire to contribute to research (Biddle et al., 2013). In anticipation that some participants might find the interviews distressing, there was a plan in place for my supervisor to be available by phone at the time of interviews. A list of support services for the participants was also available (e.g., counselling or mental health services).

Recruitment was planned with careful attention to ethical issues. No participants were directly approached to avoid them feeling pressured to participate. Potential participants were given my contact details and could choose to contact me. To ensure informed consent, participants were offered the chance to ask questions multiple times. Information about the study began at the point of advertising and communicating on websites and with interested groups. At the point when a parent expressed interest, there was an initial phone call or text conversation during which more information was given about the research and an opportunity provided for questions to be answered. Most participants were emailed the information sheet and consent form prior to our meeting. Following this, the participants were asked if they wanted to meet with the researcher to hear more about the research and decide whether they wanted to participate. At the initial interview, the researcher explained the study verbally, giving time for questions, and sought verbal consent. All participants were given a written information sheet (see Appendix B) and consent form (see Appendix C). Potential participants were informed of their rights and that they were free to withdraw from the study at any time. The interview process was done as far as possible at the convenience of the participant, with careful attention to supporting the participants and measures described above to mitigate any risk of harm.

Anonymity and protection of privacy were attended to carefully. Identifying details were removed from the transcripts and a number was assigned to each participant, which was used to identify their transcript. Files containing the transcripts or recordings were password protected. The consent forms were stored securely in a locked filing cabinet. The data will be stored for six years. After this time, the data will be destroyed. The quotes included in the thesis were edited carefully to increase participant anonymity. The edits included removing names, locations or other contextual information that could identify the participants.

Participants

The inclusion criteria for the study were, first, that they had cared for a young person who had engaged in suicidal behaviours (i.e., their child disclosed thoughts of suicide, self-harmed or attempted suicide). Second, the parents had been in a caregiving role with the child for at least two years. Third, that the parents' experience was recent: that they had cared for a suicidal young person within the previous 10 years while living in their home. Finally, potential participants were to be excluded if their child was in a phase of acute risk, as the parent may have found it too distressing to discuss. This project was a retrospective exploration of how parents had coped through the experience. However, as is commonly the case, many of the participants' children continued to engage in lower levels of suicidal risk behaviours.

Participants for this study were recruited through a range of approaches. First, the project was advertised on social media (Facebook) through mental health pages and specific online support groups for parents of suicidal teenagers (a copy of the advertisement is in Appendix A). A paper advertisement was also made available on public noticeboards at libraries and community centres around Auckland. A range of organisations that encounter parents of

teenagers were approached, and they either gave me an opportunity to speak at an event or offered to advertise the project themselves.

There were 13 participants, including 11 mothers and two fathers (one father was a stepparent). Specific details of each parent who participated are not provided; instead, I have included information about the group of participants to avoid identification. Refer to Table 1 for information about the group of participants.

Table 1

Participant Information

Demographic category		Number of parents
Gender	Mother	11
	Father	1
	Stepfather	1
Age range	45–67	All parents
Ethnicity	Pākehā/NZ European	9
	British	1
	Jewish	1
	European/Other	1
	Unreported	1
Parenting relationship	Two-parent family	7
	Blended family	3
	Single-parent family	2
	Separated co-parenting	1
Siblings or stepsiblings living in the home	Yes	10
	No	3
Period of living with concern about suicidal risk	0–1 year	1
	1–3 years	5
	3–5 years	4
	5+ years	3

The age of their child when parents became aware of the suicidal behaviours ranged from 11 to 19 years old. Most of the participants' children had ongoing periods of being at risk of suicide. Around two-thirds of the parents were still concerned about their child's suicide risk at

the time of the interview. This meant that while it was not an acute period of suicide risk, they thought there would likely be more suicidal behaviour in the future. About a third of the participants talked about having their child fully recovered with no or minimal concern about suicide risk at the time of the interview. One participant's child had died by suicide after a period of the parents being concerned about the young person's ongoing suicidal behaviour.

In all families, the suicidality occurred within a context of other difficulties. The difficulties were varied and included being a victim of bullying, eating disorders, an episode of psychosis, anxiety, aggressive behaviour and substance use issues.

Participants were not asked for employment details, but in the course of the interviews, it was revealed that about half of them worked in a range of healthcare or social-support roles, including nurse, counsellor or social worker. This came out as relevant in the analysis in how these parents experienced caring for a young person who was at risk of suicide.

Interview Schedule

Semi-structured interviews involve using a list of questions but with flexibility for interview participants to raise issues that are not specifically asked about or topics the researcher had not anticipated (Braun & Clarke, 2012). Using semi-structured interview schedules has multiple benefits, such as flexibility, and the ability to identify interesting lines of discussion and to allow participants to share their own views (Myers & Newman, 2007). The semi-structured interview schedule for this study was developed based on a review of the literature relevant to this topic and consultation with my supervisor, a parent who had cared for an adolescent at risk of suicide, and an informal university-based qualitative research group. I also reviewed an interview schedule previously used with the New Zealand Māori whānau of a young person who self-harmed (Mendiola, 2011). Interview questions were open-ended (see the full interview

schedule in Appendix D) to encourage discussion and space for participants to share their own stories. The interview style was flexible to give participants the opportunity to raise ideas important to them. This research project placed parents at the centre, where their challenges and strengths were the focus. I aimed to focus as much as possible on the parents' experiences rather than hearing them talk about their child. This was also to protect the child's confidentiality.

I began the interviews by asking the participants about their family and then their overall experience. This open start to the interviews allowed the participants to choose what they felt was most important or appropriate to say first and gave me a chance to gain a sense of their experience. The semi-structured interview included four main areas of questions; however, they were not necessarily followed in order. The first area was questions about participants' experience of, emotions and reactions to their child's suicidal behaviour. The second area was about the relationships in the family, for example, how their relationship with the suicidal child changed, how others in the family were affected, and what they did that felt useful in supporting the family relationships. The third topic involved asking about what helped them cope and come through the experience, for example, what support they sought and what made it easier for them. The fourth area related to participants' experiences of engagement with the services intended to support them. The fourth area evolved as part of the interview process, because in the interviews, parents' experiences with the services supporting their child were such integral parts of their stories. Initially, mental health service interaction was not explicitly a topic on my interview schedule; however, experiences with services were so ingrained in the stories that parents brought it up without specifically being asked about it. All participants brought it up near the beginning of the interview; most within the first few minutes.

Procedure

Prior to the interview all participants were contacted by telephone or email to ensure they met the criteria for participation. I conducted face-to-face interviews with most participants at a location chosen by the them, which included their home or a private office at the University of Auckland campus. Three participants chose to participate via Skype and one over the phone. The interviews lasted between one and three hours.

Before beginning the interview, the purpose of the research was described again, and the participant was given a chance to ask questions. Following that, the consent form (see Appendix A) was explained point by point and signed by the parent.

A few participants contacted me via email following their interview with extra thoughts they had. I added the content of the emails to the end of the participants' transcripts in order to include them in the analysis.

The interviews were done as much as possible at the convenience of the participant in terms of place and time. The option of a support person was offered to all participants but none chose to take this up. They were tape recorded with the parents' specific written consent. Interview recordings were then transcribed verbatim by myself or by a university-approved transcriber who signed a confidentiality agreement.

Safety and risk were carefully considered in this project given the sensitive nature of the topic. I asked about the participants' emotional state before commencing each interview and invited them to let me know if the interview was feeling stressful. I also attended carefully for any signs of distress. Each participant was also contacted following each interview. In anticipation that some participants might find the interviews distressing, a plan was in place for

my supervisor to be available by phone at the time of interviews. A list of support services for the participants was also available (e.g., counselling or mental health services).

Data Analysis

This study utilised a thematic analysis approach. Thematic analysis is a flexible approach that allows for identifying, describing and interpreting themes in data. Some benefits of a thematic analysis approach are providing a rich description of the data and resulting in findings that are accessible to the general public (Braun & Clarke, 2013). The approach I took was informed by the step-by-step description by Braun and Clarke (2006).

Braun and Clarke (2006) emphasised the importance of being guided by the research questions in the analysis. In this sense, I sought out data that would help me answer the questions I had about how participants had experienced their child's suicidal behaviour, how they had tried to cope with this and what supports would have been helpful for them. But while these questions shaped the way I approached the analysis, I was also open to discovering new ideas and directions in the data.

The initial step involved becoming familiar with the data. Familiarity with the data ensured that the analysis was strongly linked to what the participants actually said. I transcribed some of the interviews, which is recognised as a good way to become familiar with the content (Riessman, 1993). For the interviews that I did not transcribe myself, I listened to the audio version and checked the transcript was accurate. During this early stage of the analysis, I re-read transcripts and took notes of ideas as they arose.

The next step involved developing initial codes. Codes are the smallest element of data that can be meaningfully understood in relation to the topic of study (Braun & Clarke, 2006). While re-reading the transcripts, I had already noted some initial ideas of codes. I used a

combination of manual coding with printed transcripts and coding using software. I used NVivo software to assist in keeping track of the codes I identified. I paid careful attention to take note of accounts that deviated from the dominant narratives and ensure they were not overlooked.

The next step involved identifying possible themes and then reviewing them. While developing the initial codes, I also took note of potential themes. In forming the themes, I tried different combinations of codes. For the codes that did not seem to belong in a group with others, I used a temporary category in NVivo titled “miscellaneous”. This ensured that I could consider the current themes and notice what data could potentially be unrepresented in the findings. Through the process of refining the themes, I chose to merge some and discard others. These decisions were based on the relevance to the research objectives and how inclusive the themes were of the data. I discussed the data in each theme with my supervisor to ensure there was a good fit. Once I had established the themes and subthemes, they were further refined and given names.

The final step that Braun and Clarke (2006) outlined is “producing the report”. This involves reporting the data. The prevalence of each theme and subtheme is reported generally with terms such as “few”, “some” and “many” used to describe the data. The exact prevalence could be interesting to readers; however, it does not necessarily signify the importance of a theme (Braun & Clarke, 2006). Reporting the number of participants throughout could suggest how much confidence to have in particular findings, which was not deemed appropriate, given the small sample size and the qualitative approach used in the research. The final analysis of the data is outlined in the next chapter.

Trustworthiness in Qualitative Analysis

Qualitative research explores subjective experiences and does not claim to be absolute truth, as has already been outlined, and thus qualitative research uses different measures of quality than those used in positivist research projects. Researchers have suggested that the measures of the quality of qualitative research are trustworthiness, dependability and transferability (Guba & Lincoln, 1994; Shenton, 2004).

In terms of the trustworthiness of this research, each step of the research process has been documented in detail. Sandelowski (1993) suggested that qualitative researchers need to provide a transparent account of their research approach to help readers decide how trustworthy it is and, ultimately, judge the quality of the research. The documentation of the process from research design, method, analysis to conclusion means that it is transparent and able to be scrutinised. The detailed record of the research process means that other researchers can repeat the work even if they are not aiming to obtain the same findings (Shenton, 2004).

Dependability of this research was improved through a review process with my supervisor. We would review data, discuss transcripts and consider whether the findings were consistent with the data. Reflexivity, which was discussed previously, is also considered an important part of maintaining the rigour of qualitative research. I have reflected on my role and thought processes during the research and engaged in critical conversations with my supervisor to further support reflexivity.

Transferability refers to the concept that findings have relevance beyond the original sample (Shenton, 2004). The broader relevance of the findings is explored in the discussion chapter of the thesis.

Summary

This chapter outlined the approach I took in the methodology of this research. I conducted semi-structured interviews with 13 parents of young people who engaged in suicidal behaviours. I then used a thematic analysis approach. The findings from the analysis are outlined in the following chapter.

CHAPTER THREE: FINDINGS

In this chapter, I outline the themes from the interviews with the parents. I have split the analysis into two topics. The first topic captures key parts of the parents' experiences and how they coped while trying to support a young person at risk of suicide. The second topic concerns parents' support needs and experiences with the services who supported their child. Splitting the analysis into two topics served the purpose of having a specific section that outlines implications for clinicians working with suicidal people and their families, who are likely to be the main audience of this thesis. The topics and related themes are shown in Table 2.

Table 2

Themes in the Analysis

Analysis topic	Theme
Parents' experience of caring for a suicidal child	Feeling overwhelmed Feeling powerless and responsible No time for myself Increasing surveillance Walking on tiptoes It's difficult to talk about Other parents have gone through this Growing and learning
Parents' support needs and experiences with services	It is hard to get support from services You have to fight to get help We feel on the outside We can make a helpful contribution Recognising it is hard for us too

Topic 1: Parents' Experience of Caring for a Suicidal Child

The first section of the analysis summarises what parents said about the impacts of caring for a suicidal child and how they coped with the experience. Eight themes were identified and are outlined below.

Feeling Overwhelmed

All parents experienced uncomfortable emotions while supporting their child at risk of suicide. These emotions included shock, confusion, worry and grief. For most parents, these feelings were intense and painful. They described being “devastated”, “absolutely overwhelmed” and having “heartache”. Some parents struggled to articulate the complexity and extremity of their experience. One parent commented that “horrifying is a little simple” (Participant 1), and another said it was “the worst experience of my life” and like a “horror show” (Participant 6). One of the parents said there were times when she was getting by “hour to hour”, being at the “end of [her] limit” (Participant 2).

All parents experienced worry, concern or fear about their child's suicidal behaviour. Parents feared that the suicidal behaviour could be repeated or increase in severity. Many parents reported a state of hypervigilance, being very attentive to their child and more emotionally reactive than usual. Several parents talked about the stress easing off as their child appeared to improve, and then alarm and increased anxiety when there was an indication their child was becoming unwell again and risk of suicidal behaviours had returned. For example, one parent said, “You relax a little bit because things are OK, crashes, you feel twice as bad” (Participant 1).

Many parents talked about the loss and grief they experienced. Some felt loss because of the changes in their child from how they had previously been, or the loss of expectations they previously had for their child. One parent reflected on her learning about “invalidated grieving”,

which is a concept that captures what many other parents spoke about regarding their experiences. She spoke of how the loss experienced from having a child changed by mental health difficulties can feel like it is not a valid loss. It is a loss that others may not understand, and it is not a tangible, visible loss. She shared how this was a useful and powerful way to reflect on her experience. She said:

Invalidated grieving, where essentially what you've lost by your child having this mental health disorder but being such an unrecognised thing and that was really powerfully spoke about how it was because particularly friends who have got children of Olivia*'s age. If I go and spend time with them, they can talk about what their kids are doing. They're doing the stuff that [my daughter] should have been doing. What can I talk about. It's really difficult and so there's an element of pain in talking to them just because of what you've lost as well. (Participant 1)

Several parents talked about anticipatory grieving, in which they performed mental preparation for the potential loss of their child's life. For a few, this involved imagining their child's funeral:

I remember lying in Bali when we were on our way back, lying by the pool and just imagining what his funeral would be like. Yeah, because I didn't know whether we'd come back to him being alive. (Participant 13)

I didn't ask her because I thought that would let her think that I gave her permission to do it. But it was important to me to be able to if I had to, to know what to do, what was right for her, the last things that I could do for her. So, something would come up, like we might walk past a florist and I would say to her, "Oh, you know, I want lots of flowers at my funeral. What would you like?" And just really discreet stuff. And over the period of a

number of weeks I managed to put her funeral together. And I felt really close to her and quite bonded by that. (Participant 2)

Several parents described how the ongoing emotional impact of dealing with the situation had left them feeling as though they were “falling apart” or “broken”. A few parents talked about having ongoing trauma responses, such as re-experiencing visions of their child attempting suicide or having memories of these events “buried” away.

The emotional response left parents feeling exhausted. Parents used words such as “wrung out”, “tired” and “emotionally exhausted” to describe how they were affected by struggling with a suicidal child. One parent said she nearly fell asleep while driving, and another talked about “giving up” and doing nothing because of lack of energy.

In summary, all parents described intense impacts of caring for a young person who engaged in suicidal behaviour. Anxiety and grief were common among the participating parents.

Feeling Powerless and Responsible

This theme explores how parents felt powerless to help their child, and responsible and guilty for contributing to their child’s difficulties. Many parents talked about feeling powerless. It was sometimes linked with feeling unable to protect their child from suffering, from suicide risk or from outside influences such as bullying and peer contagion. Parents also spoke of feeling powerless when they felt their child did not want to receive their help and support. A few parents talked about feeling “shut out” by their child. Some parents talked about feeling particularly frustrated when they had previously been able to connect with their child effectively:

If I tried to talk, he’d just like, “I don’t want to talk, Mum. I don’t want to talk.” Or you know, if I’d push it he’d get angry. “I just, I told you, you know?” It’d just be, you know, yeah, it was really, just near to impossible to make contact with him. (Participant 13)

A few parents spoke of desperately wanting to help their child but not being able to “force” their child to engage with supports such as counselling. Many parents talked of having a sense that no matter what they tried they were not able to help. For example, one parent said, “Everything that I had done didn’t work” (Participant 11). This often led to parents feeling ineffective and sometimes desperate. These feelings often went hand in hand with a sense of frustration—towards the situation, themselves and their child. A few parents expressed an urge to want to be physically violent with their child when they felt like nothing else worked. For example:

There was times I was powerless, all I wanted to do was give her a good slap across the face or a shake to wake her up, but you, you couldn’t do that. Because that would’ve just pushed it even further away. The idea was that, to bring her closer. (Participant 8)

Several parents, in acknowledging their own powerlessness, found that letting go of responsibility was a helpful strategy for reducing anxiety and other difficult emotions. This was most common when parents believed they could not do anything more and recognised that the young person was the one in control of their behaviour. For example, one parent talked about feeling a sense of relief when her child reminded her of the limits to a parent’s influence, which led to her feeling less responsible and anxious about the future. She reported, “One day he said to me, ‘Mum, no matter what you do you can’t watch me 24/7’, and I just decided that day that I wasn’t going to continue to worry actively about him.” She said that, instead, she would try to “trust in the process” (Participant 4). A few parents talked about a sense of relief when their child went to hospital and care was then “out of [their] hands”.

Almost all parents talked about guilt and self-blame for their children’s difficulties and questioned their parenting. Some participants talked of feeling like they “failed” or that seeing their child’s distress led to “knocked confidence” in their role as a parent. They blamed

themselves in terms of their role in their child's upbringing, not being a good enough parent, parental separation causing problems or not doing the "right" things. A few parents indicated self-compassion in that they did the best they could with what they knew at the time. For example, one parent said, "I felt I was the worst parent ever. I was really down on myself" (Participant 12). They said that they thought differently when things were going well, but noticed feelings of guilt and doubt when they were under pressure. They said, "[You] question your own ability to parent and, yeah, worry about what other people think and all of those things come much quicker when you are so tired and stressed."

Self-blame increased when parents perceived messages of blame from others, such as their child, other parents or professionals. Many parents talked about blaming themselves for missing signs of their child struggling and wondered about what they could have done "wrong" in the past. One parent talked about how she learned about "invalidating environments" through DBT, which led her to feel guilty about her parenting during her child's upbringing. She said, "Inadvertently, we hadn't provided an environment that was ideal for the kind of personality that she had. I mean there's a huge amount of sort of guilt around that and grief" (Participant 1).

About half of the participants worked in caring professions. Many of these parents talked about how this added to their feelings of guilt and self-blame because of the expectation that they "should have known better". For some, there was an additional sense of failure when they were helping others but struggling in their own families. One mother talked about how she was supposed to be supporting families and "here I am yelling and physically assaulting my child" (Participant 11). Another talked about the pressure he felt, and how different it was when he was confronted with difficulties in his personal life compared with in his professional role. He said:

Working in the sector, you almost feel like you should know better, you should know everything. But I didn't know everything and it's totally different because when it's your child all that sort of professional judgement and skills, you know, almost goes out the window. (Participant 9)

This theme highlights how parents felt both responsible for contributing to their child's suicidal behaviour and powerless to be able to change it. The powerlessness to prevent suffering or support their child could lead to frustration and anger for some parents. Letting go of their feelings of responsibility helped parents manage their distress. While all parents felt guilt and self-blame, those who worked in the caring professions described a sense of extra guilt that they should have known better.

No Time for Myself

In efforts to protect and support their child, parents put their child first and did not attend to their own emotional needs. Despite their own intense reactions, most parents talked about holding back their own emotions or neglecting self-care in order to put their child's needs first. Some parents talked about a sense of "delayed shock", helping their child in the moment, doing what needs to be done, then later on being able to experience their emotions. Other parents talked about hiding their tears and worries in order to not let the child know. For example, one parent said she found "crying makes [her] heart feel cleansed" but she would not let her child see it (Participant 2). She said, "Gosh, she's got enough to worry about; she doesn't have to worry that she is stressing me out as well" (Participant 2). This parent would drive around the corner and cry in her car to ensure her daughter did not see her upset. However, as with other parents, she got to a point at which she could not hide her emotions; she "couldn't hide those tears". A few

parents spoke about how they did everything to try to protect their child and worried that expressing emotions could increase their child's suicide risk.

Putting the child's needs first meant parents often did not look after their own well-being until they felt their child was safe. For example, one parent said, "I think when you are going through it, you keep your own child alive more than you keep yourself well" (Participant 12). For some parents, putting their child's needs first meant not attending to their own self-care, such as spending time on hobbies, sleep or family holidays, and not attending their own therapy. One parent talked about how she had given up much of her own self-care needs to focus on her child and how trying to shift their relationship back to how it previously was with a more balanced dynamic became incredibly difficult.

Another mother struggled with the tension between constantly putting her child's needs first and not wanting to be walked over. She compared her experience of caring for her child to an abusive relationship. She felt pressure to be loving and caring towards the teenager, who she said was "attacking" her emotionally and physically. She said, "I left her dad, or I deliberately said no to that behaviour and it was abusive, and now I've got this behaviour in my family and I can't leave." She elaborated:

When you get strong enough to say, "No, leave your partner", then to have this here and people saying "love this" and "understand it" and "have empathy with it" and "go with it" and "give and give". And it's like, shit, I don't want to be a doormat anymore.

(Participant 11)

Some parents said they would advise other parents that it is important to care for their own needs and not just focus on the child. For example, "You've got to look after yourself and most parents don't realise that until they are on a wire. You can't do it yourself" (Participant 2).

A few parents described how they would try to take a break or do something nice for themselves but were unable to relax or escape thoughts of their child. A parent said their “whole holiday was taken up just thinking about him and contacting him” (Participant 13). Similarly, another parent talked about trying to take some time out to enjoy a dinner with her partner but being unable to relax. She said:

We went out and I couldn’t relax because I was too stressed about what was happening and then the phone went and [my daughter] had called me, she was beside herself. She was feeling like she was going to do it again. So we had to just go. So sometimes trying to make time for ourselves was just too hard (Participant 12)

Several participants described how their child took on the task of trying to help them manage their well-being by hiding their suicidal behaviour. They saw the young person hiding their difficulties as a way of being supportive and protecting the parents’ emotions. For example, one mother said, “I only realised in later years how much [my child] hid from me because she didn’t want to upset me” (Participant 10). They talked about how their child would sense their distress and conceal their own emotions or suicidality out of fear of causing any more distress to their parent. Parents generally saw this as a caring or protective response from their child, such as one parent who said that she had a sense her child was being “protective of the way I felt” (Participant 3). Another parent shared that they were able to discuss this together in a useful way: “We are able to talk about it and reflect on it. Part of her fear was that she was going to hurt me. So her talking about her issues she felt was going to impact on me” (Participant 12).

Parents in this study tended to be so focused on supporting their child that they neglected their own well-being, stopped self-care activities and were unable to relax when they tried to do something nice. Despite the intention to focus on the child’s well-being, it appeared that the

young people could sense their parents' distress, and this led to more secrecy and hiding the risk in an attempt to reduce the parents' distress.

Increasing Surveillance

One of the key strategies that parents talked about in this study was increasing surveillance of their child. The increased surveillance was an attempt to reduce the risk of further suicidal behaviour. Some parents described breaking privacy boundaries out of fear for their child's safety. They also described conflict between increased surveillance and supporting the young person's autonomy.

All parents in this study went to considerable lengths to keep their child safe. Some parents would not leave their child on their own, a number of them sometimes slept in their child's room, and many engaged in lengthy conversations with their child about emotional distress. One mother did not sleep for multiple nights in a row, until she accessed a respite worker who could watch her child overnight.

Many parents talked about stepping over previous boundaries with respect to their child's privacy in order to mitigate risk. They did things such as checking phone messages, looking at their child's social media and searching their room. One parent said, "You know the received wisdom is you shouldn't invade privacy but actually as a parent you would just do anything, to be honest" (Participant 1). Similarly, another talked about reading her child's text messages and trying to find information about her child: "You do become quite sneaky because, and that goes against all your grain" (Participant 7).

Many parents made efforts to prevent access to means of inflicting self-harm, such as locking away knives and medication. However, they saw this strategy as being of limited value so felt the need to also maintain proximity in order to be more effective in keeping their child

safe. The word “creative” was used by a few parents to describe how their child could find many ways to harm themselves, even if they had hidden dangerous objects. Participants said their children had used hair clips to self-harm and put forks in power sockets, and they recognised their children could go down the road and buy a \$2 craft knife. They felt they were ultimately unable to prevent access to dangerous items. There was also talk of being helpless in the face of outside influences such as peer contagion, bullying and social media. This fear added to their strong desire to maintain surveillance.

While maintaining surveillance was constant for most parents, many parents also talked about their struggle to find a balance between maintaining safety through surveillance and promoting their child’s independence. A few parents talked about giving their child space and emphasised that their autonomy was a helpful approach. This was often an approach tried after a period of more surveillance. They spoke about creating distance in a way in which they were still present and loving but reinforcing their child’s ability to be independent. They shared that their initial instincts were to give up everything for their child out of fear and wanting to keep them safe, but questioned whether acting on these instincts would be helpful; that is, it could leave their child dependent or entitled:

It’s so easy as a parent to get sucked in because and they suddenly get this sense of entitlement because you’ve just given up everything because it’s so traumatic and to then get back up and come back to where you once were is really difficult because you’re so frightened and they’ve kind of got you over a barrel as well. You know I’ve got the attention and I’ve got the support and I think it’s important to put all that away a bit.

(Participant 5)

This parent found that having her child away in an in-patient unit allowed her to reflect, and she saw the need to pull back and do some of her old hobbies. She said, “Having him off my hands, it gave me a chance to look around and think this is really bending over backwards for him.” She went on to say, “I just thought I wasn’t really helping him; if I was to help him I needed to push him away a bit and do running, things for me.”

Another parent felt it was necessary for her now adult son to move out of home to promote his independence and a life worth living. She wanted to stop a cycle of him being dependent on her, which lowered his own sense of confidence and agency, and allowed him to withdraw from the world. This parent found enforcing their child to move out was a successful approach, despite being a difficult decision to make. She talked about her stress during that time:

I was fearful, I really was. I knew I’m pushing. If something happened, if he went off, if he did something to himself, I knew that the push was part of what pre-empted it. I had to feel really clear about the necessity of it and I did. So I had a good talk to myself. In fact, every day throughout that whole process I had that talk with myself. I feel I’ve done everything I can today. If [my child] kills himself, it’s not because I didn’t do what I needed to do. I really did. I did that daily so that if something happened to him I feel I’ve done everything I could and I believed, I really did. It was on the forefront of my mind, so that I would not be blaming myself or anybody else. (Participant 6)

This theme outlined how parents tended to increase the surveillance of their child in an attempt to reduce the risk of further suicidal behaviour. The increased surveillance involved giving their child less privacy, such as by sleeping in the young person’s room or checking their phone messages. They talked of how their sense of powerlessness to outside influences could increase the desire to want to maintain surveillance. Despite their own desire to maintain surveillance,

some parents chose to support their child's autonomy and found that it was a successful approach.

Walking on Tiptoes

All parents talked about changes in their family: it "turns your family upside down"; things were "falling apart at the seams". This theme outlines how parents spoke about attempting to reduce conflict by walking on "tiptoes", changing boundaries and generally being careful not to upset the young person. Parents talked about how living with suicidality led them to lose touch with the parenting they had previously been confident in. Some described how the stress led them to act in ways that were not in line with their values as parents.

Parents described attempting to prevent their child from becoming upset or increasing the risk of suicide by changing their parenting approach. This often involved subjugating their own needs for their child's needs. Parents described "walking on eggshells" or learning to "walk around on tiptoes all the time" out of fear they might cause a negative reaction in their child. Some described how their fear of suicide enabled their child to have more power in the family relationships and contributed towards loose boundaries. A few parents talked about struggling to maintain expectations of their child to perform chores:

She just couldn't do them. You might ask her to do something. She might just either not do it or just start it and not be able to finish or do such a terrible job. Or she would just be so miserable or down or you just couldn't ask her to do it. (Participant 1)

Holding boundaries became difficult because there was so much fear that the parent's behaviour could increase their child's suicide risk or interfere with their child's recovery. One mother described trying to decipher whether she should be supporting her child socialising with peers in

the evening as part of their treatment plan, or whether this could be her child pushing boundaries when they wanted to stay out late.

The change of focus on attempting to support the young person at risk of suicide led to less focus on their other roles or relationships. Almost all parents with more than one child in the house reported focusing more attention on the child who was struggling with suicidal thoughts. For example, one participant said, “Because my daughter was suicidal, my complete focus was on her, and so it had a huge impact on the boys and their behaviour” (Participant 12). Other siblings “flew under the radar” or “got away with murder”. Many parents described how their changed parenting focus affected their couple relationships. Parents also described spending less time and energy on their paid work because of the parenting demands. Some parents described work as a source of support and a “respite” from their parenting role.

Some parents sought advice on how to respond to their child’s self-harm. One parent found advice that she should not be reactive. When talking about this advice, she said, “That’s really easy to write it down, really hard to put in practice” (Participant 7). In contrast to the advice to “not react”, she said she became a “blubbering mess”. Other parents also spoke of their emotions overpowering their previous rational approach. For example: “For me, my protective instincts were far stronger than my rational reasoning” (Participant 12).

For several parents, having suicide risk in their home led them to behave in ways they were ashamed of: “I did things as a parent that I never thought I would do” (Participant 11). Parents talked of the intensity of the situation hindering them from behaving like the type of parent they wanted to be. Behaviours included not being as responsive as they would like and showing more emotion than they would like, and a few even physically hurt their child. A few parents talked about not knowing how to respond when their child asked for help and later

regretting their responses. For example, one said, “I didn’t know what to do. I didn’t do anything and I do look back now and think that was terrible.” She also talked about regretting how she responded to her daughter when she was feeling helpless:

I dealt with things really badly. Looking back now I would cry, shout, demand. Just in those early days of discovering her cutting, I just remember being so frustrated and crying and just yelling, “Stop it. Just don’t do it anymore.” (Participant 10)

Parents in this study described how parenting changed significantly during the period of caring for a young person at risk of suicide. They became less confident in their previous parenting, such as holding boundaries, and had less focus on the other relationships in their lives. They also described the intensity of their emotions leading them to not respond in ways they wanted to, some parents even using violence or other actions they regretted.

It’s Difficult to Talk About

Most parents commented on some helpful interactions with their informal support networks of family and friends. These interactions included having friends as part of a “support crew” to look out for their child at risk, or having someone to talk to, and people who could “empathise” and understand. While many described social supports as important, almost all parents had difficulties talking to their friends and family about caring for a suicidal child. This theme outlines some of the barriers to talking about their experiences. A few parents did not share at all, while others shared their experiences but found it difficult or unhelpful. They had concerns about their child’s privacy, being a burden on friends and feeling that others did not understand. Seeking help from formal services or professionals was one way parents were able to talk about their experience with fewer barriers.

One barrier to seeking support from friends or family was not wanting to break their child's privacy. This was an ethical stance a few parents took that placed their child's right to privacy above their right to access supports in a challenging situation. Some did not reach out because they felt protective of their child and did not want to share things that would make their child feel uncomfortable. For example: "He was ashamed of where he was, he was ashamed at how he'd lost everything ... so I didn't really want to talk too much to other people about it" (Participant 13). Another parent said:

It's not something you talk about with your friends either because you don't want to break her confidence. She's been through a hard time and it would be like airing her dirty laundry as well as my own, do you know what I mean? So you become very isolated from talking. I guess friends and family would be my natural supports normally, but with this it was very difficult because it didn't just involve me; it involved her and it was a really big issue. (Participant 12)

Another barrier to talking to others was how painful the topic is to talk about. For a few parents, this meant they chose not to tell anyone about their child's risk of suicide. One mother shared, "It must have been about three years that I never told anybody about [my child's] cutting, my closest friends, not my mum, not anybody" (Participant 10).

Parents shared a concern that they would "burden people with it" (Participant 5) or that they might be socially excluded by people who did not want to be around the heavy topic of suicide. For example, one parent said that she would not talk to her friends or colleagues much because she was "protecting [herself] from rejection". She said, "Knowing that if I talk about it too much people wouldn't want to be with you, work with me, because it's heavy" (Participant

6). This parent, along with a few others, found it painful that people in their community seemed to not want to talk about it:

Close friends that knew what was going on that never would ask. They would absolutely go out of their way never to ask. They would not want to talk about it. I understand it but still it has changed things for me. Like maybe they will now, because they know he is right through it. Now they will be, oh, you know, but I know it's because they maybe couldn't handle it. That I found really difficult. (Participant 6)

She said that despite understanding it, she thought there was a sense of rejection going on for her. She said, "I found it really difficult to be with some people when I knew they didn't want to engage with that; I felt probably a real sense of rejection from that."

Some parents talked about family members or friends blaming the child or not taking the behaviour seriously, which they found unhelpful. Many parents found that their friends wanted to help, or were good willed, but their lack of experience made their contributions limited or hurtful. For example, one mother said:

A lot of friends didn't know what to say, didn't know what to do, and some friends were, "Oh, this is just a stage that [my child] is going through." Yeah, maybe a stage but for me it's my life at the moment and I need to live it and get through it. I can't be dealing with people that are not really wanting to know. (Participant 10)

Several participants felt that friends were not able to perceive how difficult their experience was. Some parents wanted a listening ear, and it appeared they found their friends often wanted to help or offer suggestions. Friends could unintentionally minimise the experience, for example, by acting like it is a normal experience:

I've got my own friends from my life but our experiences are so outside anything they can understand, although they're really good willed, et cetera, there's just no way that they understand and then they try and be really helpful. They're lovely. They try and be really helpful by telling me just how normal it is this stuff. (Participant 1)

For several participants, talking about their experience with friends who had non-suicidal children brought up sadness and loss. It could be that their child was not where the parent hoped they would be and seeing friends with easier lives, or 'normal' children, brought about painful comparisons. For example, one mother shared how her friends "really try and be helpful by normalising it based on their kids" and for her it led to "an element of pain in talking to them just because of what you've lost as well" (Participant 1).

One way that parents managed to overcome some of these barriers and still be able to talk about their experiences was to seek formal support. Most parents recognised the value of having their own formal social support, such as talk therapy, Supporting Families' clinicians or church elders. Parents used many positive words to describe these supporters, including "really helpful", "invaluable" and "wonderful". They appreciated that it was that person's role to listen, empathise and help. The clarity of a formal role allowed parents not to feel the same concern about being a burden. For example, one parent said counsellors were useful because "everyone's got their own lives and everybody has got their own family issues" (Participant 11). They also spoke of appreciating the chance to speak with someone outside the family confidentially. People in these formal social-support positions were able to offer non-judgemental encouragement, and the focus was on supporting the parent rather than the child.

Several parents talked about not seeking help for themselves, but when it was offered by others they were able to take up that support. Often it was professionals supporting their child

who suggested or referred them for their own support. For a few parents, it took time to reach a point of recognising that this was something that could be beneficial. Initially, they had not wanted support for themselves because they had been focused on their child. Often these parents appreciated professional help when they did take the step:

I just thought, What's all this about? I don't need support. I don't need this. But I filled it out and sent it off and then [a Supporting Families clinician] rang me and I am so grateful I fell into their hands. [The Supporting Families clinician] has just been wonderful.

(Participant 10)

A few parents acknowledged they wanted someone to talk to but initially did not think they needed the “emotional” support. At first, these parents thought they just wanted someone to offer them advice or to vent to but ended up valuing processing emotions about the distress associated with caring for a suicidal child:

I suppose it became clear to me that I actually needed somebody to kind of talk to. I actually saw myself just going really to get that kind of support for what I needed to do, et cetera, but actually when I got there it really has turned into, it really became clear that actually it was about processing all this emotion that I haven't kind of really dealt with. It does bank up and, yeah, you can only manage it for a certain length of time probably.

(Participant 1)

This theme outlined how parents in this study found it challenging to seek support from family and friends. They felt concerned that they could become a burden or valued their child's privacy over their own support needs. Parents also had experiences of friends not understanding and making unhelpful comments despite having well-meaning intentions. Formal social support played a role in allowing them to talk about their experiences with fewer barriers.

Other Parents Have Gone Through This

Connecting with other parents who had been through similar experiences was described as helpful by almost all parents in the study. They connected with people in organised face-to-face groups and informal social relationships, and also over social media. Knowing that others had the same struggles, reactions and emotions was helpful in normalising their experiences and reducing self-blame. Parents talked of these connections helping them to not feel “alone”, “completely abnormal” or like a “failure”. One parent talked about his experience of realising that other families have similar responses, and it helped ease some of the self-blame. He said:

It takes a bit of weight off your shoulders because you stop thinking it’s just something I’ve done or it’s something we’ve done or not done, and you realise families in similar situations as you have gone through those same feelings. So I think that’s very helpful.

And I found that helpful personally. (Participant 9)

Many parents in this study said they felt that there was a better connection when people had experienced a similar sense of suffering. Parents said these people were better able to “understand”, “connect” and “get it”. They spoke about how powerful a shared sense of suffering could be:

You were able to cry together and know that the other person’s hurt, what they were crying about and what you were crying about was the same thing. There was some strength in that. (Participant 12)

Several parents said that they appreciated the chance to vent about their experiences with others who had been through similar struggles. Parents said it could be particularly helpful because “sometimes you just need to vent” and it is not always easy to find an appropriate place to do so (Participant 10). Because suicide was not something that they felt comfortable sharing widely,

they found being with others who had been in similar situations, either face to face or over the internet, gave them a chance to share and let go of some difficult emotions. Another parent said, “It’s a way of offloading and channelling some of that really heavy emotional stuff that you carry” (Participant 12).

A few participants also said that these contacts enabled them to discover that other parents had experienced “worse” situations. Knowing that their own situation was not as bad as it could have been helped to give them perspective or a sense of thankfulness. For example, one parent said she spent some time reading online about others’ experiences and reflected, “It wasn’t, like, bad compared to some, what some people have gone through, but it’s still something that you don’t wanna go through” (Participant 7).

Many of the participants talked about receiving tips or advice from other parents who had cared for a suicidal child. One said, “That was really useful speaking to other parents and getting what worked for them, what didn’t work for them” (Participant 9). Some of the areas they received advice about included how to engage with services, managing children at home and learning about differences in suicidality. Participants talked about valuing advice about what lengths to go to in order to keep their child safe. They spoke of this being more useful from other parents than from professionals, who they said might not even have children themselves. A few parents acknowledged that each child is different and not all advice is suitable for all situations. They would have to identify which tips were relevant to their family. For example: “You could get yourself a whole wound up because you look at what other people are talking about and actually that circumstance is quite different, didn’t work in the same way” (Participant 1).

Many parents also found that supporting others and being able to offer suggestions was a way to help themselves as well as the other person. These parents shared that they felt like they

were contributing to others in a difficult time. These contributions included helping people not to feel alone, offering encouragement, sharing tips and building hope. One said she wanted to “help other parents so they don’t have to go through it alone like I felt I had to” (Participant 2). This sense of being able to be helpful for others could be particularly useful when many parents felt a sense of powerlessness. It is a place where parents can feel a sense of agency. The support was something they could offer while their own family was in the midst of the struggle, or when their child had improved, as a way to offer hope. For example, one parent spoke about how she contributed to others through sharing her child’s recovery successes:

It was kind of giving other parents who were right in the midst of it, that, yes, one day there will be, there is light at that, the end of that tunnel. It might take one month, it might take one year, it might take, but stick at it. (Participant 7)

One of the key methods parents used to find others who had similar experiences was by looking on the internet for groups on social media. Parents called their social media groups a “safe haven” and a “saviour” for them. For many parents, it was hard to find people to talk to about it, because in many social circles it is not something that is talked about. As mentioned earlier, there can be many barriers in trying to talk to family and friends. One parent expressed appreciation for being able to find other parents on the internet and wished it was something that had been available earlier:

For such a long time all I ever wanted to do was talk to another parent that had a kid that cut themselves, all I ever wanted to do. But how do you do that? Because it’s not the thing that you just bring up in everyday conversation. How do you find these other people, because it’s such a hidden thing back then? (Participant 3)

Parents shared many benefits of being able to access online support. One of the positive factors was that online groups were accessible from their own home. This was particularly important for parents who were so concerned about their child that they would not leave the house. Online forums offered a sense of privacy to talk to others in a similar situation while not having to see these people in their face-to-face lives. It also allowed parents to receive instant feedback, and after posting, they could receive an empathetic comment “straight away”. One mother said she found it therapeutic to write about her experiences online. Many spoke of creating connections, receiving support and also being able to offer support to others as a meaningful experience for them. It was described as having a sense of community:

So internet at night, it was a saviour for me to be able to speak to other parents that was going through it or had been through it, share ideas, share experiences, and it made it, you went from thinking, gosh, you’re about the only person in the world that is going through this, to realising there is actually a community of you, yeah, and to feel what you’re feeling is not that wrong. (Participant 2)

The flexibility of online groups was particularly beneficial for parents who were unable to attend face-to-face groups. Some areas did not offer local groups for parents. However, while most parents involved in the online social media groups found these helpful, one mother found it was not. She said that she was not in a place where it was helpful to see emotionally distressing content appear when she was on social media:

You were then not really in control of what you saw, what was it you were exposed to. And so I came out of that because people were posting stuff that was very emotionally triggering and actually I thought I’m not in a place, this isn’t doing me any good. (Participant 12)

Another difficulty of online connection was reported by a mother, who said she found it confronting when a woman who lived nearby began bringing up things she had shared on the group in a real-life work context. She expressed her concerns to the group organiser, who had the other woman removed from the group. These risks of online social support were the exception, and almost all of those who accessed these groups reported finding them very useful.

This theme outlined how parents found that connecting with others who had been through similar experiences made a significant positive impact on their coping. Whether it was organised groups or friendships, online or face to face, the connections were described as helpful in making people feel less alone and reducing their self-blame. They appreciated the chance to vent and share tips with others. Online social media groups were described as useful in connecting people with similar experiences. While there were many positive aspects of the online groups, some risks were also identified.

Growing and Learning

This theme concerns parents' talk about how they grew, gained knowledge and contributed to others. These positives did not outweigh the pain and difficulty of caring for a suicidal child, but from a difficult place, many parents were able to use their experience as an opportunity to reflect and grow. Parents developed new knowledge about suicidality, themselves and their child's strengths. They also found meaning through contributing to others by helping families, improving services, advancing their own professional work and reducing stigma in their communities.

Most parents described gaining knowledge while supporting their suicidal child. They talked about knowledge in a few areas, including knowledge about suicidal behaviour, knowledge of their child and knowledge of themselves.

Most parents were active in seeking information through the internet or books to assist with making sense of their child's suicidal behaviour. Some parents also gained knowledge from mental health clinicians. Parents talked about a drive to keep gaining information in order to assist with their child and themselves. One mother said, "I just research things or just read as much as I can and to try and get an understanding of what's really going on" (Participant 13). Another said that she has learned much over the years and still followed psychology pages online and continued to use resources to build on her knowledge. She said, "I feel like I am fairly saturated with my knowledge now but I am still learning" (Participant 10).

Many parents described an initial phase of being naive or knowing nothing about self-harm or suicide. They used words such as "confusing", "naive", having "no clue", and it initially being a "mystifying time". Some parents had little exposure to self-harm or suicidal behaviour: "I'd never heard of cutting" (Participant 5). Other parents had professional or academic experience in mental health contexts but found it a different experience in their own home than it was in their professional roles.

While caring for a young person at risk of suicide was still intense, having more understanding helped some parents feel more grounded and able to put the behaviour into context: "I know a lot more now than I did at that stage" (Participant 1). This process of learning helped some parents feel more confident in talking about suicidal behaviour and helped them challenge judgemental ideas:

I tell people now, now that I am a little bit more knowledgeable about these things, I say to them, if somebody is seeking attention there is a reason why. It shouldn't be thought of as a negative connotation, I don't think. It should be that you need to dig deeper and find out why they are seeking attention. (Participant 10)

However, part of the information-seeking process was deciphering which information was useful and which information was irrelevant or causing unnecessary stress. For example, a few parents reported they found “American” information that they did not regard as relevant to the New Zealand context. Another mother talked of the issue with the internet increasing her worry in an unhelpful way:

The problem with the internet is you just, you can come across all sorts of stuff and you can just make yourself far more worried than you actually need to be or you can see things that aren’t necessarily there. (Participant 1)

A few parents shared that part of their learning was understanding how there are differences in suicidal behaviour. Understanding the variability helped some parents interpret which information to pay attention to and which was less relevant to their child. Learning about differences in suicidal behaviour also allowed parents to alter their approach:

One thing I learned along the way is there’s quite a lot of difference in suicidal behaviour. Like it can look quite different. Some of the people on that group have children who it’s just like they’re being absolutely driven to commit suicide, so every time they turn around for two minutes they’ve got a cord round their neck or something, so there’s ones that are maybe schizophrenic and they’re having command hallucinations. There’s quite a lot of difference between that and then [my child’s] kind of more chronic always feeling suicidal. (Participant 1)

One of the areas in which parents gained knowledge was recognising signs of risk. This included knowledge of risk signs specific to their child and risk signs of suicide in general. When recognising signs of risk for their own child, they said they were able to identify when to be more concerned. For example, one parent talked about how things had improved and began to

feel “smoother” over time. She said, “So I can sort of pick up some signals now. Maybe even better than he can.” Despite this improvement, she said she has “never felt on top of it because he’s so unpredictable” (Participant 5). This fit with others’ descriptions of experiencing uncertainty no matter how much they learned.

A few parents said that their experience with their suicidal child made them more attentive to signs of possible self-harm in a younger sibling. This gave them a chance to pick up possible risk earlier.

For some parents, learning about the reasons for suicidal behaviour helped them understand their child and to be better able to mitigate risk. Some parents learned about how suicidal behaviours can be a way of dealing with overwhelming emotions:

I was starting to understand more that [cutting] was more of a coping mechanism for dealing with really overwhelming emotions. Yeah, because I never, ever stopped searching for answers as to why or how people do that to themselves because I had no clue in the early days, no clue whatsoever. (Participant 10)

Another said they understood suicidal thinking as a way to escape painful emotions. Seeing the function of her suicidal behaviour guided their risk management strategy of “slowing her down” so that they would be able to address the issue in another way, before she went through with an “action of trying to commit suicide to bring her emotion down” (Participant 1).

Learning about themselves was another outcome that a few parents identified from their experience. They reflected on learning about themselves in relation to their emotional reactions and communication, both with their child and with others. A few parents talked about how therapy assisted them to make sense of their own experiences. One parent described this difficult time in her life triggering a reflective learning process about how she wants to change. She said,

“I am so grateful, even though it’s been so damn hard, I am so grateful for what I’ve learnt through this experience, through her, that I needed to look at myself and change” (Participant 10).

By watching their child face difficult times, parents were able to learn about the strength and resilience of their child. Caring for their suicidal child allowed them to identify strength they may not have otherwise seen. They used a variety of words to describe this, such as seeing their child as “brave”, “strong” and wanting to “take my hat off to her”. Feeling pride in their child’s ability to endure struggles was a way parents found meaning in the difficult experience.

One parent talked about how she now saw her child as becoming stronger and more resilient through her experience. She spoke of how painful it was to see her daughter suffer. She said, “I wouldn’t wish it on any parent; it’s been the most hideous parental experience I have ever experienced.” She spoke of an example of when her child was able to courageously use her experience of bullying and share it publicly:

But if some good can come out of it ... [her daughter] as part of her recovery process stood up in front of the whole school, that is one and a half thousand girls to talk about bullying and anti-bullying and her experience. So that is a really strong place of recovery that she is in, which is some good for what she has gone through. (Participant 12)

While many parents described this sense of pride, some also acknowledged that the pride was not shared by everyone in the family. For example, one parent said that she felt “real pride” in her child coping with his difficulties and not turning to suicide and contrasted her pride to her sister’s feelings of “anger and resentment”. She linked her sibling’s critical response with past feelings towards suicide of another family member (Participant 6).

Alongside gathering information and identifying strengths, one way that parents made some meaning of supporting a suicidal child was to use their experience to make things better for others in the future. They contributed in many ways: by directly supporting families, helping services, using their experience in their professional work and reducing stigma in the community. They said they found meaning through directly talking with other parents of suicidal children, such as through a Facebook group or face to face. A few parents talked about not wanting others to feel alone. Contributions to improving services included using professional connections to assist in changing some agency policies, offering feedback to services and assisting to create an advice pamphlet for parents. Many parents spoke of taking part in this research project as a way they hoped they could help give back. Furthermore, a few parents talked about ways that their experience contributed to how they worked in their professional roles. Parents described using their private experience to reflect on their roles and responsibilities and increased their desire for better services for families. For example, one such parent talked about how he saw his work differently after being a parent of a child at risk of suicide:

It's having the personal experience has really helped me reflect on my professional experience and responsibilities as well. It's really affected me quite deeply, I would say, in a good way, in a positive way in wanting to deliver really good services to young people and families. So even though I wouldn't want any parent to go through it, it's been quite enlightening, I would say. (Participant 9)

Another participant spoke of her experience allowing her to be comfortable with distress and an ability to be with or emotionally 'hold' people who are suicidal:

I do believe that that's why I can work with suicidal or do the type of work that I am doing at [Organisation]. I absolutely know that. I don't think I am necessarily good with

words or good with things but I think that I am good with holding and that is because I am so comfortable with it. (Participant 6)

Helping to reduce stigma associated with suicide and suicidal behaviour was a way that some parents thought they could assist others. These parents talked about wanting to be able to give back to the community by educating and promoting compassionate understanding rather than stigma and judgement. A few participants said that speaking openly about suicide was essential to being able to reduce stigma: “We need to reduce stigma by actually being open and not being afraid to talk about it” (Participant 10). This mother talked of having the bravery to speak up being a process for her through which she would be encouraged by her child’s bravery. She said, “slowly over the years, as my daughter has gotten braver about showing her arms, I’ve gotten braver about speaking up and more knowledgeable too so that I can actually speak with knowledge and not ignorance” (Participant 10). Parents saw their role as one of reaching out, talking about it and helping to reduce stigma through sharing experiences.

This theme highlights the multiple ways that parents were able find gains from their difficult experience of caring for a suicidal child, such as increasing their knowledge, learning new information, acknowledging their child’s strengths and finding meaning through contributing to others.

Summary of Topic One

Overall, the first topic of the findings chapter explored parents’ experiences of caring for a young person at risk of suicide. It described the intense and wide-reaching impacts on parents’ emotions, parenting behaviour and social connections. The section also outlined some ways they coped and found meaning through their difficult experiences.

Topic 2: Parents' Experiences with the Services Who Supported Their Child

This analysis section explores what parents said about their experiences with mental health services and the professionals who were supporting their child. Almost all parents discussed their experiences with youth-specific services, and around half had also engaged with adult services. This support included both community and in-patient mental health services, as well as alcohol and drug treatment. The services that parents spoke about were mostly public services; however, many parents also talked about accessing private therapists, psychiatrists or a private residential facility.

Throughout this section, I use the terms 'clinician' and 'mental health professional' to inclusively refer to any staff working with a young person in a mental health service. Where participants have specified the role of a staff member, then their job title is used (i.e., psychologist, social worker, psychiatrist, etc.).

It Is Hard to Get Support from Services

Almost all parents described difficulties gaining access to adequate mental health support for their child. They described various challenges, including difficulty in initially accessing services, and when they eventually engaged with a service, many parents described difficulties with maintaining service support (i.e., receiving inadequate care for their child or their child being discharged before they thought it appropriate).

Most often these difficulties with access to service providers occurred in combination with support they really valued and appreciated. Some of the aspects they appreciated were positive attributes of staff, prompt service and the quality of therapy provided. A few parents had predominantly positive experiences of services throughout their child's care; however, this was the minority in the sample. Most parents reported significant difficulties.

Several parents described difficulties gaining access to support when they first engaged with services. The parents described this in two main ways: waiting a long time to receive support or being declined support because their child's situation was not deemed 'serious' enough.

Some parents felt like they waited too long for their child to receive support. As described earlier in this thesis, when a parent discovered their child was at risk of suicide, it was distressing and overwhelming, and they were likely to want support for their child straight away. Participant 9 said "she could die. It was the immediacy of getting her the support straight away" that they wanted for their child. This parent said an initial assessment appointment happened relatively quickly, but "then nothing happened" and he felt he was in "no man's land" as a parent. Other parents accessed private mental health services while they were waiting for publicly funded support to begin.

Several parents described being initially declined by services, usually with the explanation that their child's issue was not serious enough or did not meet entry criteria. Participant 5 said her son went for an assessment and was told, "There's nothing wrong with you", and later that night he self-harmed.

One parent described a particularly difficult experience trying to obtain support from CAMHS. The first time her child cut her wrists, she managed the situation at home, and when she contacted the CAMHS the next morning, her child was declined support. She reported, "They said that we didn't meet their criteria. So that was really frustrating." As a result of her child being declined service, she arranged for private counselling.

The next time her child cut her wrists, she decided to be more strategic to try to obtain CAMHS support. She took her daughter to hospital even when it was not needed because she accurately perceived that this would make the mental health services take her more seriously:

The second time she slit her wrists it was a bit worse than the first time. It didn't need any stitches or anything, but I did take her to hospital because I thought it would be a way into CAMHS and I was right.

This parent used more public service resources (hospital time) to gain access to the CAMHS support. Even once she was referred to CAMHS, she again had more challenges to face before her child could receive support:

I had organised counselling for her, and CAMHS said because she is getting counselling outside CAMHS they didn't see that she needed CAMHS and that's when I really lost it with CAMHS because ... I couldn't understand how a suicidal teenager wasn't meeting the criteria. I said I'm stopping counselling now. She's got nobody.

Once parents were able to access support for their children, many described difficulties in maintaining adequate support. Parents described inadequate support in a variety of ways, including clinicians changing frequently, a lack of access to talk therapy and a concern that their child had been discharged from services before they thought it was appropriate. Many parents felt that the difficulties they experienced in maintaining adequate support were due to a lack of resources for mental health services.

The majority of parents in this study described difficulty with their child's clinicians changing, leading to a lack of continuity of care. The importance of continuity of care was raised because it caused confusion, because the relationships being built were important, and because both children and parents did not like repeating the same (often distressing) information:

There was so many people involved that I didn't know who was who anymore really.

Everybody has got such different job titles and they don't always explain you know what is going to happen next. (Participant 9)

A few participants expressed frustration at being asked to repeat the same information to multiple people because of changing clinicians:

There has not been a progressive accumulation by one person of that knowledge about [our child] and ourselves. It was like we were constantly telling our story to another person and another person and another person and that continued the entire way through her life. (Participant 3)

Another reason that parents saw continuity of care as important was that they placed value on relational connection, which is not easily transferred to another person. A few participants talked about how clinicians sharing written notes with one another is not the same as having ongoing personal interactions, because it “loses” the relationship.

Participant 4 said that her child had difficulty opening up to people and that the relationship he developed with one person “wouldn't transfer to somebody else”. She reported that her son stopped making progress when he had to change therapists.

Parents also faced difficulties gaining access to talk therapy and felt that medications were too readily available and dispensed. Some parents were concerned about the side effects of medication and felt medication did not fit with the support that they wanted and felt was important for their child.

For example, Participant 2 said medications changed her child's behaviour and speech, and that she would sound like a “blithering idiot”, which left her wondering “what have they

done to my girl?” Despite the unwanted medication, there were limited opportunities for other therapies:

In the course of three admissions that totalled 30 weeks she saw a psychologist about four times and I used to get really cross because I always believed that therapy is just as important as medication if not more. (Participant 2)

Parents described difficulties in accessing talk therapy in both the community and in-patient settings.

Some parents felt that services were withdrawn too soon and when they felt their child still had a strong need for ongoing support. Parents described confusion and frustration when their child’s support stopped, especially when they felt the young person continued to be at risk of suicide. Participant 8 spoke of the shock of being told that his child would be discharged from in-patient services:

We went and picked her up when she said it was over, eh? And I said, she was joking. I said, “You’re joking, aren’t you?” She said, “Oh no, he said, ‘I’m OK’. I went, “OK, thanks for the service”, and it’s like, all right, I can understand he’s one person for the whole region, I can understand that and he should have more people, but each child, while you’re on that case, should’ve been dealt with. (Participant 8)

Similarly, a few participants talked about having their child discharged by adult services because they were so unwell that they struggled to turn up to appointments or stopped answering their phone. The parents spoke of their child being declined services rather than offered more support:

She was getting more sick and didn’t turn up [to her appointments], but instead of ringing her up and saying, “Why didn’t you turn up?”, and she was actually getting sicker and sicker and couldn’t get out of bed, they just said, “Well, I’m sorry, but you didn’t meet

the criteria. You've got to turn up to these sessions." But they never sent anybody to find out why she didn't turn up. (Participant 3)

These experiences highlight how the young people who were most unwell missed out on mental health services when they were most in need of them.

This theme explored some of the difficulties parents experienced navigating the publicly funded mental health system. Parents talked about challenges in accessing and maintaining adequate support for their children. The difficulties included support being initially declined, having support withdrawn, changing clinicians and a lack of talk therapy availability. While most parents described struggling to receive sufficient support for the young person, they also described times of good access to services, alongside periods of less adequate support.

You Have to Fight to Get Help

Parents in this study described having to fight to be able to receive help from services or to have to fund it out of their own pocket. When parents were struggling to access professional services, they described becoming assertive, and in some cases demanding, for their children to obtain support. This behaviour was described using a variety of phrases, such as "demanded", "lost my rag", "pushed" and refused to "back down". A few parents talked about using official processes to have their child's needs met, such as putting in complaints or requesting a mediator to help negotiate their engagement with a mental health service.

Parents who talked about being assertive found it a successful strategy in gaining support for their children. For example, one parent described a lack of support from a CAMHS service and within hours of putting a complaint in she was called and told that her child could meet with a psychologist. Another parent said that when services saw a parent who "wasn't gunna back down, they dealt with it straight away" (Participant 8).

One mother, who believed her daughter was suicidal and said that she did not know how to access support, reported that a clinician recommended she “demand help” for her child. This shows that even professionals in the area recognise that ‘demanding’ is an effective strategy.

This was useful advice for a parent who discovered the service was planning to discharge her child. The mother said, “I felt like I had to really push the issue and demand something was done.”

While it appeared a successful strategy, it also seemed that there were some difficult emotions associated with this demanding behaviour and it could take a great deal of energy. One mother, who spoke of constantly “pushing” for her child to be heard and to have adequate support, said she found it a tiring strategy. She said, “You don’t always have the energy to do that you know” (Participant 13).

Another parent, who had major difficulties trying to get her child into a CAMHS service (as described above), attributed her expressing her frustration towards CAMHS as the catalyst for her daughter receiving support from the service:

That’s how we got into CAMHS. I had to really lose my rag with it. For parents who are at the end of their tether anyway to have to battle a system to get help, it shouldn’t be that way, you know ... parents are coming with no more resilience left, you know what I mean? Their stress jars are absolutely full and for the services to put an extra stress on, it’s just ... you can understand why parents lose it. (Participant 12)

Difficulties in accessing and maintaining support for their children in the public system, meant many parents also sought private services. For some parents, private mental health support meant a significant portion of their finances went towards paying these bills:

That can be hard because it can be damned expensive and it takes out a big chunk of your income but you do it because it's your child and you want your child to be well and happy, so you just do it. But I feel for a lot of people that are really struggling financially.

(Participant 10)

For some parents, private services were not affordable. A parent of a child who died by suicide talked about contemplating paying for private residential treatment because her child had already been through multiple types of treatment and the wait for a funded bed in the programme was long. She said, "She was just going downhill so fast. I asked them what it would cost and basically ... I could have done it for about three months without selling the house" (Participant 3). After her child died, she described herself wondering if three months in a private facility could have been all her child "needed" to recover.

A few parents recognised the financial, and therefore health, inequality in access to services. Some families struggled to have their needs met in the public mental health system, and receiving support privately was only available to those with significant financial resources:

I am incredibly sad and it's really hard for anybody out there now unless you have got the finances to pay for counselling. It's actually really hard for anybody to source funded counselling, which is just not good. (Participant 10)

This theme outlined how parents had to resort to strategies such as being demanding or assertive and seeking private interventions at personal expense because of the difficulties accessing adequate support.

Parents Feel on the Outside

Almost all parents described feeling on the 'outside' in their experiences with their child's mental health services. This sense of being on the outside could be both literal—that is,

physically outside the therapy rooms—and in terms of information sharing. They felt New Zealand mental health services treat the child as the client, leaving them to find a way of understanding their role on the periphery.

This idea of feeling on the outside came up for parents across the full range of services that participants encountered. However, the importance of family involvement was more recognised in parents' experiences with youth services than with adult services.

This theme describes how parents balanced uncomfortable feelings of being on the outside, but nevertheless respected their child's privacy and confidential supportive relationships. Despite not being heavily involved in the patient–clinician relationships, parents were still attentive to, and concerned about, the relationship between their child and clinicians. Parents felt they had to cope on their own and that their potential to contribute to their child's recovery was disregarded.

Many parents described it as unsettling to be on the outside. Parents used terms such as “unnerving”, “left out”, “pushed away”, “fobbed off” and “not part of it”. Almost all parents acknowledged and respected that the service was there to primarily interact with their child, but nevertheless, many found it challenging balancing their child's right to privacy with their desire to protect their child and be involved in supporting them. Participant 12 described her experience of being on the outside of her child's individual therapy as both necessary and unpleasant:

It is, it's a really challenging place for a parent, for a parent that wants to protect their child and is in protective mode and then hand them over, their whole mental well-being over to somebody else to play with and you not be part of it. It's a really unnerving place for a parent to be. The whole procedure is necessary, I guess, but it's not pleasant for a parent. (Participant 12)

Later on in the interview she spoke about the valuable support her child received and that she thought therapy outside the family can be really important for young people. This highlighted the discomfort parents can feel about physically being on the outside of the therapy room, even when valuing individual therapy for their child.

Several participants said that being on the outside gave them a sense of powerlessness. Participant 9 said “as a parent you feel quite powerless because nobody seems to talk to you”. Another participant described her experience of waiting outside an assessment session and feeling left out and unsure. As with most other parents, she appreciated the need for privacy, but still found it hard not being involved. She said:

That’s really hard when you’ve got a 15–16-year-old and you are outside this office thinking, What on earth is going on? What is being said? Just feeling really left out of everything. And I know they are entitled to their own privacy, these kids, but I just found that really hard.

(Participant 10)

The child’s right to confidentiality and privacy was endorsed by almost all parents. While most parents felt their child could benefit from confidential support, a few expressed concerns about the age when a child should be able to have private conversations, and whether there should be more stringent limitations to the confidentiality. Parents of teenagers have the main care and responsibility for the child and may understandably be concerned that important information may be discussed and not passed on. Participant 8 expressed his concerns as follows:

I’m not happy about is this confidentiality act, is where even my daughter can have it and the parents don’t know what’s going on. Now to me, that should hit at an age of say, 15, 16, where the kids’ brains are more developed and that, because if there’s something going on, the counsellor can say, “We can’t pass on”. Now where do you draw the line?

Because as a parent you should have the main right over that child because that child is still a child. (Participant 8)

Confidentiality concerns most commonly arose when they related to the suicide risk of the child and fears that the parent would not have all the information to keep the young person safe. Many parents felt they were kept “on the outside” of decisions made about risk or that risk information was not shared with them. For example, Participant 1 said, “I wouldn’t have 100% trusted any of the professionals working with my daughter to tell me if there was a risk because there’s the whole privacy thing” (Participant 1). When parents are not advised of ongoing risk issues, it could lead them to feel their position of caring for the child at home was not acknowledged. This lack of information sharing could also mean the parents’ potential contribution to care was inadvertently ignored. Participant 7 reported that information was not passed on when she felt it should have been. She said, “[The school counsellor] said to me, ‘Oh, you know, I’m really concerned for [your child’s] safety’ and I’m like, ‘Oh, well, why did you not tell me this six months ago?’” (Participant 7).

A few parents described placing such value on their child’s right to privacy that they would be transparent with their child about any information they as parents told clinicians. This was a recognition by those parents of their role on the outside and the young person’s relationship with the clinician. Participant 6 said:

I can also understand that there is confidentiality. [My son] needs to know everything. So if I sent an email I would show him the email before I send it and from that point of view I am not doing anything undercurrent. I am not doing anything undermining or to give any information that [my son] is not aware. I ask his permission and I showed him what I would send. (Participant 6)

Many parents described trying to be involved and sharing information with the mental health professionals and feeling that it was not perceived as useful. Parents talked about not being seen as a resource, and being disregarded. Most seemed to respect the need for privacy, but found it hard that they were apparently of no use at all in the therapist's understanding their child, and therefore their child's potential recovery. Participant 6 said that when they tried to offer some information, a clinician "implicitly said to me if I need anything from you I will ask you. I am working with the client not with you."

Many parents commented on how they wanted their child to have a positive relationship with the professional they worked with, even if they were not personally involved in the relationship. Most parents understood and respected the need for confidentiality and for their child to have a one-to-one relationship with their clinician.

The parents described awareness of whether the clinician "connected", "clicked" or "related" with their child and felt this was an important part of what they wanted in their child's treatment. Participant 12 described how she found engaging with the service "absolutely hideous" as a parent; however, she was still able to acknowledge that the case manager "did fantastic work" with her child.

Many parents described finding it difficult when they felt their children were not well matched with a clinician. The parents claimed to identify this by saying the pair were not developing a rapport, clinicians were being too "soft" on their children or their child was being treated disrespectfully.

Another way parents talked about being on the outside was when they were coping on their own, outside of the system, without guidance on how to support the young person. One

mother spoke about having her son return home from hospital following a serious suicide attempt with no guidance on how to care for him. Her child was in adult services at the time:

It wasn't dealt with by the hospitals properly. We were left to just look after him when he wasn't in a state that we should've been looking after him and we didn't know what to do. I didn't know what to do but we just did our best. (Participant 13)

A few parents felt that professionals were choosing to hold back their potential guidance or clinical experience and leaving parents to figure it out themselves. Regarding his experience with a youth mental health service, Participant 9 said, "I mean a lot of it is down to you as a parent and what I found is that the clinical staff, they didn't really want to give any advice or guidance." Similarly, Participant 11 talked about how she felt that clinicians cared but held back their knowledge. She said, "I just sort of feel that maybe they were holding back with their knowledge, bringing all the empathy to the party and twenty-fold, like seriously amazing" (Participant 11). While she appreciated their care, she also talked of hoping for more guidance. She described how life felt like a "storm" when she was looking after her suicidal child, and she wanted the professional to be proactive and offer direction.

This theme of parents feeling on the outside was acknowledged by almost all parents in the study. Most parents accepted that being on the outside was necessary, but also uncomfortable. One of the key difficulties raised was whether information would be passed on to them when there were suicide risk concerns. Despite feeling on the outside, most parents were attentive to how their child connected with clinicians and saw this as important to the treatment. They also recognised that being on the outside meant they had to cope on their own when they wanted some guidance and support.

We Can Make a Helpful Contribution

Almost all parents expressed the view that being involved in their child's mental health care was important. They described feeling that they had something to offer towards their child's recovery. Many positive experiences of being involved were recounted, as well as some challenges that parents faced when they were involved. Parents wanted to be involved for two key reasons. First, to assist with the treatment of their child and, second, to receive guidance about how to best support their child. Participant 1 said, "I would really say that parents are the people who are there all the time and having them involved in a way that is constructive is really important."

The majority of parents described finding it useful when they did have opportunities to be involved in interventions with their child. For example, Participant 2 said the "family involvement was great", and Participant 10 said that relationship counselling "brought [her and her child] back together again". Participant 9 said his child's counsellor had "become a useful source of support" for the whole family.

One parent described how his experience supporting his daughter changed his view on the value of family involvement in his work supporting youth. As a professional, he previously had not focused as much on family involvement; however, the personal experience helped him see how important it is to include family:

I think it's highlighted to me the importance of family around each person and how much we involve people or don't involve people. It's having the personal experience has really helped me reflect on my professional experience and responsibilities as well. (Participant 9)

Parents described how their involvement could assist with the treatment by offering information about their child outside of the clinical context. They have been in their child's life consistently; they have known the child long before services became involved and, for most, long after services were involved. Some parents said that the information they offered would have helped clinicians understand their child's experience more accurately and be better able to give appropriate interventions.

Participant 3 said that family "are the only ones that know who this person is as a well person and what their life experiences are". In relation to her experience with adult services, Participant 4 said, "You can't really know how a person is presenting, even in a hospital ward. They say, 'Oh, they'll settle and they'll do this', still different to living in a family." She also shared the view that family have important information that can help clinicians form more accurate views. She said, "I think if the psychiatrists stopped to actually talk to us before they jumped into telling me it's fine, they might have had a different view" (Participant 4).

Parents also talked about contributing to treatment by sharing a positive view of their child. A few parents expressed concerns that mental health professionals could form pathologising understandings of their child. These parents thought this could be mitigated through parental involvement to help clinicians see a fuller picture of their child. For example, Participant 3 talked about how services wanted to focus only on the "negative" and the "clinically unusual scenarios". She said that this focus gave "such an unbalanced scenario about what actually this person is" and limited the clinician's ability to fully understand the young person's situation. Participant 3 highlighted how mental health clinicians only see people when they are struggling, whereas family are able to see each other when they are at their best, and suggested that both sides were needed for a fuller understanding of a person. Participant 10

mentioned that her child talked to a dead family member and that she “thought it was probably a gift”. However, she felt concerned that mental health professionals could dismiss the family perspective and interpret it as an indication of major mental health problems. These parents wanted clinicians to understand their child’s mental distress in a context in which their strengths and their potential were also recognised.

Some parents in the study felt that their perspectives and information were valued by clinicians and that this made a meaningful contribution to their child’s mental health treatment. For example, Participant 2 remembered being asked by clinicians to describe her child’s behaviour to try to build an understanding of what was happening. She initially expected that clinicians would already have all the expertise needed for treatment. However, over time, the mother realised that every child will have different risk signs and that, as a parent, she has valuable knowledge specific to her child.

Parents thought it was important to be involved in their child’s treatment because they wanted to receive guidance from the services in order to best provide support for their child. All parents said they wanted to know how to best support their child and keep them safe. Most parents talked about wanting involvement with services so they could draw on clinical knowledge and expertise to guide them. Parents thought that they had an important role in their child’s recovery process because mental health professionals’ involvement was time limited. Despite this, many parents talked about not knowing how to help. This highlights why it is so crucial for parents to have guidance on how to best support their child.

The people that are suicidal or struggling, they go to see a therapist or psychologist or counsellor once a week for an hour; it’s the parents at the end of the day that are there on

the ground dealing with the situation and I said, “We are the ones that are floundering for knowing how to help.” (Participant 10)

While many parents struggled because they did not have enough guidance, some parents talked about learnings that helped guide them in their approach with their child. A few parents particularly valued learning the skill of validation and described finding it incredibly useful. For example, Participant 5 said:

Biggest thing I learnt was validation and how to avoid invalidation. To make him feel understood, and believe his feelings are real was to listen, and listen really hard to the underlying cause and emotions. It’s hard as a parent to be quiet sometimes and ignore topics that can provoke arguments. (Participant 5)

A few parents talked about useful guidance from DBT groups. DBT groups are usually attended by the parent and young person in adolescent services, or just the young person in adult services. Participant 11 described DBT as a “godsend”, and she said, “I am really grateful that I’ve learnt it.” She could notice times when “therapy just clicked” and she was able to change her way of responding to her child’s behaviour. She went on to talk about the DBT phone line. She said that being able to call any time and receive “impartial” guidance was helpful. She said that knowing that “it was 24/7 is just massive”. She also mentioned that upon completion of the group she found it difficult to know which skills to use at which points and chose to do the DBT group a second time to reinforce the skills she had learned.

While most parents who talked about validation learned about the skill through DBT therapists, Participant 10 described finding out about validation through her own therapy resources. She reflected on her own parenting approach as “wrong” and not being what she would have liked. She spoke about her own parenting, saying she had done the best she could

with what she knew at the time. She talked about how learning validation could help her have a different approach in her relationships:

I've become aware of the validating of children's emotions and how we talk to them and how we react to incidents that happen in childhood. And I can look back now and I know that I did everything wrong but that was just how it was at that time because I didn't know any different. That was how I was brought up as well. So that's how I know now, with my own little grandson, how I hope that I will talk to him in a more appropriate way with his upbringing. (Participant 10)

Alongside the desire for learning skills, many parents wanted to receive information to help them understand suicidal behaviours to guide their approach. A few parents talked about the value of clinical knowledge being shared with them. The clinical information was in the form of psychoeducation, formulation or diagnosis. Many parents thought that becoming more educated about their child's difficulties was important. Participant 1 said, "We play a role in her recovery and so the more educated we are about where she is and what we need to do the better."

Information could help parents interpret, and make sense of, their child's experience. It also allowed some parents to relate ideas to their own experiences of their mental health:

It was a real eye opener and it was a really good thing. [My child] was diagnosed with depression and anxiety and also with de-realisation and de-personalisation and I had never heard of them before and she hadn't. And it was actually a really good thing because it gave me an understanding of something that I had had to deal with. I had some mental health issues as well. I just thought, Oh, I know about this stuff. I know what that is about because I have had to deal with some of that myself. So that was actually really good. I remember on our way home, because we live an hour out of town and, yeah, we

just talked really excitedly about this. It was like, yay, we're getting somewhere. I understand now. It was a really good thing for [her] because she thought she was going mad. (Participant 10)

Participant 1 talked about finding it useful when her child was given a diagnosis that fitted with her view of her daughter because it allowed her to access resources that could guide her approach with her daughter. Having the clinicians involve the parent, and share their clinical knowledge with her, was useful because she was able to feel more confident in how to respond to her daughter. She described this:

Once we found out that it was this borderline personality disorder, then I was able to actually read a book that was really useful, had a very compassionate stance on it, and that combined with the DBT, that understanding [from the book] plus the DBT skills, were really helpful in terms of kind of understanding what I needed to be doing, but prior to that we just had no clarity. (Participant 1)

Parental participation did not always have to include sessions together, because Participant 10 found sharing her daughter's CBT homework useful. She described how this was a way for them to connect, build understanding of her daughter's difficulties, and also for her to do her own self-reflection.

While much of the advice provided to parents was helpful, they also described limitations of the guidance they received. Many parents were advised to remove sharp instruments and medication, and for some parents, the professional guidance ended there. A few parents viewed this as limited advice, saying that their children could find creative ways of hurting themselves. Participant 5 was one of the parents who was advised to hide all sharp objects in the house, and

she commented, “I mean, they’ll smash a window, you know, so that cycle, I’m not going to hide the knives.”

Parents spoke of wanting more guidance than just locking up knives. Several said they wanted non-judgemental guidance that took into account the role of the concerned parent who already managed these risks at home. For example, Participant 1 said she wanted:

Some guidance from the teams that we worked with for parents, acknowledge how anxiety about not knowing when you’re the person who has to manage the situation at home all the time, they only have to manage one hour once a week for this person. You’ve got to manage the rest of it and manage the risk and keep the child safe. We got no real guidance around that other than this idea of locking the knives up and the meds up. And just the sense that it was frowned on if you found stuff out. I kind of feel somewhere there’s got to be, you’ve got all this professional knowledge, something that combines the professional knowledge and acknowledging the 24-hour kind of role of parents kind of brings that together and gives you some advice on what would be a good line to take or what are some options but isn’t particularly judgemental. (Participant 1)

This parent went on to express her concerns regarding the limitations of what advice mental health professionals could offer parents, when she suspected they did not have their own children and “there was no one who had been in that [similar] circumstance”.

A few parents talked about wanting guidance and advice, and then finding it difficult to follow if it did not fit their particular needs. Participant 1 said she would have struggled if professionals “outright said [she] shouldn’t be checking up” on her daughter because of her feeling concerned and wanting to protect her child. She talked about feeling a “sense of judgement from the professionals” for finding out information about her daughter’s risk, for

example, looking through her daughter's bedroom. She said she did it if she "absolutely needed to" and at times chose not to tell the clinicians.

Participant 12 also said it was hard to implement some advice given. She was concerned about her child's suicide risk during the night; however, she was advised not to sleep in the young person's room. She commented that "[her] protective instincts were far stronger than [her] rational reasoning" and she said her involvement with CAMHS "reinforces that kind of powerlessness. You feel like you are not part of the solution, you are part of the problem." Several parents spoke of wanting guidance that could help empower them to be an active participant in their child's recovery, rather than being seen as a negative influence.

Services involving parents in the young person's care was endorsed by almost all participants in this study. Parents felt they could contribute by using skills learned from clinicians at home, and by providing clinicians with valuable information about their child's life. As parents, they felt they could make good use of advice because they were constants in their child's life, whereas the clinicians might only see the child an hour a week. In this study, some parents talked of wanting "direction" in the "storm", and another wanted someone who just "sat back and listened". Therefore, while the participants gave the message that they wanted the option to be involved, there was variation in the type of involvement they were hoping for.

Recognising It Is Hard for Us Too

While the majority of parents clearly felt that being involved was important, it appears that some care needed to be taken in how they were involved in their child's care. Most parents talked about wanting clinicians to be aware of and sensitive to their emotional experience as the parent of a suicidal young person. Parents talked about a range of interactions with clinicians, from clinicians actively supporting their well-being to clinicians adding to their stress. Some

ways in which parents wanted to be shown sensitivity to their experience were being validated, taking a non-judgemental approach and being taken seriously.

Parents described dealing with difficult emotional responses relating to their child's suicidal behaviour, and struggling with the services supporting their child. Participant 12 talked about her view and said:

CAMHS isn't there for the parents; it's there for the child. And I understand that, but in that giving and that vulnerability you are left quite open when you leave and quite emotional. And there is some times practitioners aren't always sensitive to where the parent is at, or I feel they aren't always sensitive. (Participant 12)

Some parents talked about how clinicians were responsive to their experience in helpful ways. These included referring them to services for support, being empathetic and validating, and recognising their vulnerability. Participant 2 talked about how the psychologist supporting her daughter would call her to "just to find out how I am". She said at the time she was thinking that she "should just be a mum and carry on". She talked of the clinician's skill in identifying her possible vulnerability and wanting to support her. She went on to say "[the psychologist] understood how tough it was for carers before I understood".

While some parents had positive experiences of their emotional needs being supported by clinicians, others had experiences in which clinicians missed their emotional vulnerability or added to their stress. Some clinician responses included not recognising parents' needs for support or validation. For example, Participant 1 said:

It tended to be that the mental health professionals who see this all the time, and I understand that, were very calm, but calm to the point of laid back. So, on the one hand, you've got you who's just comes across this, finds it horrifying, doesn't understand it, et

cetera, et cetera, and then you have this “Really? Oh, yeah, lots of people do it. I’m not too bothered”, et cetera, and I think kind of what was missing was that whole DBT idea of validation that you kind of got this feeling of “Oh, yawn, suit yourself”, you know. It just, they didn’t want, obviously they were trying not to make you feel panicked or anything like that but a response that actually acknowledged how scary and what you might be feeling would have made you feel a bit better as opposed to, it didn’t actually reduce your feelings the fact that you were relaxed about it all, just made it kind of, made you feel like you were doing something that you were wrong or something. (Participant 1)

A few parents talked about how they were not offered support and had to seek out it out themselves. For example, Participant 3 said, “The other thing I really noticed as well sort of looking back in retrospect is that we were not told of any agencies beyond the hospital board at the time to support us.” Some participants suggested that they would have found it useful if staff had let them know what support or services were available to help them as parents.

Parents talked about wanting clinicians to be sensitive to their experience. Many parents described feeling judged or criticised by the mental health professionals supporting their child. Participant 12 said, “I think you naturally feel judged as a parent” when in a child mental health service. She elaborated on this point, talking about how it can make you feel very exposed and vulnerable, and suggested the context of being a parent to a young person with difficulties would mean extra care would need to be taken for parents not to feel judged.

A few parents described feeling like they were blamed for their child’s difficulties. For example, one mother described a feeling that it was her “fault” that her child was experiencing difficulties, another parent talked of being treated by clinicians as “over-anxious” and another

felt “scrutinised” by her child’s care team. As quoted earlier, Participant 12 said, “You feel like you are not part of the solution, you are part of the problem.” Participant 5 felt criticised when she was told her child was not mentally unwell and just “needed consequences”. She felt this was undermining, and that she was perceived as causing her son’s emotional distress.

All interviewees who spoke about DBT praised it; however, one parent also said DBT ideas led to a sense of self-blame. DBT theory suggests that experiencing invalidation in childhood can contribute to difficulties with emotions and suicidality. Participant 1 said it was challenging for her to make sense of the idea that she could have unintentionally contributed to her child’s emotional difficulties:

I was trying to understand how it came about that she grew up in an invalidating environment when she grew up in a stable, loving family. What did we do? Did we do things wrong? What was it that this led to this being invalidating for her when we didn’t, we weren’t kind of, you know, “Stop that crying—don’t be ridiculous”? So she and I spent quite a bit of time kind of working through what that was. (Participant 1)

In contrast to the parents who felt blamed, Participant 13 talked about being so focused on her son that she would not have been aware of any judgement. She said, “My focus was on [my son] so I didn’t feel judged myself” (Participant 13).

Another way that parents wanted clinicians to be sensitive to their experience was by taking their perspective seriously. Many parents spoke of wanting their children’s clinicians to listen and acknowledge their views. Participant 3 said she and her partner “didn’t believe that the services took us seriously and I’ve got so many examples of that”. Participant 4 said she felt clinicians were “dismissive of me as a person”.

There was a common concern among parents that their perception of risk was not taken seriously by clinicians. Participant 1 described the professionals she worked with as having a relaxed response to risk. She said she noticed “this kind of ‘oh, yeah, I’ve seen it all before’ attitude, ‘it’s not that big a deal’, so their assessment of the risk is nowhere near what my assessment of the risk is”.

Similarly, Participant 3 talked about a time when she was concerned about her daughter’s safety and felt the clinicians she spoke with did not take her view of risk seriously. She said:

I had a serious situation on my hands. And then I reached the CAT [Crisis Assessment Team] team and was told that she wasn’t at the point of needing admission and would have to wait for a regular appointment. Yeah, not feeling listened to. (Participant 3)

Participant 3 described how she felt like she was treated much more respectfully after her child had died by suicide. She expressed sadness that it had not been that way previously:

The hospital were so nice to me after she died in their care. If they had only been like that before and listened to what we had to say and realise that we were actually quite articulate, knowledgeable people, maybe the outcome might have been different. So I found that quite hard. (Participant 3)

There were also times when parents talked about being taken seriously and how valuable that was. Participant 2 said she was expecting the clinicians to not take her and her daughter seriously and to think, “Oh, this is just an emotional teen”, but she was surprised. Participant 3 also talked of having times when she felt risk was dismissed, and other times when she felt that staff acted responsively.

This theme highlighted the importance that parents placed on clinicians being sensitive to their emotional needs as well as their child’s. They acknowledged that the services were there for

their child and were happy for that to be the focus. Nonetheless, they appreciated it when they were treated with thoughtfulness. Participants described the importance of validation, offering support and taking their views seriously. Participant 3 summarised the key message in the theme when she said, “Relationship to me is extremely important in care of people who are vulnerable which means, obviously, the person themselves but also the people who are caring about them” (Participant 3).

Summary of Topic Two

Overall, this analysis described how the process of engaging with services can be difficult and uncomfortable for parents. It also highlighted a range of ways that parents can be useful in supporting the recovery of the young person. The section also highlighted how professionals who are trying to help may miss some of the parents’ vulnerability and not be as sensitive to their experiences. On the other hand, it also described how some professionals can play a major role in identifying support needs of those parents or in guiding them to be better able to support the young person.

CHAPTER FOUR: DISCUSSION

Suicide and self-harm are significant social problems facing young people and their families in New Zealand today. The high rates of youth suicide and self-harm demonstrate the need for ongoing research on ways to support young people and their families. This thesis aimed to explore how parents coped with caring for a suicidal young person. This study adds to the existing literature on suicidality by giving a glimpse into the lives of parents caring for a suicidal child in New Zealand and deepening our understanding of their experiences and support needs.

In this chapter I summarise the key findings from this study including the emotional impact a suicidal child has on parents and their parenting behaviours. I also highlight the extent to which parents felt supported and what supports they would have liked. Additionally, I identify the key challenges parents faced in engaging with services and their preferences in this regard. Finally, I summarise the clinical implications of this study, discuss areas for further research, and outline the strengths and limitations of this research.

The discussion follows the findings chapter which is divided into two main sections. The first focusses on parents' experiences in dealing with a suicidal young person and the second deals specifically with their engagement with services.

The Experience of Parenting a Suicidal Young Person

This part of the discussion draws out the most important issues arising from the eight themes that constitute this section of the findings; (1) feeling overwhelmed (2) feeling powerless and responsible (3) no time for myself (4) increasing surveillance (5) walking on tiptoes (6) it's difficult to talk about (7) other parents have gone through this (8) growing and learning.

The emotional impact. In the context of suicide risk there is an understandable tendency to focus on the child's difficulties, which means the significant impacts on parents' emotional

wellbeing can be overlooked. Participants in this study described a number of significant emotional impacts arising from parenting a child with suicidal behaviour.

All parents in this study described feeling worried, anxious, or fearing for their child's safety. Parents feeling worried is consistent with findings from previous studies (Buus et al., 2013; Byrne et al., 2008; Daly, 2005; Ferrey et al., 2016a; Raphael et al., 2006). The parents in this study found that anxiety and hypervigilance would lessen and then increase again depending on their child's wellbeing. This finding also supports what has been seen in existing literature (e.g., Buus et al., 2013).

Powerlessness was another emotion that was commonly described by the parents in this study. Parents felt unable to protect their child from suffering. They spoke of taking on a lot of responsibility for their child's happiness, safety, and recovery, but not feeling they could effectively help their child. This sense of powerlessness has been similarly described in previous studies (e.g., Buus et al., 2013; Daly, 2005). In this study some parents talked about letting go of feeling overly responsible for their child's suicidality as a helpful way of managing a sense of powerlessness. Relinquishing responsibility for things one cannot control has been recognised as a healthy way of coping with challenging situations in common therapy models such as Acceptance and Commitment Therapy (ACT; Hayes, Strosahl, & Wilson, 2011) and Dialectic Behaviour Therapy (DBT; Linehan, 1993). These therapy models propose an active acceptance, knowing what is out of our control and focusing on what is in our control. While letting go of responsibility can be a healthy coping strategy, it could alternatively lead to parents feeling disillusioned, ineffective, and no longer trying to support their child. Previous studies have talked about parents disengaging after a period of high emotional distress about their child's suicide risk (Daly, 2005). Emotional or physical disengagement could leave the child feeling more alone and

less supported. Mental health and suicide literature have recognised the danger of how, when parents feel powerless, they can shift into hopelessness and being less active in the recovery of their child (Brown 2018; Omer & Dolberger, 2015). Omer & Dolberger (2015) emphasized how it is important for parents to move from hopelessness to presence and agency when dealing with suicide threats. While it seems like relinquishing responsibility and exercising agency might be opposite strategies, healthy acceptance that they cannot control their child's behaviour could be central in ensuring parents do not become overwhelmed and free them up to better support their child.

Feelings of guilt and self-blame were common among parents in this study with participants describing feeling like failures or that they caused their children to be struggling. The prominence of guilt and self-blame is consistent with the existing literature (Buus et al., 2013; Byrne et al., 2008; Ferrey et al., 2016a;). An unanticipated insight from this research related to how the parents who also worked in the health field experienced suicidality in their family. Even though a significant portion of participants in this study had professional or academic experience in the area of self-harm, they still spoke of feelings of shock, and how it was significantly more difficult to manage in their own lives than in their professional work roles. These parents even spoke about an added sense of guilt; feeling not good enough in both their roles as a parents and as professionals. This 'double guilt' is similar to what was found in a small English study whose sample was mostly parents in caring professions (Rose, 2011). However, alongside the double guilt, parents in the current study spoke about being able to use their personal experience to strengthen their professional practice, such as helping their ability to sit with distress, to work more closely with family, and to provide motivation to work. This

recognition that there might be advantages for helping professionals from caring for their own child expands on the existing literature.

Parents in this study also spoke of the grief and loss that came with having a child at risk of suicide. For most, this was not a tangible loss, but rather a loss of how things used to be, or loss of what they hoped for their child. This intangible loss has been recognised as part of the experience of being a parent to a suicidal young person (Daly, 2005; Raphael et al., 2005). In the current study, parents described how they would experience anticipatory grieving where they mentally prepared for the feared outcome of their child's death, as was described by Daly (2005). It appears parents were intuitively doing the DBT 'cope ahead' skill, by planning for how they could effectively manage a feared outcome in order to better manage their distress (Linehan, 2014). Anticipatory grieving could be considered as a way parents tried to manage their feelings of anxiety and powerlessness by preparing for the worst. The idea of anticipatory grieving could also be considered another way of reaching acceptance or could be linked with a less helpful sense of hopelessness and disconnection with their child.

This study showed how the distress of dealing with a young person's suicidal behaviour affected parents' ability to take care of their own needs. Consistent with existing literature, parents in this study reflected on not being able to use previous strategies or perform adequate self-care, as they were so concerned about their child (Ferrey et al. 2016a; Oldershaw et al., 2008). In the context of high self-blame or shame, it can be difficult for parents to act in ways that are kind to themselves (Gilbert 2009; Neff, Kirkpatrick, & Rude, 2007). However, the inability of parents to properly take care of their own needs is likely to impact on the extent to which they can support their child. High levels of distress together with a lack of adequate coping strategies could lead to a vicious cycle resulting in the child feeling less supported. Some

parents acknowledged this cycle by stressing the importance of self-care. Most of the parents in the study seemed to have gained this awareness retrospectively. Previous research suggests that maintaining their self-care could allow parents to break the cycle, manage their own reaction, and become more supportive for their child (Gunderson & Hoffman, 2007).

The analysis also suggested a further impact of parents' not attending to their own emotional needs. Participants in this study described how their child noticed the parents' distress and took it on themselves to try to help reduce the distress of the parent by keeping their suicidal thoughts and actions secret. Previous studies similarly described children hiding suicidal behaviour from their parents (Chandler, 2018; Madge et al., 2008). A recent qualitative study also found young people hid self-harm to reduce stigma and possible burden on others (Rosenrot & Lewis, 2018). The current study extends the existing literature by re-framing such secrecy as a caring behaviour on the part of the young person which was intended to 'protect' the parents' against distress. Despite that some parents appreciated their child's act of caring, the unintended consequence may be that the parents would not know when their child most needs their help.

Impact on parenting. The analysis also highlighted that managing suicidal behaviour had a big impact on participants' parenting. Consistent with the existing literature, parents felt ill-prepared and lacked confidence in dealing with their child following suicidal behaviour (Stewart et al., 2018). Parents described how they felt deskilled, and lost contact with parenting they were previously confident in. This perceived loss of skills was particularly difficult in a time when parents were most needed by their children. The strategies parents described trying were similar to those outlined in other research, such as walking on eggshells, maintaining surveillance, and overstepping privacy boundaries (Buus et al., 2013; Ferrey et al., 2016b; Oldershaw et al., 2008). Increased care and associated surveillance often meant there was less

time for other relationships or roles in the parents' lives. Researchers have noted that this prioritising of the young person and constantly subjugating the parents' needs could risk increasing the young person's sense of control to a point where this was not helpful (Omer & Dolberger, 2015).

Negotiating the balance between maintaining surveillance and also supporting the child's autonomy was a struggle for many parents. Gaining more autonomy from their family is described as an important developmental task of adolescence, which involves a shift in family relationships (Carter & McGoldrick, 1999). Previous literature tells us that parents of young people with mental health difficulties struggle to find a balance between encouraging autonomy and support (Gerten & Hensley, 2014; Jivanjee et al., 2009; Lindgren et al., 2016). In the context of suicidal behaviour, parents tend to increase surveillance of the young person and reduce their autonomy out of fear for their safety as well as a concern to support the young person. Negotiating how much support a young person with suicidal behaviour might need is a difficult task. Focusing on the child at times of high risk is important and enables them to feel loved and supported. We know that parental warmth and care is associated with reduced risk of suicide (Donath et al., 2014). However, increased parental warmth as a response to a child's suicidal behaviour could act to inadvertently reinforce the suicidal behaviour. For example, if a young person is feeling unloved or unworthy of care, they may subconsciously learn that suicidal behaviour is a way of accessing more parental attention and care.

Most parents in this study opted for greater control and surveillance over their child and the parents who chose to support autonomy found this a difficult decision and then difficult to carry out. The parents who did encourage autonomy (such as encouraging young adult children

to move out or becoming less available to the young person) found it challenging. They spoke of the struggle and needing to have the conviction that it was the right thing to do.

It was clear that the parents in this study were deeply concerned about the young person's wellbeing, but in spite of this found themselves responding in ways that they recognised as unhelpful. Parents in the study spoke about acting in ways they regretted, illustrating how well meaning and loving parents can still respond in ways which are unhelpful to their child's recovery. Some parents got to a point of distress where they physically hurt their child. Physical violence is problematic and is associated with increased suicide risk (Bruffaerts et al., 2010; Zatti et al., 2017). Those parents who took part in this study are likely to be those who are willing to share these regrets and it may indicate there is worse happening in families who do not feel as open to sharing their experiences. This issue illustrates how crucial it is for parents of a young person with suicidal behaviour to get support and guidance themselves.

Finding support. This research found that while parents had some positive experiences of gaining support in their personal networks, they also detailed barriers to getting support from their family and friends. They described suicide as being a difficult topic to talk about with others. They were concerned about burdening those around them and they also felt shame and stigma. Stigma can get in the way of parents accessing support that could help them cope (Ferrey et al., 2015). When parents in this study did talk about their child's suicidal behaviour they sometimes found friends could make well-meaning but unhelpful responses. These barriers to parents utilising social supports around them could leave them feeling isolated, a finding that has been highlighted in previous qualitative studies (Buus et al., 2013; Ferrey et al., 2016a; Oldershaw et al., 2008).

Parents in this study described another barrier to social support was that they did not want to breach their child's privacy. Maintaining secrecy around suicidal behaviour in order to protect the privacy of a person at risk of suicide has also been described in other studies (Bach, 2019; Ferrey et al., 2015; Omer & Dolberger, 2015). Not feeling able to talk about the suicidal behaviour can compound feelings of isolation, fear, and powerlessness. Professional workers acknowledge the burden of supporting suicidal clients and recognise that risk overrides privacy rights (e.g, Code of Ethics Review Group, 2002; Bach, 2019). It is usually mandated that suicide risk concerns are reported so that risk concerns can be shared among professionals where support is gained. Parents, however, are generally not given such guidance and can be living with their worry 24/7. Parents may benefit from letting their concern about risk override their child's desire for privacy and asking for help when they need it. However, they may also need support to be able to negotiate this conversation with their child in a way that feels supportive for all.

Parents in this study described how speaking with other parents of suicidal children allowed them a way of gaining support, connection, and understanding. This is consistent with what was found in the existing literature (Hughes et al., 2017; Power et al., 2009; Stewart et al., 2018). The participants emphasised how different it was talking with parents who had been through similar experiences compared with their usual support from other social relationships. Only a few parents in this study had been involved in professionally run groups with other parents, but those who had been involved found them useful. For those unable to attend face-to-face groups, online support groups were seen as a way parents were able to still connect with others in a similar situation.

One finding from this study, not specifically noted in previous research, was the high value that informal online social media groups was accorded by parents. There is some existing

research indicating that peer-to-peer online support groups can be useful for parents of children with disabilities (Ammari et al., 2014), premature babies (Thoren, Metze, Bühler, & Garten, 2013), and asthma and allergies (Stewart, Letourneau, Masuda, Anderson, & McGhan, 2011). This study adds to this existing research by highlighting the use of peer-led social media groups as a means of supporting parents of suicidal young people. Participants identified many benefits to online groups. Firstly, these online groups can be available anywhere that internet is available e.g., rural communities which have a more limited amount of resources available to them. Secondly, it could be a way of connecting and building community for parents who felt unable to leave their homes, whilst watching their suicidal child. Lastly, from a public health perspective, social media groups are a cost-effective option where parents can get support without using any finance from the health budget. Online support groups could be particularly helpful in talking about an issue which is stigmatised in society. Online resources are available for parents in this position (e.g., Oxford University Centre for Suicide Research, 2016) but the interactive, informal social connection was particularly important for parents in this study.

While this study highlighted the potential benefits of social media online support groups, there were also some risks identified by participants. These risks included the possibility that discussions could be re-traumatising when parents heard about other parents' distressing experience. Parents in this study also noted that there could be difficulties when if people in their offline social life joined the online groups, threatening the sense of privacy that online interaction provides (Feigleman, Gorman, Beal, & Jordan, 2008). Furthermore, participants noted the risk that social media information could pop up at any time, which may contribute to parents becoming all consumed by their concerns and ruminating about their child's situation. Further risks could potentially arise with having parent led groups without professional

moderation. For example, parents would have to process advice from other parents that may have been helpful in different situations but was not useful for them. It may also expose parents to people with extreme views. Previous research illustrated how social media has increased the spread of inaccurate health information (Young, 2011). While there are clearly benefits for many from social media support groups, they are a relatively new modality and our understanding of potential benefits and pitfalls is limited. Further study is needed to support strategies for optimising benefits and minimising risks for these groups.

Parents in this study also spoke about how they valued being able to contribute to others going through similar experiences. Informal social media support groups were seen as one way parents were able to give back and support others. Parents being able to give back to others was a way of gaining some sense of agency and meaning in situations where most were feeling powerless to help their own child. This raised the question of whether there is more we can do to increase avenues for parents in these challenging situations to be able offer and receive helpful support from each other; where both offering and receiving can be seen as therapeutic. Lived experience expertise has been valued for a long time in the addictions field (Bassuk, Hanson, Greene, Richard, & Laudet, 2016; Valentine, 2010) and more recently in the mental health services (Davies & Gray, 2017; Noorani, 2013). Family shared experience could be an important way for parents to be able to achieve a sense of agency, purpose, and community, as well as for those to receive support, especially in the context where there are so many barriers to families utilising their existing support networks.

Finding strength. The idea of growing out of difficult life experiences is an ancient concept (Tedeschi & Calhoun, 2004). Across the themes parents in this study were shown to be active in reflecting on their own processes, adapting and trying different approaches to support

their child. They described ways of coping with the emotional difficulties such as letting go of some responsibility and being mindful to take care of their own needs. Some parents used the crisis provoked by their child's suicidal behaviour as a trigger to go to therapy and learn about themselves and their own ways of coping with emotional difficulties. Several had read a range of resources, building mastery, and had worked hard to make sense of their child's needs and their own experiences. Some parents described an increased ability to identify risks in their other younger children. These findings are in line with previous literature which identified that parents developed their knowledge and understanding of the self-harm or suicidal behaviour through their experiences (Hughes et al., 2017).

Parents talked of being active in considering their parenting approaches and changing the ways they responded to their child. Some described a walking on tiptoes approach for a while and then changing again as they anticipated their child having different needs or as guided by therapists. Some parents were able to pick up valuable new skills such as validation and described as improving their relationship with their child. Oldershaw et al., (2008) also reported that family relationships could improve following self-harm.

Parents in this study described learning to negotiate with services to advocate effectively for their child. Some described being able to contribute to their child's treatment. They were able to provide a context for their child's difficulties and also share their positive view of their child. Some described building their own support communities particularly in online forums. Parents also described using their experiences and learnings as a way to give back and support others, which helped them feel better about themselves too. Self-determination Theory (Ryan & Deci, 2017) identifies three essential human needs; relatedness, autonomy, and competence. Meeting these needs enhances people's wellbeing. Having a suicidal child undermines experiences of all

these needs as parents in this study described feeling isolated, powerless, and inadequate in their functioning as parents. This study has identified ways in which parents can be active themselves in addressing these needs. They repair loss of a sense of competence by learning about suicide and self-harm, contributing to their child's therapy and effective action in terms of supporting others. Engaging in group support processes also reduces their sense of isolation and contributes to experiences of relatedness. This research suggests that experiences of powerlessness can shift towards experiences of autonomy as parents make choices to engage in these processes.

Parents in this study also described being able to see resilience of their child as they coped with suicide related difficulties. They conceptualised the young person as strong and brave seeing them come through it all. Feeling pride in their child's ability to endure struggles was a way some parents found meaning in the difficult experience.

Some of the stories of strengths and growth that parents described fit with the concept of post-traumatic growth in terms of people shifting their priorities and finding new paths for themselves as contributing to others (Calhoun & Tedeschi, 2014). Overall, these findings prompt us to remember that while these times would undoubtedly be challenging for parents, there can be growth.

Parents' Experiences with Services Supporting the Young Person

In addition to exploring parents' experiences directly in relation to their child's suicidal behaviour, this research also explored parents' experiences of services that supported their child. This discussion draws from the five themes that were identified through the analysis: (1) it is hard to get support from services; (2) you have to fight to get help; (3) we feel on the outside; (4) we can make a helpful contribution; and (5) recognising it is hard for us too.

Parents identified a range of deficits in the services supporting their child. Key concerns they raised included difficulty accessing services, long wait times and being discharged from services before they felt it was appropriate. Problems with access to mental health services have been identified as an ongoing problem in New Zealand (Elliott, 2017; New Zealand Government, 2018), with similar complaints reported overseas (Ferrey et al., 2015; Stewart et al., 2018). The New Zealand Government Inquiry into Mental Health and Addictions: He Ara Oranga concluded that we need greater access to services for people experiencing mental health and related difficulties (New Zealand Government, 2018). Providing access to these services can, however, be difficult to do in our overstretched mental health system (Elliott, 2017).

The parents in this study described other frustrations with services such as lack of talk therapy options and constantly changing clinicians. The pressure on mental health systems and limited resourcing impacts the ability of clinical staff to work in the best practice most supportive ways for clients and their families (Elliott, 2017; Dempsey et al., 2019). In a high-pressured system, it is likely that quickest option will be favoured, and this could mean that medication or repetitive risk assessments could be prioritised over talk therapy options (Fortune & Clarkson, 2006). The experience of having multiple different clinicians described by parents in the study could in part be due to the high turnover of staff and difficulty retaining staff in youth mental health services (Werry Workforce Whāraurau, 2019).

Parents in this study highlighted the way that deficits in the system forced them to become increasingly assertive in asking for help for their children. This finding has not been clearly articulated in previous studies. Parents shared that using a strategy of being demanding or assertive meant they were able to get more care for their child. Parents feared that without their advocacy, their child would be discharged from the support when they were too unwell to attend

appointments. Parents also spoke of going to lengths to be taken seriously such as becoming ‘demanding’ or putting in complaints. This would be likely to have an emotional toll on both the parents and on the health system’s resources. For example, the parent who chose to go to a hospital emergency department in order to be taken seriously raises the concern that people in our health system needed to use more public resource for families to get mental health support. Importantly, the assertive behaviour required by these parents to get support raises the concern that people who are most unwell and in need of support may not get access to services without someone advocating for them. If this is a wider pattern in our mental health system, it raises questions about equity of resources and who in our communities are most likely miss out. Certain cultural groups, for example, may be less likely to be assertive with health professionals as they are generally more deferential to authority figures (Davis & Konishi, 2007; Hofstede, 2011). The participants in this study included professionals who have resources, knowledge and power to be able to negotiate the mental health system and be assertive. Disempowered members of society, such as those from ethnic minorities or those who are less educated, may be intimidated by medical professionals and less likely to confidently assert their rights (Kalyanpur, Harry, & Skrtic, 2000; Trainor, 2010). This is concerning as disempowered groups, such as some cultural minorities or those living in deprivation, can be at greater risk of suicide (Ministry of Health, 2019b) and may be less likely to assertively request support. Also, it seems important that resources are allocated where they are most useful rather than to the most assertive families. Parents are struggling with the job of parenting effectively and this is where their energy is most needed. Raising issues can lead to damaged relationship in professional settings (Rothschild, 2008), and parent advocacy can cause issues with parent relationships with schools (Hess, Molina, & Kozleski, 2006). It may also make it harder for parents to build an effective

therapeutic relationship if they are in the role of fighting for their child to be seen. This is not a good basis for a positive parent-clinician collaboration.

Societal inequality of mental health care was also reflected in parents' discussion of the decision to pay for private mental health support. The financial burden of not having needs met through the public system is also recognised in a qualitative UK study (Ferrey et al., 2015) which described the lack of funded talk therapy, immediate response, and residential treatment. There are double the number of fatal suicides in the poorest parts of New Zealand compared to the wealthiest (Ministry of Health, 2019b). The idea that some young people get better care than others could be seen as out of line with New Zealand values of equality and providing access to health treatment for all (Liu, 2005). The serious implications of inequality were illustrated by the mother who wondered if she could have saved her daughter's life if she had the money to pay for residential treatment.

The parents in this study highlighted how they want greater involvement with the services supporting their child. They described how they often felt on the outside and not listened to, an experience which is consistent with the existing literature (Lindgren, Astrom, & Granehem, 2010; Rose, 2011; Stewart, 2018). Parents feeling that they have little guidance when they leave a service is also consistent with the report that less than half of people being released from inpatient care have a discharge plan (Allan, 2018). The parents recognised that youth services tended to include more family involvement, but they noted that this was particularly rare in adult services.

The Government Inquiry into Mental Health and Addiction; He Ara Oranga, also found that family often felt excluded in their loved one's treatment and wanted to be more involved (New Zealand Government, 2018). While none of the participants in the current study identified

as Māori, family involvement is particularly relevant in the New Zealand context where the indigenous Māori population emphasize the importance of family/whānau in healing processes (Te Rau Matatini, 2015). This research indicates that if services in New Zealand became more culturally responsive it could potentially benefit those not from collectivist cultures. It has previously been found that including cultural elements, such as whānau involvement, in treatment programmes can be just as beneficial to non-Māori as to Māori (Nathan, Wilson, & Hillman, 2001).

Through the themes it emerged that parents were conflicted between their wish to be guided by clinicians versus wanting to be seen as an expert about their own child and family. This could prove to be a difficult dialectic for clinicians to negotiate. Parents know their child best and can contribute their knowledge of the child in their home environment to clinical situations in helpful ways (De Los Reyes et al., 2015). Despite this unique ability to contribute, parents in this study felt their perspectives were not valued or listened to which may represent a missed opportunity. However, while parents wanted to be acknowledged as the experts of their own family, they also expressed a need for clinical guidance. The parents described times where they felt out of their depth regarding their child's suicide risk. Some felt that at these times they were treated as though they could manage because they knew their child best. Parents and clinicians can therefore find themselves in a difficult dilemma where parents are both the expert and also desperately seeking assistance for the safety of their family. This requires careful navigation and clinicians working with families of suicidal youth may find it useful to hold simultaneously the possibility that parents can be experts and be in need of assistance.

What parents found helpful varied across their descriptions; thus, it is a difficult area for health professionals to work in when different approaches worked for different parents. Some

parents talked about wanting guidance in the ‘storm’ and some wanted clinicians to sit back and listen. Some commonalities, however, across the parents was desire for sensitivity to their experience. It might sound like a simple task for clinicians to validate, support, and take parents views seriously, and it is likely that many clinicians feel that they do work in this way. However, in practice it is clearly not a consistent experience for the parents engaging with services. Many parents walk into mental health services already feeling self-judgement and that it was their flaws which contributed to their child’s suicidal behaviour. So, regardless of how a staff member acts it is possible these expectations of negative judgement are projected onto them. Rutherford (2005, as cited in Buus et al., 2013) also hypothesised that parents could become angry and critical with professionals as a subconscious way of protecting themselves from further guilt that they could have contributed to their child’s suicidality in some way. However, staff may unwittingly contribute to the parents’ feeling that they are to blame. For many in mental health or psychology training, our ways of understanding difficulties emphasize how parents contribute to their child’s difficulties. For example, there is the idea of invalidating environments in DBT (Linehan, 1993), core beliefs shaped by parents in CBT (Beck & Beck, 1995), and insecure attachment due to parenting behaviour in attachment theory (Bowlby, 1952) amongst others. These ways of understanding seep into clinician’s ways of conducting assessments and frame the questions they might ask. Given parents’ likely sensitivity to these nuances, clinicians need to take extra care to help parents not feel judged, and to offer a compassionate understanding of the difficulties they face.

Being sensitive to parents’ experiences can also be challenging when clinicians are dealing with their own emotional responses to suicide risk. Professionals working with suicide experience a sense of burden for caring for self-harming patients (Wilsrand, Lindgren, Gilje, &

Olofsson, 2007), and some professionals can see clients with suicidal behaviours as ‘hopeless cases’ who take resources from those who were ‘really ill’ (Wilstrand, et al., 2007). UK research found that there was a tendency among mental health staff to distance themselves from clients who self-harm, and from their families (Smith, 2002). Clinician’s emotional responses could get in the way of clinician’s providing the validation that parents require. Alternatively, clinicians could be focusing on the emotions and experience of the young person with less attention paid to validating the experiences of the parents. This corresponds with parents’ accounts of the focus on the young person as the client, while they occupied a role on the periphery.

Despite the challenges parents experienced in their engagement with services, they were also able to acknowledge what they found helpful. Across the themes of the second section of the analysis, much of what parents found useful was related to talk therapy, particularly DBT. They noted aspects such as learning the skill of validation, having a phone line and skills groups (with their child or just as the family member) as being particularly helpful. This indicates further support for usefulness of DBT as an approach with youth at risk of suicide as well as for having parents included in the programme.

Overall this study highlights how a young person’s suicidal behaviour has significant impacts on the parents and wider family. From a systemic perspective, parents’ experiences are very important as they often play a significant role in the young person’s life over many years or decades and they can both contribute to difficulties and be part of the recovery process. This research illustrated how when parents’ wellbeing is impacted negatively it has flow on effects into how well they can support their child. Despite the crucial role parents play in young people’s lives they can often be ignored or overlooked by professionals, particularly when the young person transitions into adult services.

This research added a unique contribution to the existing knowledge in a few areas, such as identifying the potential support value of social media groups for parents of a suicidal young person and finding that being assertive or ‘demanding’ was a necessary strategy in accessing mental health support for their child. Parents in this study also described issues which have previously been identified in research such as the need for easier access to services, shorter wait times, reduced strain on staff in the pressured system and increased family involvement (Allan, 2018; Elliott, 2017; Fortune & Clarkson, 2006; New Zealand Government 2018). While there are ways that people are looking to improve these issues, it is unlikely that change will be a quick process as these issues have been ongoing. What this study offers is some smaller practical suggestions that clinicians who work in the pressured system can attempt to implement, outlined below.

Implications for Psychological Intervention

There are several practical implications indicated from the findings for professionals working with suicide risk. This study suggests that parents could be more involved in treatment for suicidal youth and that they would appreciate support referrals, and validation of their emotions. Additionally, this study indicated the need for greater access to services, including talk therapies, and the need to reduce pressures on the professionals trying to support young people at risk of suicide.

The main implication for clinicians working with suicidal young people is to consider the role of the parents. Intervention studies indicate that involving parents make treatment more effective for suicidal young people (Brent et al., 2013). This study supports that parents do want to be involved and that it is important for clinicians to understand ways that they want to contribute to their child’s recovery. For example, parents can be used to contribute information

about the child's context, and to receive guidance about how to best support the young person outside of the therapy room.

The findings from this study can contribute to the education of clinicians about the range of emotional responses that are common amongst parents who are supporting a suicidal young person. The findings of the study underline the importance of communicating with parents in an empowering way. Increasing sensitivity to judgmental language, unintentional judgments and respectful acknowledgement of the efforts parents make are likely to address challenges parents identified in this study. The simple act of validating parents' emotional responses could assist therapists in engaging the parents. This study suggests there could be a need for training that goes beyond 'risk assessment' and offers clinicians an opportunity to explore and challenge their own emotional responses related to clients who self-harm. This could be valuable in lessening the risk of unintentional judgment on the part of the clinician.

Given that parents appreciated being referred for support in their community, clinicians could consider identifying supports in their area and referring parents to them if possible. Online support groups on social media could be one option for support, particularly for parents feeling alone or isolated. Services could consider how to make better use of online support.

The findings indicated DBT was highly valued by parents, suggesting that modalities already employed by services are working for parents too. It would be good for services to continue existing DBT programmes, or to consider starting them up where possible. Even where full DBT programmes are not practical, some specific skills could be helpful such as acceptance skills within the parent role, to be able to let go of feeling overly responsible while remaining present. Clinicians could also consider teaching parents the skill of validation, as this was a piece of

guidance particularly valued. Parents could benefit from being given access to this training as part of a standard approach.

Given the concerns that parents experience about repeat self-harming behaviour or even suicide, it would be useful for clinicians to explore some of these fears and anxieties. Clinicians might encourage parents to speak about their fears of their child dying. They could provide skills to help parents prepare to cope as effectively as possible with an anticipated stressful future event. Clinicians could consider using Linehan's (2014) 'cope ahead' skill to help parents who may be struggling to navigate their feelings of powerlessness and losing hope. It could help them to accept the distress and move towards agency.

It could also be useful for clinicians to talk with parents about boundaries and the balance between surveillance and encouraging their child's autonomy. It could be useful to offer information to parents on how inadvertent reinforcement of suicidal behaviour can easily happen in the context of caring and loving parenting. Clinicians should attend carefully to the balance between listening to parents and supporting them to make their own decisions from their own expertise and the clinician offering expertise. Parents described difficulty with some of the guidance given. The process of offering guidance or supporting parents to find their own solutions could be supported by seeking structured feedback in the way Scott Miller recommends (Miller, Duncan & Johnson, 2000). However, even highly attuned clinicians can never get it right all the time and providing a way for parents to get feedback on how they are managing this balance could limit any loss of rapport. It would be important for clinicians to remain mindful that families have different needs.

It could be helpful to provide public information about the range of factors that can contribute to suicidal behaviour and for clinicians to refer parents to information that may help

them make sense of their child's behaviour. More information on what causes suicidal behaviour, and ways to make sense of their child's experiences could help parents through shock. It could be that making sense of reasons for self-harm or suicidal behaviour could lead to reducing the guilt or shame that parents feel. As with other research, parents in this study stressed that information needed to be trustworthy and relevant (Hughes et al., 2017). The parents also indicate we would need information on understanding suicide to be delivered in a way that is compassionate to the parent.

For clinicians and family members, it could be useful to offer time to reflect on what strengths have come out of the difficult time in their family. Where there could be possibilities of growth or finding new ways of connecting and finding agency. Exploring strengths could be a way that clinicians can help parents feel they are part of the solution rather than part of the problem.

There are also broader implications for policy, service provision and funding decisions. This study is among others which highlight the need for better access to mental health services in New Zealand (Elliott, 2017; New Zealand Government, 2018). Services with limited resources can only stretch so far and increasing access to entry to the service is often associated with early closure of cases or limited quality of service provided for people in the services. Parents in this study indicated they wanted more talk therapy options, which is consistent with the New Zealand Inquiry into Mental Health and Addiction; He Ara Oranga (New Zealand Government, 2018). Providing more funded talk therapy options could assist more parents to access the support they want for their family rather than leaving it to those who can afford to seek it privately.

This research indicates that further funding for parent support groups could be beneficial. It is a way of helping the family to manage their own wellbeing, as well as better resourcing the

young person. The better the family is coping the better they can support a young person in crisis. It could be particularly important in situations where a young person was not wanting to engage with formal supports. Working with parents is itself an intervention for the young person. The young person is embedded within their context, and the suicidal behaviour may be a symptom of issues in their wider context including the parents' experiences. Involving parents in an intervention strengthens the whole family unit. Supporting the whole family is consistent with Māori perspectives of health, where treatment is at the whānau (family) level, not just pathologising or individualising the young person (McLachlan, 2008; Te Rau Matatini, 2015).

Overall, this study adds another voice to the many which are asking for more access to services, more talk therapy options, and greater involvement of family/whānau. This study also offers small practical suggestions that clinicians who work in the pressured system can attempt to implement such as being more conscious to validate parents' emotions. Having a greater awareness of the issues parents face in supporting a young person at risk of suicide can guide the ways that clinicians support these families.

Strengths and Limitations

This was a qualitative study which allows complex issues to be explored and new ideas to be found (Guest et al., 2011). A strength of having the qualitative methodology was the in-depth interviews which enables a more comprehensive understanding of experiences and an ability to clarify participants meaning than could be provided by other methodologies such as surveys. Parenting a suicidal child is a topic filled with complexities and using a qualitative approach allowed multiple aspects to be explored with greater detail including the emotional impacts, family changes, coping strategies and recovery process from the perspective of the participant themselves.

This study had a relatively small number of participants. Small scale qualitative research of this kind is not intended to lead to statistical generalisations from the data, but rather to increase the depth of understanding of the experience of parenting a young person at risk of suicide. It has been suggested that around twelve participants can be used to effectively reach saturation in qualitative research (Guest et al., 2006; Morrow, 2005). However, the characteristics of the sample do limit the range of experience that might have been elicited. The make-up of the sample was mostly mothers, which is consistent with the overrepresentation of females in psychological research (Phares, Lopez, Fields, Kamboukos & Duhig, 2005). A further limitation was the limited range of ethnicity of participants. This is particularly important because of increased suicide risk among Māori and Pacifica youth (Teevale et al., 2016; Ministry of Health, 2019).

The self-selection recruitment process meant that participants were also likely to be particularly conscientious, thoughtful, or open parents willing to explore an uncomfortable topic. Interestingly, a significant portion of the sample had professional or academic knowledge of self-harm or mental health. This could be a limitation as they have more knowledge to draw on, and greater power themselves in the health system due to that knowledge. Therefore, they may not represent the experiences of parents who do not have access to those resources. Nonetheless, with access to knowledge of the health system they were able to make useful critical comments about how it works, and had strong ability to express themselves through language, including conveying complex emotional reactions.

Directions for Future Research

There are a range of directions in which future research would be able to take. The broad focus of the research meant that not all areas could be explored in great depth. One area which

warrants further research is the use of social media support groups for parents of a suicidal child. It could be useful to get an understanding of parents' experiences as well as an analysis of the content in the group. It could be useful to explore what types of issues get discussed, what type of support or advice is offered, and whether concerns would arise in groups without professional moderation. This could lead to better understanding the ways parents are supported and utilising social media in supporting their child. It could also be useful to explore what online information is available on the internet, and how parents use it.

As parents in this study were New Zealand European, or of Caucasian descent it could be useful to get the perspectives of different demographic groups. Suicide has different meanings across cultures (Chu et al., 2017; Pumariega & Sharma, 2018) and particularly given the range of cultures in the New Zealand context it would be useful to gain understanding of the parent experiences among different ethnic minorities.

This research indicates that suicidal behaviour has large impacts on parents and the wider family. Future research could explore the ways siblings were impacted and coped with having a sibling engaging in suicidal behaviour. Parents in this study described ways their parenting changed and how siblings were impacted, so future research could explore siblings' experiences from their own perspectives. As this study and others have had difficulties recruiting men, it could be interesting for research specifically with fathers.

This research identified some of the unique ways that parents who worked with mental health or suicide in the professional roles could draw on their experiences in their professional work. Future research could specifically target parents who work in the mental health/suicide field to better understand how parents manage the parallels of professional and personal lives.

Conclusion

Being a parent of a young person engaging in suicidal behaviour can cause great distress. This study, alongside other research, identifies a need for parents to be considered as clients in their own right. We also know young people are hard to engage with formal support, and parents can be important sources of support, so it is important for services to work with parents as part of the solution.

APPENDICES

Appendix A: Research Advertisement

SCHOOL OF PSYCHOLOGY
Faculty of Science



Parents and Suicide Risk

Have you cared for an adolescent who you felt was at risk of suicide?

Parenting an adolescent who has talked about suicide or even attempted it is not an uncommon experience. Even so, many parents describe feeling isolated. I'm interested in hearing about your experience, and your advice for other parents in a similar situation. Your contributions to this research could help to support parents of at-risk adolescents in future.

My name is Clare Stanton and I am a Clinical Psychology Doctoral student from The University of Auckland. I am currently carrying out research exploring the experiences of parents who have cared for a young person who engaged in suicidal behaviour (e.g., suicide attempts or talking about suicide). I am interested in hearing about how the suicidal behaviour affected you and your family. I would also like to know about what was helpful or unhelpful in coping with the experience. Participation will involve private one-to-one interviews and your information will be kept confidential. A \$30 voucher will be offered to cover travel.

You can take part in the study if: You have parented a teenage child who has been suicidal. If your child was under the age of 18 when this occurred. If this happened within the last 10 YEARS. Because I am focusing on how parents have coped with this experience in the past, we will not be interviewing parents who are currently in a care giving role for a teenager who actively carries out suicidal behaviour.

From this research I am aiming to produce a set of recommendations to be shared with parents and clinicians working with families of a suicidal adolescent.

Please contact me: Clare Stanton on 021 2338726, csta064@aucklanduni.ac.nz, or
<http://clareannestanton.wix.com/parentsandrisk>

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS
ETHICS COMMITTEE ON 11/12/2015 for 3 years, Reference number 016236

Appendix B: Participant Information Sheet



27 September 2015

PARTICIPANT INFORMATION SHEET FOR PARENTS

Parenting adolescents who engaged in suicidal behaviour

Principal Researcher: Clare Stanton

Supervisors: Fred Seymour and Kerry Gibson

Dear potential participant,

My name is Clare Stanton and I am a Doctoral student from The University of Auckland, School of Psychology. We are currently carrying out research to better understand the experiences of parents who have cared for a young person who has been suicidal.

About the Study

The main aim of this study is to better understand the experience of parenting an adolescent at risk of suicide in order to better support parents through this process. We are interested in hearing about how the suicidal behaviour affected you and your family. We would also like to know what was helpful or unhelpful in coping with the experience. We would also like to hear what advice you would give other parents in a similar situation.

Participation

We are interested in hearing from parents who have cared for an adolescent who was suicidal within the last 10 years. The suicidal behaviour (e.g., attempting suicide or talking about suicide) must have occurred when the child was under the age of 18. Because we are interested in how people have managed this situation in the past, we will not be interviewing parents who are in a care-giving role for a teenager who is currently engaging in suicidal behaviour. If you meet these criteria, then you are invited to take part in this study.

I will conduct the interviews face-to-face or over skype. Each interview will be audio taped (with your consent). The tapes will later be transcribed (by either myself or an approved Transcriptionist). You may stop the interview or ask to have the audiotape switched off at any time and do not have to answer all of the questions. The interviews will be approximately 60-90 minutes long and we can do these at a time and place to suit you. We can provide a private room on the University of Auckland City or Tamaki campuses, or meet you at a location of your convenience.

There will also be an option to take part in a second interview between one week and two months after the first. This is to allow a chance to reflect on any thoughts you have had about the first interview or say things that may not have come to mind during the initial interview.

Transcripts will be made available to you upon request. You will have an option to request these on the consent form, or in writing to myself. If you would like to check and edit the transcript content, then the request must be made within two weeks following your participation. You have the right to change the transcript within a two-week period following its receipt.

Confidentiality:

Your decision to participate in this research (or not) and all personal information collected from you will remain confidential to the researchers. Our research focuses on your experience of parenting an adolescent at risk of suicide, but we appreciate that talking to us about that may involve disclosure of information about your child and other members of your family. The information will be subject to limitations on confidentiality explained below. Transcriptions of interviews will be de-identified (i.e., stored using a code number and not your name). Your name will only appear on the consent form, which will be stored separately from transcriptions. All information collected during this research will be stored in a locked filing cabinet and in password-protected electronic files for six years following publication of research findings. It will only be accessible to the researchers. After six years, all data will be destroyed (paper records will be shredded and electronic files will be permanently deleted).

Research findings will be published in the form of research reports and may be published in academic journals and presented at international conferences. Identifying information will be changed, and a pseudonym given to any of your data used in publications arising from this research. This means that your identity will never be made public.

Withdrawal

You are free to withdraw from the project at any time without giving reasons. You may also withdraw any data related to you until two weeks after participation, or up to two weeks after receipt of your transcript (should you request this). In this case please contact a member of the research team, and any electronic files and/or documents related to you would be deleted and/or shredded.

Risks of participating

We hope that talking about your experiences will be helpful to you and to others. However, given the sensitive nature of this research it is possible that you may experience some distress. In the event that talking about the experience is very distressing for you, you will be able to discuss this with me and I can assist you to seek further support should you want it. Further support could include a referral to counselling or mental health services. You are also welcome to pause or discontinue the interview at any point.

If you anticipate that taking part in this research could cause significant distress, please think carefully about the decision to participate.

If you tell us about anything that makes us concerned about the safety of yourself or anyone else, we would be obliged to report this to a relevant authority or service.

What are the benefits of participating?

We hope that this research will be useful to parents in a similar situation to what you experienced, and also to clinicians working with such parents. The results of this study will be disseminated to appropriate parenting and community networks, and mental health clinicians. A list of recommendations will be created for clinicians working with families. It is hoped that this research will support clinicians to provide a better service to parents of adolescents at risk of suicide. As such, your participation may help to lessen the difficulties of parents going through experiences similar to your own.

You will also be offered a \$30 petrol voucher in order to cover transport costs.

Research findings

You are welcome to a summary of the research findings (please indicate on the consent form whether you would like to receive a copy).

Thank you for making the time to read about and consider taking part in this study. If you have any questions or would like to discuss participation, please contact:

Clare Stanton,
021 2338726, csta064@aucklanduni.ac.nz, School of Psychology (Tamaki Campus), The University of Auckland, Private Bag 92019, Auckland.

For any other queries you may contact

Professor Fred Seymour (supervisor)
School of Psychology
The University of Auckland
Ph. 09 923 8414
f.seymour@auckland.ac.nz

Professor William Hayward (Head of School)
School of Psychology
University of Auckland
E: w.hayward@auckland.ac.nz
Tel: 09 373 7599 ext. 88516

For any queries regarding ethical concerns you may contact the Chair, The University of Auckland Human Participants Ethics Committee, The University of Auckland, Research Office, Private Bag 92019, Auckland 1142. Telephone 09 373-7599 extn. 87830/83761. Email: humanethics@auckland.ac.nz

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON 11/12/2015 for 3 years, Reference Number: 016236.

Appendix C: Participant Consent Form



PARENT CONSENT FORM

This form will be held for a period of 6 years following publication of research findings

Parenting Adolescents who engaged in Suicidal Behaviours

Principal Researcher: Clare Stanton

Supervisors: Fred Seymour and Kerry Gibson

I have read and I understand the Participant Information Sheet for the study designed to better understand the experiences of parents of adolescents who engaged in suicidal behaviours. I understand the study, and have had the opportunity to ask questions and had them answered to my satisfaction. I have had time to consider whether to take part. I understand that participation involves being interviewed for approximately one hour and that taking part in this study is voluntary (my choice).

- I agree to take part in this research.
- I understand that I am free to withdraw my information at any time up to two weeks after participation without giving a reason.
- I understand that interviews will be audio recorded and transcribed. I understand that I can stop the interview, choose not to answer particular questions or have the audio recorder turned off at any point.
- I understand that a transcriber who has agreed to a confidentiality agreement will transcribe the audio recording of my interview. This transcript will be coded with no identifying details.
- I would like to receive a copy of the transcription Yes/No (please circle)
If Yes, please provide an email address: _____
- I understand that I am able to edit the transcription and return the edited version to the researchers within two weeks of receiving the transcription.
- I understand that all personal information collected from me will remain confidential to the researchers and that no identifying information will be published.
- I understand that data from this research may be used in Clare Stanton's doctoral thesis, academic publications, reports and/or presentations.
- I understand that this consent form will be stored separately from my interview data in a locked filing cabinet at the University of Auckland for a period of six years and then

destroyed

- I understand that all data will be securely stored for 6 years following publication of findings, after which they will be destroyed.
- I understand that if I disclose any issues related to the safety of myself or others, the researchers are obligated to report this to the relevant authorities or services.
- I am aware that I may find participation in the study distressing and that referral to a supportive service can be made if I am experiencing distress.
- I understand that I will be offered a \$30 voucher in acknowledgement of my participation.
- I would like to receive a summary of the research findings Yes/No (please circle)
If Yes, please provide an email address: _____

Name: _____

Signature: _____ Date: _____

APPROVED BY THE UNIVERSITY OF AUCKLAND HUMAN PARTICIPANTS ETHICS COMMITTEE ON
11/12/2015 for 3 years, Reference Number: 016236

Appendix D: Semi-Structured Interview Schedule

Interview Schedule

Welcome, introduce the study, discuss confidentiality and sign consent forms

Learn a little about the family – perhaps do a genogram and find out who's living in the home

The interview will start with an open question such as; can you tell me about your experience?

Then I will more specifically ask around the three topic areas below: their experience, the relationships in the family, and support/coping. Below are the questions guiding my interview, however they will not necessarily be asked in this order.

1. Their experience:

- How did you find out about your child's suicidal behaviour? (I will not ask about specific details of the child's behaviour)
- What did you do? Or how did you react?
- What was the emotional impact of your child's DSH on you?
- Can you tell me how this has affected your/your family life or daily routines in anyway?
- How has your child engaging in suicidal behaviour affected how you think or feel about yourself?

2. Relationships in the family:

- How would you describe your relationship with [child]?
- How was it before the suicidal behaviour, how has it changed?
- How close to your child did you feel before? And Now?
- Have there been there been times when you've felt able to support the child?
 - o How did those go? What support were you able to offer?
- What has been helpful for your relationship since the SB?
- What has helped you cope with the relationship changes? Or what helped you keep the positive relationship?
- How have relationships in the rest of the family been affected? (e.g., prompt, siblings, partner etc)

3. Support/coping

- What things have made it easier for you and your family?
- What would have made it easier for you and your family?
- What type of support for your child have you noticed working well/being helpful?
- What things have made it harder / didn't help you and your family following the suicidal behaviour?

- Did you seek support and advice? (if not, what stopped you?)
 - o Where did you go to seek it? (friends, family, mental health services, internet – explore each if relevant)
 - o What support and advice was available to you?
 - o What about this was useful or not?
 - o Looking back, what support would you have liked for the family, yourself, or for the young person?

Closing

What is some advice you'd have for another family going through a similar experience? (Or advice you wish you had been given?)

Is there anything else you'd like to say or anything you'd like to let us know?

How has this been for you?

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