"I am scared of what I might do to myself":
Young People's Communication about Suicide on a Text Message Counselling Service

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Abstract

This research used a qualitative methodology to explore what young people experiencing suicidality communicated about their experience via a text message counselling service. The aim was to identify the reasons young people gave for feeling suicidal, their experience of suicidality, the barriers that prevented them from seeking support, and why they were reaching out to a text message service whilst in crisis. The data consisted of 125 text message counselling transcripts where the young person was experiencing suicidality. These were obtained from Youthline's text message counselling service, which were collected as part of their normal service delivery. The data was analysed using thematic analysis. The analysis found that in a moment of crisis young people experiencing suicidality identified multiple difficulties across different domains which contributed to why they were suicidal, the experience of suicidality was dynamic and heterogenous, the ambivalence and uncertainty young people had about suicide, difficulties in communicating their suicidality, help-seeking barriers that were reflective of young people's unique needs and wants, and the value of text message counselling as a medium through which they could seek help. Utilising the perspectives of young people experiencing suicidality and prioritising their voice should be a key component of youth suicide prevention strategies.

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Introduction and Brief Overview of the Study

The high rate of youth suicide in New Zealand (NZ) is well-documented (Clark et al., 2013; Heled & Read, 2005). Findings from the Global Burden of Disease Study indicate that when compared to 18 other developed countries, NZ had the highest rate of youth suicide among 15 to 19 year olds from 1998 to 2016 (Shah et al., 2019). Despite the immense effort which has been directed towards suicide prevention, the rate of youth suicide in NZ continues to be identified as a major health issue (Ministry of Health, 2019a). Young people's help-seeking and engagement with support for their difficulties has historically been poor (Michelmore & Hindley, 2012; Rickwood et al., 2005). This is an issue, as adequate support is a salient factor in reducing the risk of suicidality among youth (Rickwood et al., 2005). However, young people have responded well to support services, which have adapted to meet the immense changes in technology and digital landscapes (Gibson & Cartwright, 2014). In particular, text message counselling has been identified as meeting many of their needs, but little is known about how youth experiencing suicidality use these services and what they value about them (Gibson et al., 2016).

While there is a considerable body of research which has explored youth suicide, academics argue that this literature has focused on conducting research *on* young people, as opposed to *with* them (Balen et al., 2000). Consequently, there is a dearth of research which prioritises the voice of young people and their communicated experience of suicide (Bennett et al., 2003; Lake et al., 2013). I was therefore interested in further understanding youth suicide, from the perspectives of young people themselves.

In my research, I analysed the transcripts of text message interactions between young people experiencing suicidality and their counsellors. These text message counselling interactions were conducted as part of a service offered by Youthline, a youth development agency, which provides free text message counselling to young people in NZ (Youthline, n.

d.). Young people's real-time communications of suicidality on a text message counselling service offered a unique opportunity to explore the reasons they gave for feeling suicidal, their experience of suicidality itself, and what helped or hindered their help-seeking.

This thesis is comprised of four chapters. Chapter One reviews the relevant literature related to my research. In Chapter Two, the methodologies of the study are outlined, including the theoretical framework, methods, and thematic analysis steps. Chapter Three consists of the results, where 30 themes across the four research questions are discussed. Finally, in Chapter Four, the findings are reviewed in detail, along with outlining the study's clinical implications, limitations and strengths, and recommendations for future research.

Chapter One: Literature Review

The aim of this literature review is to provide context for my research. In this review, I consider the key research findings related to youth suicide and factors that influence suicidal young people's help-seeking and engagement with support. Firstly, I discuss the high rate of suicide and mental health difficulties among young people, drawing attention to this important issue. Secondly, I locate these statistics in contemporary youth culture, highlighting from developmental and social-cultural perspectives how young people's experiences and understandings of suicidality are shaped by the context. Thirdly, the reasons for youth suicide are reviewed, emphasising how the risk factor research has informed models of suicide, whilst arguing that more research that prioritises young people's perspectives is needed. Fourthly, I explore research into the experience of suicidality among young people by reviewing the prevalence and course of the phenomena, whilst highlighting gaps in the literature. Fifthly, I examine help-seeking barriers for both informal and formal sources of support among young people who are experiencing suicidality. Sixthly, engagement with formal support services among young people experiencing suicidality is discussed, with a focus on elucidating the distinct needs and priorities of suicidal youth when they engage with support services. Lastly, I examine the changes in the psychological support context to meet young people's needs when seeking and engaging with support, with an emphasis on text message counselling.

Youth Mental Health and Suicidality

The World Health Organisation (WHO) defines young people as those between the ages of 10 and 24 (Ministry of Health, 2002). Suicide remains a major global health concern among this age group (Pelkonen et al., 2011; Shah et al., 2019). In the following section, I define suicide before reviewing statistics related to young people's mental health and suicidality, highlighting how this group may be particularly vulnerable to experiencing suicidality.

In NZ, the classification of a death as a suicide is determined by the coroner's findings, with suicide being defined as the act of intentionally taking one's life (Ministry of Health, 2013; Ministry of Health, 2019a). However, the definitions of suicidal and self-injurious behaviours have changed over time and vary among researchers and clinicians (Asarnow & Miranda, 2014; Jacobson & Gould, 2007). Thus, there is considerable debate as how to best define suicide-related behaviours (Nock, 2012; Silverman et al., 2007) and in particular, how to differentiate between suicidal behaviour and deliberate self-harm with no suicidal intent (Fliege et al., 2009; Hargus et al., 2009; Jacobson & Gould, 2007).

A widely accepted definition of a suicide attempt is a non-fatal self-inflicted behaviour with at least some inferred or explicit intent to die (Silverman, et al., 2007). Some researchers argue that the major distinction between a suicide attempt and deliberate self-harm is based on whether the behaviour was motivated by a desire to end one's own life (Nock, 2010; Nock & Kessler, 2006). Deliberate self-harm with no intent to end one's life has been defined as non-suicidal self-injury (NSSI). Although previous research has focused on adult populations, the limited studies which have examined young people who attempt suicide and those who engage in NSSI indicate that there are a number of differences between them (Jacobson & Gould, 2007). For example, research has found that suicide attempts and NSSI among young people differ in regards to the function of the behaviour (Baetens et al., 2011), response to treatment (Ougrin et al., 2015), method use (Rodham et al., 2004), and help-seeking (Baetens et al., 2011; Michelmore & Hindley, 2012). To further understand youth suicide, it is recommended that NSSI and suicide are examined separately (Chapman & Dixon-Gordon, 2007; Jacobson et al., 2013). For the purpose of my study, I defined suicidality as all behaviours and thoughts, including suicidal ideation, attempts, completion, and communications where there was some intent to die (Cash & Bridge, 2009).

It is well-documented that the risk of suicidality increases dramatically during adolescence (Fombonne, 1998; Gould & Kramer, 2001; Hawton et al., 2012; Pelkonen et al., 2011). In line with global findings, the highest rate of suicide in NZ has consistently been reported in the youth age group (Ministry of Health, 2013; Shah et al., 2019). For example, data from 2013 shows that the overall suicide rate was 11 deaths per 100,000 people, but the youth suicide rate was 18 per 100,000 people (Ministry of Health, 2013). Accordingly, young people have been identified as being a particularly vulnerable group, with suicide being the second leading cause of death worldwide among those between the ages of 15 and 29 (World Health Organization, 2014). However, data from the Ministry of Health indicates that from 1996 to 2016 the youth suicide rate decreased significantly from 25.9 per 100,000 to 16.8 per 100,000 (Ministry of Health, 2019b). Despite this decline, when compared to other developed countries NZ continues to have one of the highest rates of youth suicide, which has been identified as a major health concern (Ministry of Health, 2013; Shah et al., 2019).

It is widely recognised that the youth life stage is associated with its own distinct array of health concerns and problems (Dubow et al., 1990). Globally, research indicates that young people have the highest incidence and prevalence of mental health issues across the lifespan (McGorry et al., 2013; Pelkonen et al., 2011). For example, through anonymous online surveys in a community sample of NZ young people, Clark and colleagues (2013) found that 38% of females and 23% of males reported experiencing low mood for at least two weeks over the previous 12 months, with 16% of females and 9% of males experiencing clinically significant symptoms of depression.

Collectively, these findings suggest that suicidality and mental health difficulties are critical issues among young people. Consequently, improving the mental wellbeing of young people, both nationally and globally, is an important area that warrants further attention (Pelkonen et al., 2011).

Understanding Suicidality in Context

In order to contextualise the above statistics, it is important to understand what it means to be a young person today and the factors that might contribute to suicidality in this group. In this section, I discuss why it is important to locate young people's experience of suicidality within youth culture. I then explore traditional psychological theories of developmental understandings of youth and how this may influence their vulnerability to experience suicidality. Lastly, social-cultural perspectives of young people, which emphasise the importance of context in meaning-making, are reviewed.

Suicide has been conceptualised in a number of different ways throughout history, with the context influencing how understandings of the phenomena are shaped and mediated (Bourke, 2003; Colucci, 2006; Szasz, 2002). As a result, understandings of suicide are thought to be engrained within the culture and structures of communities, which ultimately influences how suicidality is experienced (Fullagar et al., 2007; McDermott & Roen, 2016; Philo, 1996). It is therefore important to locate young people's experience of suicidality within youth culture in order to fully understand the phenomena (White et al., 2016). Like suicide, the concept of youth is also argued to be a social construct (White & Wyn, 2012; Wyn & White, 1997). Consequently, there are different ways of conceptualising youth and youth culture, which informed the findings of my research (White & Wyn, 2012).

From a traditional developmental perspective, youth is generally understood through the concept of 'adolescence', which is regarded as a period of complex biological, socio-emotional, psychosocial, and cognitive development as young people shift into adulthood (Steinberg, 2005). It is thought to be a developmental phase defined by transition as young people negotiate intrapersonal and interpersonal changes within a context of changing family, peer, and school environments (Sauter et al., 2009).

It is well-acknowledged in the developmental literature that this life stage is when young people seek autonomy from their family (Bandura, 1972; Erikson, 1968). Due to this developmental task of individuation, young people are argued to place importance on control, agency, and self-reliance (Santrock, 2015; Lerner & Steinberg, 2004). Youth is also recognised as a developmental period where young people's need for attachment, acceptance, and connection shifts from their family to their peers, and intimate relationships become important (Buhrmester, 1996; Goossens, 2006; Parkhurst & Hopmeyer, 1999). Moreover, young people's value on being social and having meaningful connection with others has been well-documented (Heinrich & Gullone, 2006; Schinka et al., 2012). Due to the importance youth place on social acceptance, they may be vulnerable to negative social influences, such as ostracism, stigma, and meeting the expectations of others, which may influence their experience of mental distress and suicidality (Heinrich & Gullone, 2006; Holmbeck et al., 2006; O'Connor et al., 2009).

Youth is also posited to be one of the most influential periods of identity formation and consequently when identity issues are intensified (Erikson, 1968; Steinberg, 2005). It is a time when young people are argued to navigate the crisis of identity versus role confusion, as they make sense of who they are while they individuate from their family (Erikson, 1968). From this perspective, completion of the developmental task of identity formation is associated with successful transition into adulthood. Whereas in contrast, if a young person is unsuccessful in completing this task they may struggle with a sense of self, with suicide being regarded as the ultimate developmental breakdown (Erikson, 1968; Laufer & Laufer, 1984).

However, it is important to note that much of the traditional developmental literature has focused on young people below the ages of 18 (Jaworska & MacQueen, 2015). Over the past two decades, there has been growing awareness of the unique developmental tasks that 'emerging adults' face as they transition to adulthood (Wood et al., 2017). These include

social, cognitive, and emotional changes as youth navigate leaving home, furthering their education, entering the work force, forming romantic relationships, and considering parenthood (Schulenberg & Schoon, 2012).

More recently, researchers have shifted their attention from traditional developmental theories of youth to approaches which recognise the social-cultural context. From this perspective, developmental influences are not viewed as static, but instead are thought to be shaped and influenced by the ever-changing contexts of young people's worlds (Wyn & Harris, 2004). Thus, the experiences of youth and what it means to be a young person is thought to be dependent upon the context (White & Wyn, 2012). Furthermore, researchers contend that without understanding how young people see themselves and how they construct themselves in their own world, it is difficult to fully comprehend their perceptions, thoughts, and behaviours (White & Wyn, 2012).

Being a young person in itself is frequently conceptualised as an inevitable risk factor for a number of health and social issues (Bennett et al., 2003; White, 1994). However, researchers have criticised this conceptualisation of 'at-risk' youth, arguing that the origin of these problems is viewed as being innate to young people, as opposed to being due to a complex interaction of cultural, political and social difficulties, and individual biology and personality (Hill & Fortenberry, 1992; Sharland, 2006). Accordingly, the social context is argued to significantly contribute to the elevated rates of mental health issues and suicidality among young people (Wyn & Andres, 2011).

It is widely recognised that the youth age group has limited power in society (White & Kral, 2014; White & Wyn, 2012). Due to age-based criteria, young people are posited to have limited agency and control over the decisions in their lives, with little influence over their environment (Evans, 2007; White, 1994). From this perspective, young people are seen as being constrained by norms and rules determined by adults, which compromises their

agency and positions them as vulnerable and marginalised in society (Ergler & Wood, 2014; White, 1994; Wyn & White, 1997). Despite this relative powerlessness, young people are also posited to be active participants in meaning-making, who are able to resist dominant discourses and instead form their own norms and understandings, albeit with difficulty (Roen et al., 2008). Consequently, they are argued to have invaluable insights into their own experience of suicidality, which may differ to dominant conceptualisations of youth suicide (Bourke, 2003; Freake et al., 2007).

There is a general agreement in the youth literature that a key defining aspect of the current generation is their immersion in digital communication technologies, which is a global phenomenon (White & Wyn, 2012). The youth of today are understood to be growing up in a society where rapid changes in technology continue to change people's lives in ways that were previously unheard of (Gibson et al., 2016; White & Wyn, 2012). Consequently, the traditional ways of communicating with others has transformed, which has impacted youth culture and how young people connect with the world (Rickwood, 2012; White & Wyn, 2012).

In summary, from a developmental perspective, the youth life stage is a period associated with distinct difficulties and developmental needs. However, the context is also argued to be important in informing youth culture, identity construction, and consequently how young people experience suicidality. In particular, it is important to consider their status in society, as well as how changes in digital technology may increase young people's opportunities to communicate their distress more clearly through online mediums.

Reasons for Suicidality among Young People

In order to understand young people's suicidal behaviour and ideation it is important to consider some of the issues, which might be thought to contribute to this. In this section, I review the key risk factors associated with youth suicide, whilst also highlighting gaps in the

literature. I then discuss how models of suicide have been developed, underlining the need to prioritise young people's perspectives. Finally, I explore research which has focused on young people's views and experiences of suicidality, arguing that they have important things to say about the reasons they experience the phenomena.

Research on Risk Factors for Youth Suicide

Considerable empirical attention has been paid to the risk factors that increase young people's risk of suicide (Beautrais, 2000b; Evans et al., 2004; Gould et al., 2003; Pelkonen et al., 2011). These studies suggest there are multiple risk factors, which contribute to suicidality among young people, with many of the same factors predicting both suicide attempts and deaths by suicide (Beautrais, 2003). However, the relationship between these risk factors and suicidality among young people is complex, with research indicating that multiple factors across different domains combine to increase suicide risk (Beautrais, 2000b; Gould et al., 2003; Grimmond et al., 2019). The reviews of the youth suicide literature have identified a number of consistent risk factors, which can be divided into the following domains: Psychiatric and psychological; familial; and social and environmental.

Psychiatric and Psychological Risk Factors for Youth Suicide. The findings from reviews of youth suicide literature consistently suggest that mental health issues are a major risk factor for youth suicide in both community and clinical samples (Beautrais, 2000b; Bridge et al., 2006; Cash & Bridge, 2009; Evans et al., 2004; Gould et al., 2003; Gould & Kramer, 2001; Hawton et al., 2012; Pelkonen et al., 2011). For instance, in Bridge and colleagues' (2006) review of risk and protective factors for youth suicide, the authors argue that psychiatric disorders were present among almost 90% of young people who had died by suicide. A number of mental health issues have been associated with suicidality among youth, such as depression, anxiety, substance abuse, and antisocial behaviours (Beautrais, 2000b; Bridge et al., 2006; Cash & Bridge, 2009; Keith Hawton et al., 2012; Pelkonen et al., 2011).

Moreover, a high rate of comorbidity has been found in young people who attempt suicide and among those who die by suicide (Beautrais, 2000b; Evans et al., 2004; Goldston et al., 2009; Groholt et al., 2006; Pelkonen et al., 2011). Depression, in particular, has consistently been identified as one of the strongest risk factors for suicidality (Beautrais, 2000b; Cash & Bridge, 2009; Evans et al., 2004; Gould et al., 2003; Pelkonen et al., 2011). For instance, in a review of the literature, Gould and colleagues (2003) found that the rates of depressive disorders among young people who died by suicide ranged between 49% and 64%.

Research indicates that feelings of hopelessness are associated with an increased risk of suicidality among young people (Czyz & King, 2015; Esposito et al., 2003; Evans et al., 2004; Wilson et al., 2005). Studies suggest that hopelessness mediates the relationship between suicidal ideation and coping strategies, which is argued to contribute to the powerlessness and inescapability that young people experiencing suicidality may encounter (Rajappa et al., 2012; Williams, 1997). Despite these findings, numerous studies suggest that the relationship between hopelessness and suicide is attenuated once depression is controlled for (Bridge et al., 2006; Esposito-Smythers et al., 2014; Goldston et al., 2001). However, some studies have still found that even when depression is taken into account, hopelessness still predicts suicidality among young people (Groholt et al., 2006; Stewart et al., 2005). There is thus a need for a greater understanding of the role hopelessness plays among young people experiencing suicidality.

A number of studies indicate that deficiencies in problem-solving may be a vulnerability factor for suicidality among young people (Orbach et al., 1999; Speckens & Hawton, 2005). For example, McLaughlin and colleagues (1996) examined self-harm behaviours regardless of intent among 51 young people who had taken overdoses. When asked whether they thought that taking the overdose would change their problems, 38% of the participants reported that they could not think of anything else to do (McLaughlin et al.,

1996). Furthermore, suicidality among young people has been associated with beliefs surrounding problems being irresolvable, with research indicating that youth view problem-solving as a threatening task (Orbach et al., 1999; Orbach et al., 2007). However, the nature of the relationship between problem-solving skills and suicidality among young people is argued to be complex (D'Zurilla et al., 1998; Esposito-Smythers et al., 2014; Speckens & Hawton, 2005). For instance, a review of 22 studies, which examined social problem-solving among adolescents with suicidal behaviour concluded that it is not clear whether depression influences poor problem-solving skills, or if it is deficiencies in problem-solving that leads to depression and subsequent risk in suicide (Speckens & Hawton, 2005). More research is therefore required to understand how reduced problem-solving abilities contribute to young people's experience of suicidality.

Studies suggest that emotional dysregulation is associated with an increased risk of suicidality among young people (Cha et al., 2018; Dour et al., 2011; Esposito et al., 2003; Hatkevich et al., 2019; Jeglic et al., 2007; Pisani et al., 2013; Rajappa et al., 2012; Wolff et al., 2018). For example, through anonymous online surveys, a cross-sectional longitudinal study of nearly 8,000 students in a community sample found that difficulties identifying emotions and limited emotional regulation strategies were associated with a heightened risk of a suicide attempt in the previous 12 months (Pisani et al., 2013). Similar findings were demonstrated in a recent study by Wolff and colleagues (2018), which explored risk factors between chronic and declining suicidality trajectories among 104 young people in a clinical sample. Through structured interviews and self-administered questionnaires they found that difficulties with regulating emotions and non-acceptance of emotional responses were associated with chronic suicidality (Wolff et al., 2018).

Externalising behaviour patterns and disorders, such as aggression and conduct disorder have received empirical support for increasing the risk of suicidality among young

people (Beautrais, 2000b). However, less attention has been given solely to how anger influences youth suicide (Park et al., 2010). Despite the comparatively fewer studies, research suggests that anger contributes to suicidality among young people (Esposito et al., 2003; Jang et al., 2014; Khan et al., 2020; Lehnert et al., 1994; Park et al., 2010). In spite of these findings, these studies have often examined anger as one construct, resulting in the different dimensions not being examined independently (Esposito et al., 2003; Jang et al., 2014). Consequently, it is not clear what role anger plays in contributing to suicidality and how internalised and/or externalised anger may influence young people. More research is therefore needed into the different components of anger, with researchers arguing that qualitative methods should be used in future studies (Khan et al., 2020).

Little empirical attention has been given to how the experience of suicidality may influence a young person's self-concept and subsequent risk. From a developmental perspective, researchers have argued that disrupted identity development during adolescence and young adulthood may contribute to youth suicide (Everall et al., 2005; Rasmussen, Dyregrov et al., 2018; Rasmussen, Haavind, et al., 2018). A number of psychological autopsy studies support this argument (Rasmussen et al., 2014; Rasmussen, Haavind, et al., 2018; Törnblom et al., 2015). For example, Rasmussen and colleagues (2014) interviewed the close contacts of ten young men who took their lives. Their findings suggest that the young males suicidality was linked to disconnect between their ideal and actual self, which was compounded by pressure to meet both self-imposed and societal standards (Rasmussen et al., 2014). Although these findings provide meaningful insight into what may contribute to suicidality, they exclude the perspectives of young people themselves and thus invaluable information may have been lost. Moreover, many of these studies have focused on gender identity, and thus further research is required to elucidate how disrupted identity development may contribute to suicidality.

Familial Risk Factors for Youth Suicide. Reviews of the youth suicide literature suggest that familial factors, such as parental psychopathology, family history of suicidality, and parent-child discord are predictors of suicidality among young people (Beautrais, 2000b; Bridge et al., 2006; Gould et al., 2003; Gvion & Apter, 2016; Hawton et al., 2012). For example, Brent and colleagues (1994) compared familial loading for psychopathology between 67 adolescent suicide victims and 67 demographically matched controls and found greater familial loading for depression and substance use among suicide victims. Furthermore, parental psychopathology was identified as a risk factor for youth suicide when mental health issues in young people were controlled for (Brent et al., 1994). This suggests that familial psychopathology contributes to the risk of suicide by mechanisms other than increasing the likelihood of similar psychopathology in young people (Brent et al., 1994; Gould et al., 2003).

A number of studies suggest that parent-child discord and poor family relationships increase the risk of suicidality among young people (Beautrais, 2000b; Brent et al., 1996; Evans et al., 2004; Gould & Kramer, 2001; Hawton et al., 2012; Hedeland et al., 2016; Joffe et al., 1988). Although this provides support for family relationship difficulties contributing to youth suicide, it offers little insight into the nature of these tensions. Gvion and Apter (2016) argue that due to these familial risk factors, it is imperative that the family environment be given particular consideration, in addition to genetic risks. Accordingly, it is important to consider how environmental trajectories, such as how a family communicates and dynamics within the family system, influence suicidality among young people (Brent & Melhem, 2008).

Social and Environmental Factors for Youth Suicide. A number of studies suggest that interpersonal difficulties are a prominent risk factor for youth suicide (Cash & Bridge, 2009; Gvion & Apter, 2016). For example, Johnson and colleagues (2002), using a

community based sample, found that interpersonal difficulties, such as problems making new friends, conflict with adults in authority, and cruelty towards peers in early adolescence, independently predicted suicide attempts in late adolescence and early adulthood. Bullying has also been identified as a risk factor in youth suicide literature, among both victims and perpetrators (Cash & Bridge, 2009; Kaltiala-Heino et al., 1999; Kim et al., 2009; Klomek et al., 2009).

Disconnection and lack of belonging are well-recognised contributing factors for suicidality among young people (Arango et al., 2019; Gvion & Apter, 2016; Joiner, 2005). Youth are thought to be especially vulnerable to the adverse impacts of social isolation, given the importance they place on social connection (Heinrich & Gullone, 2006). Particular attention has been paid to loneliness, with studies demonstrating that it predicts both suicidal ideation and suicide attempts among young people (Gallagher et al., 2014; Schinka et al., 2012; Wichstrøm, 2000). However, the association between loneliness and increased risk of suicidality remains unclear, with some researchers purporting that the relationship is mediated by psychopathology (Cha et al., 2018). Of note, some researchers have also argued that chronic social disconnection has a greater influence on the risk of experiencing suicidality than a specific interpersonal event (Jeglic et al., 2007). For example, Jeglic and colleagues (2007) explored contributing factors to suicidality among a community sample of 47 university students who had attempted suicide, who were then matched to controls with no previous suicide attempts. Through surveys and interviews they found that young people who attempted suicide reported significantly lower rates of perceived support from family and friends than those with no history of attempts. The authors argue that suicidality among young people may be associated with pervasive dissatisfaction with their sources of support, as opposed to a particular interpersonal conflict (Jeglic et al., 2007).

Researchers have criticised the lack of distinction between different relationships

when studying disconnection among young people experiencing suicidality (Hedeland et al., 2016). Furthermore, when subtypes of connection for young people have been studied, this has predominantly focused on the family (Czyz et al., 2012). More recent research suggests that it is important to understand and consider the subtypes of interpersonal connection among young people experiencing suicidality (Arango et al., 2019; Czyz et al., 2012). For example, Arango and colleagues (2019) conducted a longitudinal study to explore the relationship between connectedness subtypes and suicidality among young people who experienced bullying. The sample consisted of 142 young people who were recruited from an emergency department, but had no prior suicide attempts. The authors found that connectedness with family, school, and community were all negatively associated with suicidal ideation (Arango et al., 2019). Although these findings provide further insight into the importance of connectedness among young people experiencing suicidality, the study failed to explore peer relationships.

There is currently limited research into how peer connectedness contributes to suicidality among young people (Czyz et al., 2012). Given youth is regarded as a developmental period where connection with peers is important, this is surprising (Goossens, 2006). Of the studies which have been undertaken, findings suggest that peer support and robust friendships are associated with less severe suicidality among young people (Bearman & Moody, 2004; Czyz et al., 2012; Lewinsohn et al., 1996). However, research is inconsistent, with some findings suggesting that peer relationship difficulties are not an influential contributing factor in youth suicide, whereas romantic relationships are (Cash et al., 2013). These findings highlight the need for further understanding into the role that peer connectedness plays in young people's experience of suicidality.

Stressful life events have been identified as another risk factor in the youth suicide literature (Beautrais, 2000b, 2003; Gould et al., 2003; Hawton et al., 2012; Wilburn & Smith,

2005). Many studies indicate that young people are at increased risk of suicide when they are exposed to multiple stressful life events (Beautrais et al., 1997; Esposito-Smythers et al., 2014; O'Connor et al., 2012). Research also suggests that poverty and lower socio-economic status is associated with increased risk of suicide among young people (Burrows & Laflamme, 2010; Hawton et al., 2012; Page et al., 2014). However, in a review of the literature, Evans and colleagues (2004) found little evidence of a strong relationship between family socio-economic status and youth suicide. Thus, a greater understanding of how socio-economic factors may influence suicidality among young people is needed.

A large body of research has examined the relationship between childhood abuse and subsequent suicidal behaviour (Cha et al., 2018; Evans et al., 2005). However, the majority of these studies have focused on adult survivors of sexual abuse and consequently, the relationship between abuse and suicidality among young people is less well understood (Evans et al., 2005). Despite this, studies which have examined suicidality among young people have found that a history of physical, sexual, and/or emotional abuse predicts suicidal thoughts and behaviours in adolescence (Afifi et al., 2008; Beautrais, 2000b; Evans et al., 2004; Fergusson et al., 2008; Hawton et al., 2012; O'Connor et al., 2009). Although some researchers argue that the main effect of abuse on suicidality is mediated by an increased risk of psychopathology (Fergusson et al., 2000), some studies still found an effect when psychopathology was controlled for (Bridge et al., 2006; Molnar et al., 2001).

The process where one suicide facilitates the occurrence of another suicide is known as contagion (Insel & Gould, 2008). This can result in suicide clusters where an excessive number of suicides occur in close temporal and geographical proximity (Gould et al., 1989). The increased risk of suicide among young people due to exposure to suicide, either directly through a peer or indirectly through the media, has been researched extensively, with many studies finding that exposure is a risk factor (Bridge et al., 2006; Insel & Gould, 2008;

O'Connor et al., 2012; Pirkis et al., 2016; Portzky et al., 2009; Stack, 2000). However, in a review of the literature, Insel and Gould (2008) concluded that suicide contagion only accounts for a small minority of suicides among young people. Nonetheless, some countries have adopted media censorship laws and guidelines for the reporting of suicide (Collings & Kemp, 2010; Keith Hawton et al., 2012), which have been attributed to reductions in suicidality (Niederkrotenthaler & Sonneck, 2007). For example, in NZ, there is a voluntary media-generated protocol for the reporting of suicide and a statutory restriction on suicide coverage without permission from a coroner (*Reporting Suicide: A Resource for the Media*, 2015).

Limitations in the Risk Factor Research

The research into the factors that increase young people's risk of suicidality has been influential in increasing awareness and understanding surrounding how to develop prevention strategies that are empirically sound (Evans et al., 2004). However, there are a number of limitations in these studies and consequent gaps in the literature (Beautrais, 2000b; Pelkonen et al., 2011). Dour and colleagues (2011) argue that it is the interaction of risk factors, as opposed to the presence of an independent risk factor, which is imperative in the development of suicidality among young people. Although research suggests that the reasons for suicide among young people is multifaceted, major contributions to the youth suicide literature have focused on how single risk factors contribute to suicidality. Consequently, there is limited understanding of the relationship between stressors and how they may interact to effect suicidality among young people (Dour et al., 2011). Researchers have also argued that the absence of evidence of risk factors does not mean that other factors do not influence young people's risk of suicide (Keith Hawton et al., 2012). Furthermore, the majority of these identified risk factors frequently occur among young people in the community who do not experience suicidality (Bourke, 2003).

As discussed previously, the definition of suicidal behaviours has varied over time and between researchers making it difficult to compare the findings of studies. This inconsistent and undefined nomenclature in the youth suicide literature has been identified as a key difficulty in researching suicidality and may explain the inconsistencies in some studies (Beautrais, 2000b; Berman et al., 2006; Pelkonen et al., 2011). The youth suicide literature is also fundamentally limited in that information cannot be directly obtained from people who die by suicide (Berman et al., 2006). As a result, the majority of findings come from psychological autopsy studies, where researchers have relied on key informants whose information and retrospective accounts may be incorrect, biased, or incomplete (Hjelmeland & Knizek, 2017). Moreover, despite the ability for close relatives to provide salient information, academics argue that their narratives may be influenced by defensive constructions in attempts to protect themselves (Owens et al., 2008). Further, the majority of these studies, and in fact most research in adolescent suicidology, have been through quantitative analyses (Hjelmeland & Knizek, 2010). Although quantitative methods have increased our understanding of the risk factors for youth suicide, in order to gain a deeper and more nuanced account of suicidality among young people the WHO has recommended that future studies examine the phenomena using qualitative methods (Nock, 2012).

Models of Suicide

There are three predominant categories of suicide theories in western society which have been informed by the youth suicide literature: sociological, psychological, and biological (Maskill et al., 2005). Although models have been developed that recognise the complex interplay between these categories, they are often viewed separately (Maskill et al., 2005).

Prior to approaches which relied on empirically driven frameworks to inform models of suicide, researchers focused on theoretical understandings of the phenomena (Collings & Beautrais, 2005). These understandings of suicide have been shaped by legal, religious, and

moral discourses which are often pejorative (MacDonald, 1989; Marsh, 2010). More recently, suicide has been conceptualised through a medical lens, which views the phenomena as a sign of mental illness and focusses on attempting to identify and reduce 'risk factors' that contribute to young people experiencing it (Fullagar, 2005). It is unsurprising then that much contemporary research on suicide focuses on the causes and risk factors of suicidality (Collings & Beautrais, 2005). However, some researchers have questioned the validity of focusing solely on risk and protective factors, arguing that they offer limited insight into young people's emotional experiences and lives (Fullagar, 2005; White, 1994). Fullagar (2005) posits that concentrating exclusively on these risk factors fails to account for the dynamic and complex nature of young people's environment and experiences. As a result, young people's distress is quantified into categories of risk, as opposed to a dynamic social and cultural process (Rose, 1998).

Nonetheless, since the 18th Century the construction of suicide has become increasingly medicalised (MacDonald, 1989). Currently, the bio-medical model receives the most attention from both a clinical and policy perspective in NZ. As a result, suicide is frequently conceptualised as an issue located within the individual, even when social and contextual influences are taken into account (Wray et al., 2011). Among academics, there has been immense criticism over this understanding of suicide. A common argument is that the medical model is unable to integrate important sociological, cultural, psychological, and philosophical factors into its conceptualisation of youth suicide (Hjelmeland & Knizek, 2010; White & Kral, 2014). There are also concerns that framing suicide risk factors from within a medical perspective may be unhelpful for young people as they may feel powerless to change (Besley, 2010; Thompson & Wyllie, 2009) and due to the stigma associated with mental health issues may be reluctant to seek support for suicidality (Lake et al., 2013). Furthermore, a number of researchers have argued that the relationship between mental ill health and

suicidality has been oversimplified, contending that this understanding lacks the nuance and complexity that contributes to both suicide and mental health issues (Bennett et al., 2003; Roen et al., 2008).

More recently, psychological models of suicide have also been purported in attempts to conceptualise and explain the phenomena (Collings & Beautrais, 2005), such as Interpersonal Theory (Joiner, 2005; Van Orden et al., 2010) and the Cry of Pain model (Williams, 1997, 2001). For example, Interpersonal Theory considers how thwarted belongingness, perceived burdensomeness, and acquired capability contributes to suicidality (Joiner, 2005; Van Ordern et al., 2010). Despite this relational focus, the model still places great importance on the individual and consequently does not take into account context and the unique landscapes young people inhabit. Similarly, the Cry of Pain model, which argues that suicidality is a response to a stressful situation that is characterised by feelings of defeat and beliefs that there is no escape and rescue (Williams, 1997), also locates suicidality within the individual.

In contrast to these individualised understandings, other researchers have followed Durkheim's seminal work, which posits that social integration and social regulation within society are integral factors in understanding why suicidality occurs (Durkheim, 1951). From this perspective, it is suggested that youth suicide should be thought of as a social-cultural, political, economic, and relational phenomena, which affects entire communities (McDermott & Roen, 2016; White & Kral, 2014). By shifting dominant conceptualisations of youth suicide, which rely on singular and individualised theorisations, and instead locating suicidality in the social-cultural context, it is posited that more possibilities for understanding the phenomena might become apparent (McDermott & Roen, 2016; White, 2012). Moreover, by considering the context, this is thought to gain a more accurate account of how young people make sense of suicide, and consequently how it is experienced (White et al., 2016). It

is thus essential that future studies consider the broader context that young people's difficulties are located in when elucidating what contributes to youth suicide (Bourke, 2003; White, 1994). The fact that young people and adults have largely the same risk factors for suicidality highlights how the social-cultural context has often been excluded in models of suicide (e.g. Hawton & van Heeringen, 2009).

In order to fully consider the social-cultural context that youth suicide is located in, it is imperative that the perspectives of young people themselves are prioritised (Lake et al., 2013). This is important as researchers have argued that current conceptualisations of suicide may be incongruent with how young people understand the phenomena (McDermott & Roen, 2016). In particular, the rapid changes in technology are thought to have given young people vast opportunities to research and discuss sensitive topics, such as suicide, which previously they had limited access to (Gibson et al., 2019; Hawton et al., 2012; McDermott & Roen, 2016). This may be especially relevant in NZ where open communication surrounding suicide is actively discouraged (Gibson et al., 2019). Due to this cultural shift, it is unclear how current models of suicide are accepted by young people, and if they challenge and transform them to fit their own understandings (Stubbing & Gibson, 2018). It is therefore critical to understand the way young people make sense of suicide within youth culture in order to elucidate means to prevent it (White et al., 2016). This highlights the importance of utilising young people's perspectives and own experience of suicidality, which are often missing from current models of suicide.

What do Young People Say about their Reasons for Suicidality?

Historically, research has positioned young people as developing beings, whose full status is not achieved until they reach adulthood (Claveirole, 2004; Coyne, 1998; Holloway & Valentine, 2000). As a result, data has traditionally been collected from adults close to the young person or through objective measures where the young person's options for their

responses have been predetermined by the researcher (Claveirole, 2004; Duncan et al., 2007). Consequently, the research focus of youth suicide has been *on* young people, as opposed to *with* them (Balen et al., 2000).

More recently, however, researchers have realised the importance of focusing on the perspectives and experiences of young people to expound how suicide is constructed in youth culture (Claveirole, 2004; White, 2015). A number of methods have been applied to give young people the opportunity to have an active voice in the youth suicide literature, such as surveys, focus group discussions, and interviews (Lachal et al., 2015). From a social-constructionist perspective, understanding how suicide is conceptualised within youth culture is essential in determining key prevention strategies (White et al., 2016). However, research from youth perspectives still remains scarce (Lake et al., 2013). Consequently, there is limited knowledge surrounding how youth communicate their understanding and experience of suicide, particularly from young people who have personally experienced suicidality (Bennett et al., 2003; Roen et al., 2008).

Research, which has focused on young people's experience and perception of suicide, suggests that their understanding of suicide may differ from how professionals have conceptualised it (Schwartz et al., 2010). In particular, recent studies which have explored young people's attitudes and beliefs about youth suicide indicate that they do not always associate suicidality with mental illness (Heled & Read, 2005; Issakainen, 2014; Lake et al., 2013). For instance, Heled and Read (2005), through open-ended surveys examined 384 undergraduate students' reasons as to why NZ has a high youth suicide rate. The most frequently mentioned response by the students was pressure to conform and perform, whereas depression was only cited by 5% and mental illness by 1% (Heled & Read, 2005). This explanation of suicidality through societal processes, as opposed to personal characteristics or psychopathology, is consistent with a number of other studies, which have explored young

people's perspectives on suicide (Fortune et al., 2008a; Lake et al., 2013). For example, Lake and colleagues (2013) examined the attitudes surrounding the role of mental illness in suicidal behaviour in a community sample of 2419 young people through self-administered questionnaires. They found that less than one fifth of their participants viewed mental health issues as a risk factor for suicidality. Moreover, young people in the study who were suicidal were less likely than their non-suicidal peers to associate suicide with mental illness and were more likely to associate suicide with negative life experiences (Lake et al., 2013). Although these studies provide valuable insight into young people's perspectives, the surveys utilised predetermined responses, which may offer a restricted account of their experiences and views.

The finding that many young people do not view suicide as an individual pathology is consistent with the limited number of qualitative studies on how young people communicate their understanding of suicide (Bennett et al., 2003; Bourke, 2003; Fortune et al., 2008a; Fullagar, 2003; Roen et al., 2008; Stubbing & Gibson, 2018; Westerlund, 2013). These studies suggest instead that young people see suicide as an understandable response to life's difficulties (Lachal et al., 2015). For instance, Roen and colleagues (2008) through interviews and focus groups among 69 young people in the general population conducted a discourse analysis on how youth make sense of suicide. They demonstrated that young people constructed the possibility of suicide as accessible and omnipresent for all youth. The participants did not position suicide as a sign of individual psychopathology, but instead 'rationalised' suicidality as a reasonable response to life's circumstances (Roen et al., 2008). Researchers have noted concerns with framing suicidality as normative, suggesting that it may negatively influence help-seeking as the need for help is not perceived as necessary (Biddle et al., 2007).

A number of studies also suggest that young people experience significant discursive

tensions when conceptualising suicide (Bennett et al., 2003; Roen et al., 2008; Stubbing & Gibson, 2018). Academics have argued that due to the domination of particular discourses, young people may have few available alternatives to understand suicide (Bennet et al., 2003). For example, in Roen and colleagues (2008) study discussed above, another key framework in young people's understanding of suicide was the positioning of suicide and suicidal subjects as 'other'. The authors argue that young people may thus experience considerable discursive tensions between suicide being conceptualised as accessible, while simultaneously viewing it as taboo or shameful (Roen et al., 2008). Similar findings were found by Bennet and colleagues (2003), who explored how depression influenced the suicidal behaviour of 30 young people who had attempted suicide. Through discourse analyses, they found that many young people positioned themselves within a medicalised discourse, where the perspectives of health professionals were prioritised, and depression was constructed as a disease over which they had little control. Although this medicalised discourse was salient for a number of young people, others drew on a moral discourse where young people who experienced depression and suicidal behaviours were positioned as failures. In an attempt to challenge the stigma associated with experiencing mental health issues and reduce judgement, many deployed normalised discourses as an alternative position. However, due to the pervasiveness and dominance of moral and medical discourses, for young people to position themselves and their suicidal behaviour as a normal response was complex and problematic (Bennett et al., 2003). Discursive tensions were also evident in a recent qualitative study in NZ. Through focus groups in a community sample, Stubbing and Gibson (2018) found that suicide was conceptualised as an understandable response to both internal and external difficulties. However, tensions were observed between positioning suicide as normative and understandings which pathologised the phenomena (Stubbing & Gibson, 2018).

Although these studies provide valuable insight into the reasons young people give for

suicidality, the majority utilise community samples where the participants may not have experienced suicidality themselves. Whilst this increases our understanding of how youth in general perceive and understand suicide, it offers little insight into the lived experience of suicidality among young people.

A small number of studies have explored the experience of suicide amongst survivors of suicide attempts, which have highlighted salient factors that contribute to suicidality (eg Everall et al., 2006; Gulbas et al., 2019; Holliday & Vandermause, 2015; Orri et al., 2014; Sinclair & Green, 2005). Findings from these studies support epidemiological research, which indicates that suicidality is due to the complex interaction of a number of factors (Grimmond et al., 2019; Lachal et al., 2015). For example, in a review of 27 qualitative studies which explored young people's experience of suicidality, Grimmond and colleagues (2019) identified a number of common themes for triggers and vulnerability factors for suicide. Although many of these themes were consistent with previous quantitative research, the findings highlighted factors that contribute to suicidality among young people, which have received less empirical attention. For instance, the review found that a common theme across the studies was the prevalence and impact of the social stigma related to suicidality and emotional expression among young people. The authors argue that it is paramount that the stigma surrounding suicide and 'negative' emotion expression is reduced, which will require a shift in societal attitudes (Grimmond et al., 2019). Although this review offers new insights, it included studies of close contacts of young people and it is not solely reflective of youth perspectives.

Qualitative studies have also identified that young people experiencing suicidality may experience a lack of control in their lives (Grimmond et al., 2019; Lachal et al., 2015; Orri et al., 2014; Sinclair & Green, 2005). For example, Sinclair and Green (2005) interviewed 20 participants, who 8 years previously were admitted to hospital following an

act of deliberate self-harm. Through thematic and narrative analyses, they found that those who were adolescent at the time of their hospitalisation described living in unpredictable family environments where they had limited control and autonomy. Although the study provides important insight into how powerlessness may contribute to suicidality among young people, the study is limited by not differentiating between NSSI and suicidality (Sinclair & Green, 2005). Other findings have also suggested that suicide may be viewed as the only way young people can cope with their emotional pain and may be seen as their only option (Everall et al., 2006; Orri et al., 2014).

Although these studies provide crucial insight into young people's perspectives, the majority have relied on retrospective accounts of young people's experience of suicidality. As a result, important information could have been lost or their perception of the experience may have changed over time (Boergers et al., 1998; Jacobson et al., 2013). There is consequently limited understanding into how young people in crisis communicate the reasons for why they are suicidal.

To further understand young people's experience of suicidality in the moment of crisis, a small number of studies have examined young people's internet posts to elucidate their overall experience of the phenomena (Cavazos-Rehg et al., 2017; Jashinsky et al., 2014), as well as the specific reasons they give for why they are suicidal (Ali & Gibson, 2019; Cash et al., 2013; Westerlund, 2013). For example, Ali and Gibson (2019) explored the reasons young people gave for their suicidality by thematically analysing 210 posts on a social media platform. They found that identity stigma, failing to meet expectations, being helpless, feeling worthless, mental illness, and loneliness contributed to young people experiencing suicidality. Although this study provided in the moment accounts of what suicidal young people were experiencing, the context of their participants' posts were limited (Ali & Gibson, 2019). Furthermore, as social acceptance is argued to be valued by youth, the

fear of stigma and rejection may have influenced how they talked about suicidality with their peers.

The Function of Suicidality among Young People

Despite the debate surrounding the definitions of self-harm behaviours, there is general consensus among researchers that the function of young people's suicide attempts is important (Jacobson et al., 2013). While the function of suicidality may not always be fully known to the person who is experiencing the phenomena, it is possible to illustrate this by exploring the motives they describe. Research into young people's self-reported motives for attempting suicide is comparatively limited (Jacobson et al., 2013). Accordingly, how youth explain their own suicidal behaviours based on their own experience is an area which requires further exploration (Boergers et al., 1998; Jacobson et al., 2013).

Of the small number of studies which have been conducted, many of them cite wanting 'to die' as the main reason young people give for their suicide attempt (Boergers et al., 1998; Kienhorst et al., 1995; Rodham et al., 2004). However, many studies suggest that young people who attempt suicide give reasons other than ending their own life. These include reasons, such as wanting to escape, wanting to gain relief, and communicating distress (Boergers et al., 1998; Hawton et al., 1982; Jacobson et al., 2013; Kienhorst et al., 1995; Scoliers et al., 2009). Moreover, findings suggest that young people often endorse more than one reason for their suicidality (Hargus et al., 2009; Jacobson et al., 2013; Madge et al., 2008). For example, Madge and colleagues (2008) found through online questionnaires among 30,000 young people in a community sample that many participants simultaneously cited wanting to die and relieve their distress as their motive for self-harming. However, the authors did not clearly delineate between self-harm and suicidality, which may have influenced their findings.

These studies are limited in that many of them use the Reasons for Overdose Scale

(Hawton et al., 1982), which only allows yes or no responses to nine pre-determined motives for wanting to die. Consequently, some of the functions of young people's suicidality may have been missed. For example, Scoliers and colleagues (2009) argue that the endorsement of multiple items suggests young people experience ambivalence surrounding their suicidality. However, they contend it is difficult to capture this experience in quantitative methods where items do not acknowledge or recognise ambivalence (Scoliers et al., 2009).

A limited number of qualitative studies have explored the motives behind young people's suicide attempts (Gair & Camilleri, 2003; Holliday & Vandermause, 2015). For example, Gair and Camilleri (2003) conducted in-depth interviews with nine young people who had attempted suicide and found that they had a range of motives and varied intent, which was unique to each attempt. The motivations for the attempts varied from not wanting to live anymore to "just didn't want to be in the world for a while" (Gair & Camilleri, 2003, p. 88). These findings are in line with Holliday and Vandermause (2015), who interviewed six young people following being hospitalised for a suicide attempt. Although they found that all the participants saw death as a means to end their suffering, the young people in their study used a number of terms to communicate their intent, which were often ambiguous and unclear. Consequently, the authors argue that young people themselves may not understand the reasons behind their suicide attempt. Moreover, the study highlights that young people's description of their motive and intent, may be misinterpreted by clinicians (Holliday & Vandermause, 2015).

Although communicating distress has been a well-established motive in previous research, qualitative analyses have allowed for a deeper understanding of this relational function (Grandclerc et al., 2019; Holliday & Vandermause, 2015; Orri et al., 2014). For example, Orri and colleagues (2014) conducted a retrospective phenomenological study through semi-structured interviews with 16 young people who had attempted suicide. They

found that participants described suicide as being their only way to communicate their anguish and get others to listen to them. Interestingly, another relational theme identified was revenge, with young people communicating a vengeful meaning behind their suicide attempts, such as wanting to make their support people feel guilty for their death (Orri et al., 2014). Suicidality with an interpersonal function is frequently conceptualised as a cry for help (O'Connor et al., 2006). However, there has been some criticism in the literature in regards to this understanding, and instead researchers argue it is more helpful to view it as a cry of pain (Holliday & Vadermaus, 2015; O'Connor et al., 2006; Williams, 1997). For example, Holliday & Vandermause (2015) argue that young people may not have the language to communicate their distress and consequently may subconsciously use their suicidality as means of help-seeking in an attempt to relieve their pain. Moreover, O'Connor and colleagues (2006) suggest that the salient motivation for those experiencing suicidal ideation is to reduce their distress, as opposed to influencing the behaviour of others. There is thus a need for a greater understanding on the interpersonal function of suicidality among young people.

These findings suggest that young people's suicidality serves a number of functions. Although these studies provide greater insight into the function of suicidal behaviour among young people, they rely on retrospective recall. This may have influenced their findings as young people may ascribe other reasons to their suicidality after the fact (Boergers et al., 1998). There is consequently limited unstructured research of young people's real-time expression of their motives for suicidality, which utilises qualitative methods. Further research is needed to fill this gap in the literature as this may provide greater insight into the function of young people's suicidality.

Summary of Reasons for Suicidality among Young People

There are a number of factors across a variety of domains, which are thought to contribute to why young people experience suicidality. This research has been applied to inform models of suicide (Collings & Beautrais, 2005). However, current models of suicide are limited in that they do not fully consider the unique social-cultural context that young people reside in and have not prioritised the perspectives of young people themselves. This is important, as research from the perspective of young people has not only highlighted factors which have received less empirical attention, but also suggests that young people may conceptualise suicidality differently to adults (Grimmond et al., 2019; Lake et al., 2013). There is thus a need for future research to explore the reasons young people themselves communicate for why they are experiencing suicidality. Moreover, due to limitations in the study designs of previous research, the use of qualitative methods which explore the real-time expressions of suicidality among young people is required.

Understanding Suicidal Behaviour and Suicidal Ideation in Young People

In order to provide adequate and effective prevention of suicidality among young people, it is important to understand how they themselves experience the phenomena. In the following section, I explore the prevalence and trajectory of suicidality among young people, highlighting the dynamic nature, heterogeneity, and pervasiveness of the phenomena. I then discuss the limited number of qualitative studies, which have explored the course and experience of suicidality among young people, arguing that more research that prioritises young people's communicated experience is needed.

Prevalence of Youth Suicide

Suicidality among young people is argued to be relatively common (Clark et al., 2013; Evans et al., 2005; Nock et al., 2013). Although death by suicide among young people is rare, a number of studies indicate that suicidal ideation and attempted suicides occur far more

frequently (Evans et al., 2005; Nock et al., 2008, 2013; Pelkonen et al., 2011). For example, Nock and colleagues (2008) in a review of the research and government data found that the 12 month prevalence estimates for suicidality among young people in the United States of America was 15-29% for suicidal ideation, 12.6-19% for suicidal plans, and 7.3-10.6% for suicidal attempts.

Suicidal ideation is argued to be a necessary precursor to suicide attempts (Robinson, Bailey, et al., 2018), with research suggesting that suicidal ideation predicts future suicide attempts (Andrews & Lewinsohn, 1992; Miranda et al., 2008). However, a number of studies suggest suicidal ideation occurs far more frequently than suicide attempts (Kokkevi et al., 2012; Nock et al., 2008). For example, in a systematic review of the international literature on the prevalence of suicidal phenomena among young people, Evans and colleagues (2005) found that the mean lifetime prevalence of attempting suicide was 9.7%, whilst 29.9% of young people reported experiencing suicidal ideation at some point in their lives. This is somewhat consistent with NZ data, which through anonymous online surveys of young people in the community found that 21% of females and 10% of males had seriously contemplated suicide in the previous year, whilst 6% of females and 2% of males had attempted suicide in the previous 12 months (Clark et al., 2013). Although these findings suggest a slightly lower prevalence of suicidality among NZ young people, this may be due to the participants in the research completing the survey whilst at school, which could have reduced their willingness to disclose suicidality.

It is also important to recognise that due to differences in definitions and sample characteristics, estimating the prevalence rates of suicidality among young people is difficult (Pelkenon et al., 2011). Accordingly, the frequency of suicidal ideation and behaviours among young people is thought to be under-estimated. The stigma associated with suicide may further influence the validity of suicide research and statistics (Barker et al., 2013; Evans

et al., 2005). For instance, research suggests that higher rates of disclosure of suicide attempts are reported in methods where the participant remains anonymous, compared to methods which are non-anonymous (Evans et al., 2005). Moreover, the majority of statistics on suicide attempts rely on hospital samples, which are thought to only account for one third of attempted suicides (Kann et al., 2000). Consequently, the true prevalence of suicidal thoughts and behaviours among the general population remains largely unknown (Gvion & Apter, 2016).

Youth Suicide Trajectories

Although there is limited research into suicide trajectories among young people, the most frequently documented pattern of suicide is that at the start of adolescence the risk of first onset for suicidality significantly increases, peaking at age 16, and remains elevated until the young person's early twenties (Nock et al., 2008, 2013). However, findings from longitudinal trajectory studies suggest there is immense heterogeneity among young people experiencing suicidality and that different courses of suicidality exist (Czyz & King, 2015; Esposito et al., 2003; Fortune et al., 2007; Mandell et al., 2006; Wolff et al., 2018). For example, using life-charts of psychological autopsy information from 27 young people who had ended their lives, Fortune and colleagues (2007) found 3 types of suicidal processes. The first group was characterised by enduring difficulties at home, school and with their peers. Their suicidal process was longstanding, with a number of suicide attempts and direct communication with their peers and family about their suicide plans. The second group was characterised by evidence of an established mental health issue and they experienced either a brief suicidal process of around one year or a prolonged process, which lasted between five to nine years. The third group was characterised by the emergence of the suicidal process as an acute response to adverse life events among young people with no experience of mental health issues or previous suicidality (Fortune et al., 2007).

Despite differences in trajectories, there is general consensus among researchers that suicidality among young people is thought to be dynamic, with a number of studies suggesting an escalation occurs over time (Nock et al., 2008, 2013). For example, Nock and colleagues (2013) explored the lifetime prevalence of suicide behaviours among nearly 6500 young people in a community sample through face-to-face interviews. They found that approximately one third of young people who experience suicidal ideation will develop a suicide plan and approximately 60% of young people who develop a plan will attempt suicide. Moreover, they found that the majority of young people who transition from ideation to a suicide plan and ideation to a suicide attempt do so within 12 months after first experiencing suicidal ideation (Nock et al., 2013). However, their study relied on retrospective recall and consequently the findings may have been influenced by recall bias.

Variability in suicidality over short time periods has also been documented among young people (Czyz et al., 2019). For instance, using mobile phone technology Czyz and colleagues (2019) captured daily records of young people's suicidality in the month following a suicide attempt. They found considerable day-to-day fluctuations in the frequency, duration, and urge severity of suicidal ideation. Although this offered a fine-grained account of young people's experience of suicidality, which is lacking in the literature, the study is limited as young people had to choose their responses from predetermined answers (Czyz et al., 2019).

The findings of suicide trajectory studies suggest the experience of suicide among some young people can be chronic and persistent (Czyz & King, 2015; Lewinsohn et al., 1996). These longitudinal studies have also indicated that more severe and persistent suicidal ideation is associated with an increased risk of transitioning to a suicide attempt and engaging in multiple suicide attempts (Czyz & King, 2015; Lewinsohn et al., 1996). Research into young people who have attempted suicide also suggests that the experience of suicide is pervasive and ongoing (Everall et al., 2006; Hedeland et al., 2016). For example, Hedeland

and colleagues (2016) used a cross-sectional case-control study to explore risk factors and characteristics of suicide attempts among 381 hospitalised young people. Through questionnaires and medical records, the researchers found that 44% of young people experienced suicidal ideation for more than six months before they attempted suicide.

Many studies suggest that suicidality among youth is a reoccurring experience (Cash & Bridge, 2009), with research indicating that if a young person experiences suicidality, they are at increased risk of future suicidal ideation, attempts, and completion (Bostwick et al., 2016; Madge et al., 2008; Miranda et al., 2008; Spirito et al., 1992). For example, Madge and colleagues (2008) explored self-harm behaviours among 30,000 young people through anonymous questionnaires. They found that just over 50% of both males and females who had harmed themselves over the past year, had done so more than once (Madge et al., 2008).

Despite the above studies suggesting that the experience of suicidality is often prolonged and pervasive, researchers have posited that suicide attempts by young people often involve minimal planning (Bridge et al., 2006). For example, findings indicate that only 21% of young people who attempted suicide had planned their suicide attempt for more than 24 hours in advance (Hedeland et al., 2016). Moreover, impulsivity has been associated with increased risk of suicidality among young people (O'Connor et al., 2012). However, there are conflicting findings regarding the extent to which young people's suicidal behaviours are impulsive or planned (Nock et al., 2008, 2013). For example, Jacobson and colleagues (2013) explored self-reported motives for suicide among a community sample of 99 young people who had attempted suicide. They found a significant relationship between premeditation and a motivation to die, whilst the same correlation was not found for impulsivity. Consequently, the research remains unclear and further research is needed to elucidate the roles of planning and impulsiveness in the behaviours of young people experiencing suicidality (Nock et al., 2013).

A number of studies suggest that young people use a variety of methods of suicide (Beautrais, 2000a; Hawton et al., 2012). In NZ, hanging, suffocation, and strangling are the most common methods of suicide (Ministry of Health, 2018). Restricting access to means has been identified as important suicide prevention initiatives (Beautrais, 2000a; Hawton et al., 2012). However, as these methods are widely available and difficult to restrict, limiting their access may be less effective in reducing suicidality among NZ young people (Beautrais, 2000a).

The Experience of Suicide from Young People's Perspectives

Although growing attention has been given to the course of suicidality, there is still limited understanding of young people's experience of suicide, particularly from their own perspective (Orri et al., 2014). Through interviews with young people who have attempted suicide, a comparatively small number of qualitative studies have explored their experience of suicidality (e.g. Bergman et al., 2009; Everall et al., 2006; Grandclerc et al., 2019; Holliday & Vandermause, 2015). Qualitative research has given greater insight into the course of suicide among young people as this method allows for a more comprehensive and nuanced account of their experience. For example, Everall and colleagues (2006) examined the emotional experience of being suicidal, through interviewing 50 young people who had attempted suicide, which were then analysed through a grounded theory approach. Their findings indicate that the suicidal state among young people was marked by overwhelming despair, shame, and social disconnection (Everall et al., 2006).

This body of research has also enabled the exploration of more subtle phenomena like ambivalence. Although ambivalence has received little attention in the youth suicide literature and is often unaccounted for in theoretical models of suicide, qualitative studies suggest young people experiencing suicidality are often ambivalent about taking their life (Bergmans et al., 2009; Grimmond et al., 2019; Holliday & Vandermause, 2015). For

instance, Bergmans and colleagues (2009) used a qualitative grounded theory analysis from interviews with 16 young people who had a history of multiple suicide attempts to explore their recovery from chronic suicidality. They found that young people experiencing suicidality went through periods of ambivalence as they deliberated whether they wanted to live or to die (Bergmans et al., 2009). This is consistent with research in an adult community population, which demonstrated that nearly 95% of those deemed highly suicidal reported experiencing an internal life-or-death debate one or more times (Harris et al., 2010).

Summary of Suicidal Behaviours and Suicidal Ideation among Young People

In summary, the youth suicide literature has prioritised research into the prevalence of suicidality among young people, as opposed to the trajectory and experience of suicide. Consequently, there is limited understanding into suicidal processes among young people, particularly from their own perspectives (Fortune et al., 2007; Orri et al., 2014). As research has often relied on retrospective recall and medical notes, this further limits the understanding surrounding young people's real-time experience of suicide. Moreover, the majority of previous research is quantitative which may struggle to capture the subtleties of young people's experience (Hedeland et al., 2016; Hjelmeland & Knizek, 2010). Thus, there is a need for qualitative research to provide an unrestricted account of young people's communicated experience of suicidality which prioritises their voice (Orri et al., 2014).

Help-Seeking among Young People Experiencing Suicidality

Despite the high rate of mental health issues among young people and the availability of professional help services, an extensive number of studies, both in NZ and internationally indicate that young people do not seek support for mental health problems (Mariu et al., 2012; Raviv et al., 2000; Rickwood et al., 2005; Rickwood & Braithwaite, 1994; Zwaanswijk et al., 2003). Of concern, this low rate of help-seeking is particularly evident among young people experiencing suicidality (Baetens et al., 2011; Carlton & Deane, 2000; Cigularov et

al., 2008; Deane et al., 2001; Mariu et al., 2012; Pirkis et al., 2003; Pisani et al., 2012; Rickwood et al., 2007). It is therefore important to understand the barriers that prevent young people from seeking support for their suicidality. In this section, I briefly discuss why help-seeking for suicidality is important. I then provide an overview of who young people experiencing suicidality are thought to turn to for support, highlighting the limitations with these sources of support. I then review common help-seeking barriers reported in the literature among both informal and formal sources of support, before exploring research, which has prioritised young people's perspectives on what influences their help-seeking.

A number of studies indicate that young people who experience suicidality are at greater risk of subsequent suicide attempts, suicide completions, and poor health outcomes (Cole et al., 1992; Goldman-Mellor et al., 2014; Pelkonen et al., 2011; Wichstrøm, 2000). For instance, longitudinal research in NZ has found that young people who experienced suicidal ideation or had attempted suicide were at increased risk of suicidal ideation, suicide attempts, psychopathology, and physical health difficulties in later life (Fergusson et al., 2005; Goldman-Mellor et al., 2014). However, studies indicate that the development of acute suicidality and suicide completion can be mitigated when the appropriate support is sought (Kalafat & Elias, 1995; Rickwood et al., 2007; Rubenstein et al., 1998). Appropriate help-seeking is consequently regarded as a protective factor for young people experiencing suicidality, with researchers purporting that seeking support may protect young people at all levels of suicide risk (Kalafat & Elias, 1995; Rubenstein et al., 1998; Wilson & Deane, 2001). For the purpose of my study, I have defined help-seeking as the "behaviour of actively seeking help from other people" in response to an issue or distressing encounter (Rickwood et al., 2005, p. 4).

Who do Young People Experiencing Suicidality go to for Support?

Research indicates that young people experiencing suicidality are more likely to seek help from a variety of informal sources of support, such as their family and friends, as opposed to professional support, such as a general practitioner (GP), school counsellor, or psychologist (Arria et al., 2011; Freedenthal & Stiffman, 2007; Gair & Camilleri, 2003; Michelmore & Hindley, 2012). Although the rates of professional help-seeking vary, a review of 23 studies into help-seeking among adolescents who experienced suicidal ideation and self-harm found that the majority of young people did not seek formal support for their distress (Michelmore & Hindley, 2012). For example, Wang and colleagues (2003) found through a self-administered questionnaire that only 37% of 2,372 high school students who were experiencing suicidal ideation and suicide-related behaviours had sought professional help in the previous 12 months. Furthermore, research into help-seeking intentions found that over half of a community sample of young people aged between 18 and 25 thought it was unlikely that they would access professional support if they were suicidal (Wilson, Rickwood, et al., 2011).

Family members have been recognised as important sources of informal support for young people experiencing suicidality (Biddle et al., 2004; Michelmore & Hindley, 2012). Research suggests that family members play important roles in supporting young people experiencing suicidality to recognise they need help and facilitate their engagement with professional support services (Arria et al., 2011; Block & Greeno, 2011; Hassett & Isbister, 2017; LeCloux et al., 2016; Nada-Raja et al., 2003; Rotheram-Borus et al., 1996; Wilson, Rickwood, et al., 2011; Wilson & Deane, 2001). However, studies indicate that the quality of the relationship is important, with findings suggesting that the perceptions of social support mediated whether young people would seek help for their suicidality from their family (Yakunina et al., 2010).

Of concern, is that studies indicate young people who seek help from their family may not always be provided with the support they need (Hedeland et al., 2016). Findings suggest that parents often show low mental health literacy, which can reduce young people's engagement with professional help services (Jorm et al., 2007; Logan & King, 2001). For instance, Jorm and colleagues (2007) using telephone surveys, demonstrated that parents believed it was unsafe to ask young people if they were experiencing suicidal ideation. Research from suicide attempters also suggests that when young people do disclose their suicidality to their family, their parents may not understand their experience and provide inadequate support (Everall et al., 2006; Gair & Camilleri, 2003; Hedeland et al., 2016). Moreover, some studies suggest that young people experiencing suicidal thoughts may be reluctant to seek support from informal supports, particularly their parents (Deane et al., 2001; Freedenthal & Stiffman, 2007; Rickwood et al., 2005).

Nonetheless, research indicates that peers are an important support, with many studies suggesting they are the main source of help for young people experiencing suicidality (Biddle et al., 2004; Coggan et al., 1997; De Leo & Heller, 2004; Fortune et al., 2008b; Michelmore & Hindley, 2012; Nada-Raja et al., 2003). There are concerns with this however, as findings suggest peers may be ill-equipped to provide adequate support on their own (Cigularov et al., 2008; Deane et al., 2001; Dunham, 2004; Sweeney et al., 2015). For example, through the use of hypothetical situations, Dunham (2004) found in a community sample of 288 undergraduate students that fewer than one quarter of young people supporting a suicidal peer would disclose to an adult or encourage their friend to seek formal help.

More recently, research indicates that young people are using digital mediums to get support and to find information, with increases in text-based counselling, social media, and the internet being well-documented (Cox & Hetrick, 2017; Daine et al., 2013; Jones et al., 2011; Kauer et al., 2014; Owens et al., 2015; Rickwood, 2012; Rickwood et al., 2015;

Robinson et al., 2016). Interestingly, findings suggest young people are more likely to self-initiate online support, whereas offline help-seeking often required facilitation from family (Rickwood et al., 2015). Although studies indicate young people find online support helpful, there are concerns regarding the lack of regulation on these mediums, as well as the potential for them to increase suicidality (Best et al., 2014; Cavazos-Rehg et al., 2017; Daine et al., 2013; Owens et al., 2015; Pirkis et al., 2016; Rickwood et al., 2015; Robinson, Hill, et al., 2018).

Another area of concern in the help-seeking literature is that a number of studies suggest many young people experiencing suicidality do not seek support from any source (Coggan et al., 1997; Freedenthal & Stiffman, 2007; Gould et al., 2004; Holliday & Vandermause, 2015; Madge et al., 2008). For example, Gould and colleagues (2004) examined help-seeking intentions among high school students and found that up to a quarter of young people experiencing depression or suicidal thoughts stated they would not talk to anyone about their distress. Studies have also found that young people who attempt suicide often do not disclose this to anyone and consequently fail to receive medical attention (Fortune et al., 2008b; Holliday & Vandermause, 2015; Madge et al., 2008; O'Donnell et al., 2003).

Collectively, these findings indicate that many young people who are at risk of ending their life are not seeking the psychological support they need (Gulliver et al., 2010; Mariu et al., 2012) and little is known about to whom or where they go to for help (Deane et al., 2001; Fortune et al., 2008b; Horowitz et al., 2009). Consequently, the WHO has identified a need for more research into where and how young people seek support for their distress (Barker, 2007).

Barriers to Help-Seeking among Young People

To facilitate help-seeking among young people experiencing suicidality it is important to understand the barriers that prevent them from seeking support from both formal and informal sources. Research indicates that young people's help-seeking behaviour can be distinguished between individual determinants and structural factors. When and how young people seek and engage with support for suicidality is argued to be determined by the interaction of these factors (Downs & Eisenberg, 2012; Mariu et al., 2012; Rickwood et al., 2007). Previously, help-seeking was understood as a one step process (Saunders et al., 1994). However, more recently, help-seeking has been identified as a complex multidimensional process, which involves more than experiencing psychological issues and then seeking appropriate support (Downs & Eisenberg, 2012; Rickwood et al., 2007). Accordingly, there is greater awareness of the various factors that influence if and how young people seek support (Rickwood et al., 2005, 2007) . A number of barriers have been identified which are posited to reduce young people's chances of seeking formal support and/or informal support.

Individual Determinants of Help-Seeking. Research indicates that the nature of what young people experience affects their help-seeking (Boldero & Fallon, 1995; Deane et al., 2001; Rickwood & Braithwaite, 1994; Rickwood et al., 2007). Although findings are inconsistent in regards to how particular mental health issues influence young people's formal help-seeking (Mariu et al., 2012), research has consistently shown that young people experiencing suicidality show low rates of help-seeking (Hom et al., 2015; Michelmore & Hindley, 2012; Rickwood et al., 2005). A number of studies suggest that as young people's thoughts of suicide increased, their help-seeking intentions for both formal and informal sources of support decreased, which is known as help-negation (Carlton & Deane, 2000; Deane et al., 2001; Saunders et al., 1994; Wilson et al., 2005; Yakunina et al., 2010). Interestingly, Saunders and colleagues (1994), through school-based surveys of over 17,000

students in a community sample, found that higher levels of suicidal ideation among high school students was associated with a greater chance of the young person identifying that they needed help. This suggests that young people are aware of the potential risk of suicidal thoughts and recognise the need to seek support. However, higher levels of suicidal thoughts were also related to a lower probability of young people actually seeking support (Saunders et al., 1994). Suicidality in itself is thus argued to be a help-seeking barrier (Rickwood et al., 2005; Saunders et al., 1994).

Research suggests that young people are more likely to seek support if they can identify they are experiencing difficulties and have the knowledge and skills to access support (Gulliver et al., 2010; Kelly et al., 2007; Rickwood & Braithwaite, 1994; Zwaanswijk et al., 2003). Poor mental health literacy is therefore understood to be a considerable barrier to help-seeking among suicidal young people (Arria et al., 2011; Czyz et al., 2013; Dubow et al., 1990; Freedenthal & Stiffman, 2007). For example, Czyz and colleagues (2013) explored formal help-seeking among 165 college students who were at heightened risk for suicidality. Through online surveys, young people who had not received any professional support were asked an open-ended question about why this had not been sought. The most endorsed barrier to formal help-seeking was a lack of perceived need for help for their suicidality (Czyz et al., 2013). Although this study allows for a greater understanding into what prevents young people from seeking support, the barriers were coded using pre-determined established barriers, which may have limited their findings.

It is well-documented that emotional competency influences help-seeking among young people (Ciarrochi et al., 2003; Rickwood et al., 2005, 2007). Research indicates that young people experiencing suicidality may struggle to identify, express, and manage their emotions, which negatively influences their help-seeking behaviours with both formal and informal sources of support (Cigularov et al., 2008; Fortune et al., 2008b; McDermott, 2015;

Wilson, Bushnell, et al., 2011). For example, Cigularov and colleagues (2008) explored perceived barriers to help-seeking among high school students through questionnaires in a community sample. They found one of the key barriers to help-seeking for suicidal thoughts was related to young people's perceived inability to express to an adult how they were feeling, with half of the respondents noting they did not feel confident talking to their parents, teachers, or school counsellors about their distress (Cigularov et al., 2008). Findings also suggest that family home environments may influence emotional competency among young people (Everall et al., 2006). For example, Everall and colleagues (2006) found that young people who had attempted suicide described living in family environments where emotions were not talked about and adaptive coping and emotional expression were not modelled, which impeded their ability to seek support from their parents.

A number of studies have highlighted how young people's beliefs and attitudes influence the process of professional help-seeking for mental health issues and suicidality (Carlton & Deane, 2000; Rickwood et al., 2005, 2007). The most frequently reported attitudinal barriers to professional help-seeking are self-reliance, stigma, and professional support being unbeneficial (Deane et al., 2001; Rickwood et al., 2005).

Research indicates that self-reliance is a barrier for both formal and informal help-seeking among young people experiencing suicidality (Carlton & Deane, 2000; Cigularov et al., 2008; Culp et al., 1995; Curtis, 2010; Downs & Eisenberg, 2012; Fortune et al., 2008b; Freedenthal & Stiffman, 2007; Nada-Raja et al., 2003; Rickwood et al., 2005, 2007; Wilson et al., 2011; Wilson & Deane, 2001). For example, using a mixed methods approach, Curtis (2010) examined help-seeking intentions and knowledge of suicide among NZ university students in a community sample. Their findings indicate that the students' perceived need to be self-reliant was a salient barrier to seeking professional support (Curtis, 2010). Academics argue that the need for help may be perceived as a threat to young people's desire for

autonomy and independence (Raviv et al., 2000). From this perspective, young people may feel like they 'can' or 'should' be able to deal with their problems, regardless of how distressing these may be, which acts as an attitudinal barrier to professional help-seeking (Carlton & Deane, 2000; Gould et al., 2004; Nada-Raja et al., 2003; Wilson et al., 2005; Wilson, Bushnell, et al., 2011).

Studies suggest that stigma toward help-seeking is another key attitudinal reason why young people do not seek professional support for mental health issues and suicidality (Dubow et al., 1990; Fortune et al., 2008; Radez et al., 2020; Rickwood et al., 2005, 2007). For instance, Wilson and colleagues (2011) explored help-seeking intentions for suicidality among 641 university students in a community sample through anonymous online questionnaires. Their findings suggest young people were reluctant to pursue formal support due to negative pervasive discourses surrounding help-seeking (Wilson, Rickwood, et al., 2011).

Stigma surrounding mental health issues and suicide has also been identified as a pertinent help-seeking barrier (Arria et al., 2011; Curtis, 2010; Fortune et al., 2008b; Freedenthal & Stiffman, 2007; Gilchrist & Sullivan, 2006; Nada-Raja et al., 2003; Radez et al., 2020; Rickwood et al., 2005). In a review of the literature, Michelmore and Hindley (2012) found that stigma and anxiety surrounding treatment were prominent barriers to professional help-seeking among young people experiencing suicidality. Fears of the consequences of seeking professional help, such as unwanted hospitalisation and being labelled as mentally unwell were identified as barriers to seeking support among suicidal young people in a number of studies (Cigularov et al., 2008; Freedenthal & Stiffman, 2007; Nada-Raja et al., 2003). Concerns surrounding confidentiality have also been noted as a help-seeking barrier among young people (Dubow. et al., 1990; Fortune et al., 2008b; Gilchrist & Sullivan, 2006; Michelmore & Hindley, 2012; Rickwood et al., 2005, 2007; Wilson & Deane,

2001).

Beliefs surrounding professional support services being unhelpful is another well-established barrier in the literature, particularly if a young person experiencing suicidality had sought support and it had been ineffective (Carlton & Deane, 2000; Gibson et al., 2016; Rickwood et al., 2005, 2007; Wilson et al., 2005). A number of studies indicate that formal support was unhelpful for young people experiencing suicidality, which may account for their negative attitudes towards professional help services (Michelmore & Hindley, 2012). For instance, in face-to-face structured interviews of a community sample of over 6,000 young people and their parents, Nock and colleagues (2013) found that over half of young people experiencing suicidality had sought treatment *before* the onset of suicidal behaviours. These findings suggest that formal treatment had been ineffective in preventing suicidality (Nock et al., 2013). Research also indicates that the experience of the emergency department is particularly difficult and punitive for young people experiencing suicidality (Holliday & Vandermause, 2015; Owens et al., 2016; Sinclair & Green, 2005; Taylor et al., 2009). Findings from qualitative research have demonstrated that accident and emergency clinicians may not know how to respond effectively to young people experiencing suicidality (Holliday & Vandermause, 2015) and may lack empathy (Taylor et al., 2009). More research is needed to explore the experience of professional help-seeking among suicidal young people and why they hold negative beliefs towards formal support services.

Young People's Perspectives on Individual Barriers. Although the above studies provide invaluable insight into help-seeking barriers among young people experiencing suicidality, they have, like much of the research in this area, predominantly relied on quantitative methods (Freake et al., 2007; Gair & Camilleri, 2003). To get a more in-depth understanding of what prevents young people experiencing suicidality from seeking support, a number of more recent qualitative studies have explored help-seeking barriers (Gulliver et

al., 2010). By prioritising young people's own experience, these studies have identified barriers, which have previously received less attention.

A number of studies suggest that young people experiencing suicidality worry that their suicidality will not be understood or taken seriously (Everall et al., 2006; Gibson et al., 2016, 2019; Gilchrist & Sullivan, 2006; Grimmond et al., 2019; Lachal et al., 2015). In a review of the qualitative youth suicide literature, Lachal and colleagues (2015) conducted a thematic analysis from 44 studies which explored the perspectives of suicide attempters and their support people. They identified that misunderstandings between young people experiencing suicidality and their support people were a salient factor in reducing help-seeking behaviours. More specifically, the review found that young people experiencing suicidality did not feel understood, heard, and valued by their support people (Lachal et al., 2015). In particular, research suggests that young people fear their parents will not understand their experience of suicide, which prevents them from speaking with them about their difficulties (Gilchrist & Sullivan, 2006). Findings from interviews with suicide attempters suggest that young people may want to disclose their suicidality to their parents, but due to past adverse help-seeking experiences with their family, are afraid of how their parents will react to their negative emotions (Everall et al., 2006). It therefore no surprise that research indicates young people value help-seeking relationships where they are listened to and their experience is validated (Fortune et al., 2008a; Wilson & Deane, 2001). As being misunderstood has received less attention in the literature, there is a need for a greater understanding surrounding how this barrier influences help-seeking.

Young people's feelings of isolation while experiencing suicidality have been well-documented, with research suggesting this acts as a help-seeking barrier for both formal and informal sources of support (Freedenthal & Stiffman, 2007). Findings suggest that young people experiencing suicidality may struggle to identify people whom they feel safe or

comfortable to talk to due to fears of being misunderstood, stigma, and shame (Freedenthal & Stiffman, 2007; Fullagar, 2003; Gibson et al., 2019; Gilchrist & Sullivan, 2006). Importantly, research has found that parents may view themselves as being accessible to their children, whereas, young people experiencing suicidality may not trust their parents and regard them as being unapproachable (Gilchrist & Sullivan, 2006).

Despite stigma surrounding suicide being a well-established barrier in the literature, qualitative research has provided greater insight how fear of judgement influences help-seeking among young people experiencing suicidality (Curtis, 2010; Everall et al., 2006; Fortune et al., 2008b; Grimmond et al., 2019). Due to societal pressures to be happy, a number of studies have demonstrated that young people experiencing suicidality fear judgement from others for experiencing and expressing negative emotions and suicidal ideation (Grimmond et al., 2019). Consequently, young people experiencing suicidality may conceal their distress from others by putting up a façade to hide their true experience (Everall et al., 2006; Holliday & Vandermause, 2015; Rasmussen, Haavind, et al., 2018). Academics have described this façade as an "artificial emotional identity" where suicidal young people are argued to have a private self and a public self (Everall et al., 2006, p. 383).

In line with these findings, research also indicates that embarrassment and shame surrounding experiencing suicidality may reduce help-seeking among young people (Everall et al., 2006; Freedenthal & Stiffman, 2007; Gilchrist & Sullivan, 2006; Holliday & Vandermause, 2015; Törnblom et al., 2015). For instance, studies suggest young people avoided disclosing their suicidality to their doctor as they did not want to appear weak (Holliday & Vandermause, 2015). Interestingly, findings indicate that embarrassment and the stigma associated with suicide may be more apparent barriers among informal sources of support (Freedenthal & Stiffman, 2007). As previous research has demonstrated that young people highly value what others think of them, this demographic may be particularly

vulnerable to fear of judgement and shame for experiencing suicidality (Medina & Luna, 2006).

Difficulties trusting others with sensitive information has been a well-established help-seeking barrier among young people experiencing suicidality (Pisani et al., 2012; Rickwood et al., 2005, 2007). However, qualitative studies have allowed for a greater understanding of how trust and confidentiality concerns act as barriers to young people in seeking support (De Leo & Heller, 2004; Gair & Camilleri, 2003; Gilchrist & Sullivan, 2006; Wilson & Deane, 2001). For example, Gilchrist and Sullivan (2006), explored attitudes and behaviour towards help-seeking for distress and suicidality among young people. Through interviews with young people, parents, and support workers in a community sample of 41 participants they found that trusting others was integral for young people to openly communicate how they were feeling. However, young people in the study often communicated not trusting that teachers and counsellors would keep their information safe (Gilchrist & Sullivan, 2006). Of note, research has also found that young people's concerns with trust is still evident when seeking help from their peers (De Leo & Heller, 2004; Gilchrist & Sullivan, 2006).

Although less well-documented, qualitative research has also found that young people's concerns surrounding hurting the people they care about has prevented them from seeking support (Burton Denmark et al., 2012; Fortune et al., 2008b; Freedenthal & Stiffman, 2007). Burton Denmark and colleagues (2012) using an online questionnaire asked 558 students who had experienced suicidal ideation why they had not sought support for their suicidality. Through a content analysis of this open-ended question, concerns regarding how the student's disclosure would impact others was the second most prevalent reason given. The authors argue that this fear of burdening others may be why some young people prefer seeking help from formal support services, as opposed to family or friends (Burton Denmark

et al., 2012). Interestingly, Grimmond and colleagues' (2019) thematic synthesis of 27 studies found that being a burden was not identified as a theme by authors in the individual studies, despite it being evident in their review. This highlights the need for future research to explore perceived burdensomeness as a barrier to help-seeking, particularly among informal sources of support.

From the limited number of qualitative studies on young people's understanding of suicide, findings suggest that discursive tension between normalised, immoral, and medicalised understandings of suicide may negatively influence help-seeking (Bennett et al., 2003; Roen et al., 2008). These findings suggest that although young people may not frame suicide as an individual psychopathology, the social-cultural context, which often positions suicide as deviant and immoral, may negatively influence their help-seeking (Bennett et al., 2003). Moreover, many researchers argue that young people may be reticent to seek help in an attempt to actively reject the medicalisation of their experience and to position themselves as normative (Biddle et al., 2007; Fullagar, 2005; Prior, 2012). The help-seeking process may consequently be problematic for young people who are experiencing suicidality as they negotiate their need for help and their fear of the stigma associated with suicide (Bennett et al., 2003; Fullagar, 2005). Although these studies provide new insights into how discursive tensions may influence help-seeking, they have often relied on community samples and retrospective recall; highlighting a need for future research to explore how young people in crisis communicate their understandings of suicidality and how this may influence their help-seeking.

Structural Barriers to Help-Seeking. Michelmore and Hindley's (2012) literature review found practical help-seeking barriers, such as not being able to get to an appointment and wait-times, were not as influential as individual determinants of help-seeking among young people experiencing suicidality. This is in line with findings from a number of

qualitative studies, which suggest that structural barriers are less influential among suicidal youth (Fortune et al., 2008b; Freedenthal & Stiffman, 2007). However, some qualitative studies indicate that accessibility is in fact a salient help-seeking barrier among suicidal young people (Czyz et al., 2013; Jordan et al., 2012). For example, young people in Czyz and colleagues' (2013) study frequently described being too busy to seek professional support, noting they found it difficult to fit it into their lives. Moreover, research into online self-harm support groups found that accessibility was a barrier to seeking support, with many self-harmers noting that services were not available when they were needed (Williams et al., 2018). Practical components that make a service more accessible, such as it being free and open after hours have also been identified as important (French et al., 2003). Furthermore, findings suggest that due to stigma surrounding suicide, young people experiencing suicidality value support services they can access discreetly without others knowing (Jordan et al., 2012). Overall, the impact that structural barriers have on young people's help-seeking remains unclear and findings are inconsistent. Therefore, to further understand how structural components influence help-seeking with professional support among young people experiencing suicidality, more research is needed.

Summary of Help-Seeking among Young People Experiencing Suicidality

A number of barriers to both informal and formal help-seeking for suicidality among young people have been identified. Studies which have prioritised the perspectives of young people have highlighted areas of importance, which have previously been given less empirical attention. This suggests young people have important and useful perspectives, which will provide much needed insight into their specific needs and wants from their support people (Freake et al., 2007). However, the majority of previous studies have relied on retrospective recall or help-seeking intentions using quantitative methods. There is thus a gap in the literature surrounding how young people in crisis communicate their barriers to seeking

support. This highlights the need for more qualitative research in the help-seeking literature, particularly from the perspective of young people experiencing suicidality.

Young People and their Engagement with Mental Health Support Services

Once young people experiencing suicidality seek help, their engagement with professional support has been identified as another area of concern (Michelmore & Hindley, 2012). It is therefore important to understand the factors that influence suicidal young people's engagement with support to elucidate their unique needs and wants. In this section, I explore the idea that young people are a difficult group to engage in therapy. I then review research on young people's perspective and experience of therapy, highlighting factors that are thought to increase engagement with professional support among young people experiencing suicidality.

Studies indicate that many suicidal young people are not receiving ongoing professional help, with findings suggesting low compliance to treatment and high dropout rates among young people who have attempted suicide (Groholt et al., 2006; Haw et al., 2002; Michelmore & Hindley, 2012; Piacentini et al., 1995; Spirito et al., 1992, 2002). As clients are argued to be active participants in the therapy process, engagement in treatment is important to ensure clinical interventions are effective (Bohart, 2000). However, previous research has focused on attrition among youth experiencing mental health issues and less attention has solely been given to the factors that influence engagement among young people experiencing suicidality (Block & Greeno, 2011; Zirkelback & Reese, 2010).

Young people are often viewed as a difficult to engage client group, both in the literature and by professionals (Church, 1994; Freake et al., 2007; Hanna & Hunt, 1999). They are frequently depicted as believing they do not require treatment and will only attend therapy due to pressure from their parents or authority figures (Church, 1994; Everall & Paulson, 2002). However, other researchers contend that young people's difficulties with

engagement are due to developmental and cultural influences, which are unique to young people and are often not taken into account by professionals (Block & Greeno, 2011; Church, 1994; McGorry et al., 2013). McGorry and colleagues (2013) posit that mental health services have not been developed to meet these developmental and cultural needs, which can account for the high treatment dropout rate among young people. This highlights a need for a greater understanding of young people's priorities and preferences when engaging with psychological support services, so that their engagement with therapy increases. In order to elucidate these needs, young people's perspectives, which previously have been undervalued in research, are vital (Block & Greeno, 2011; Duncan et al., 2007).

Young People's Perspectives on Therapy and Increasing Engagement

Due to the belief that young people are unable to provide accurate accounts or feedback of their experience of psychological intervention, research on young people's experiences of therapy is limited (DiGiuseppe et al., 1996; Zirkelback & Reese, 2010). Consequently, there is a dearth of understanding about what enhances engagement with psychological support services from the perspective of young people, particularly among those experiencing suicidality (Duncan et al., 2007; Hollidge, 2013; Watsford & Rickwood, 2015). However, research which has explored young people's experience of formal support services through qualitative methods suggests that youth have distinct needs and priorities when engaging with professional support (Buston, 2002; Gibson et al., 2016; Gibson & Cartwright, 2014; Midgley et al., 2016).

Consistent with the development literature, a number of studies have highlighted that young people desire autonomy and control when engaging with psychological support services (Church, 1994; Everall & Paulson, 2002; Gibson et al., 2016; Gibson & Cartwright, 2013; Hassett & Isbister, 2017; Binder et al., 2011; Wilson & Deane, 2001; Wisdom et al., 2006). Moreover, findings indicate that a clear preference among young people is to exclude

their parents from the therapy process (French et al., 2003; Gibson et al., 2016; Harper et al., 2014). Research also suggests that young people's experience of agency when engaging with professional support may help facilitate engagement and positive treatment outcomes (Binder et al., 2011; Dunne et al., 2000; Everall & Paulson, 2002; Freake et al., 2007; Gibson & Cartwright, 2013). Despite the above findings providing pertinent insight into how the need for autonomy, control, and agency may influence engagement among young people, there is little research into how these needs may affect those experiencing suicidality.

The therapeutic alliance has been widely recognised as being essential for the process and outcome of therapy with clients of all ages (Block & Greeno, 2011; DiGiuseppe et al., 1996; Bolton Oetzel & Scherer, 2003). Research examining young people's priorities for engagement with support services indicates that the therapeutic relationship is highly valued by them and they respond well to a genuine and strong relational connection (Bolton Oetzel & Scherer, 2003; Bury et al., 2007; Buston, 2002; Gibson et al., 2016; Wisdom et al., 2006; Zack et al., 2007). Furthermore, studies have found that a strong therapeutic alliance can have a moderating effect on reducing suicidal ideation among young people (Everall & Paulson, 2002; Gulbas et al., 2019; Gysin-Maillart et al., 2017).

Young people have also communicated a desire for certain characteristics in their therapists, such as being empathetic, non-judgemental, and understanding (Binder et al., 2011; Buston, 2002; Everall & Paulson, 2002; French et al., 2003; Gulbas et al., 2019; Hollidge, 2013). For example, Gulbas and colleagues (2019) explored suicide trajectories and resilience building after a suicide attempt in a longitudinal qualitative study among seventeen young people from an ethnic minority group. They found that therapy was a core part of the participant's recovery process and an integral component of this was having a trusted and empathetic relationship with their therapist (Gulbas et al., 2019). Research also suggests that young people may value getting practical information from therapy, which is argued to

increase their connection with their therapist (Wisdom et al., 2006).

Findings indicate that young people experiencing suicidality value the therapeutic relationship when it is positioned as a friendship where they can work collaboratively, as opposed to a professional partnership (Everall & Paulson, 2002; Gair & Camilleri, 2003; Hassett & Isbister, 2017; Jordan et al., 2012). This may be related to young people's need for autonomy and control as this style of relationship is argued to reduce power differentials (Hanna & Hunt, 1999) and normalises both help-seeking and emotional distress (Wisdom et al., 2006). For example, Hassett and Isbister (2017) explored initial help-seeking and ongoing engagement with community mental health services through interviews with eight young men who had self-harmed with or without suicidal intent. The findings suggested that the factors that facilitated engagement among the participants were having control and choice, as well as an egalitarian partnership with their clinician where they were treated as equal (Hassett & Isbister, 2017).

The desire for a genuine connection with their therapist, as well as the need to maintain autonomy and control, is argued to contribute to young people's difficulties in engaging with support services as they may struggle to have these contradictory needs met (Gibson & Cartwright, 2014). Thus, psychological support services that can help young people balance these needs may be particularly effective in increasing their engagement (Binder et al., 2011; Gibson & Cartwright, 2014).

The accessibility and flexibility of psychological services has also been identified as another area of importance in increasing engagement among young people (Gibson et al., 2016; Knight et al., 2018; Spirito et al., 2002). Through structured telephone interviews with young people and their parents, Spirito and colleagues (2002) examined barriers to treatment engagement among 63 young people who had attempted suicide in a longitudinal study. They found that service barriers, such as difficulties making appointments had a negative influence

on treatment participation (Spirito et al., 2002). Studies also suggest that young people may value informal therapeutic interactions, where they have the flexibility of being able to stop and engage in therapy when they want and need (Block & Greeno, 2011; French et al., 2003; Gibson et al., 2016; Jordan et al., 2012; Knight et al., 2018). From this perspective, young people's dropout from mental health support services may not be due to their discontentment with the service, but instead could be related to changes in their needs over time (Gibson et al., 2016).

Summary of Engagement with Mental Health Services

In summary, young people have distinctive needs and priorities when they engage with formal support services. However, studies that specifically explore engagement among suicidal young people are scarce. More research from the perspectives of young people experiencing suicidality is needed to increase our understanding of their experience of formal help sources, so that these services can be adjusted to meet their unique needs (Bury et al., 2007; McGorry et al., 2013). In particular, academics have argued that future research should focus on what facilitates ongoing engagement among young people by exploring where and how they seek support (Barker, 2007; Hassett & Isbister, 2017).

Text Message Counselling

Text message counselling is becoming increasingly popular among young people (Haxell, 2014; Nesmith, 2018). It is therefore important to elucidate why they value this medium, particularly among those experiencing suicidality. In this section, I discuss how changes in digital technology have shaped how mental health services provide support to young people. I then explore how young people experiencing suicidality use text-based counselling through a range of mediums. Following this, I review the development of text messaging, before discussing research into text message counselling using short message service (SMS).

Utilising Digital Mediums to Provide Formal Support

To increase young people's engagement with mental health services the acknowledgement of contextual issues, such as developmental influences and youth culture is argued to be essential (Church, 1994; Hollidge, 2013; Sauter et al., 2009). In an attempt to meet the diverse needs and priorities of young people, the context of psychological support services has transformed to encompass the immense changes in digital technologies (Gibson et al., 2016). Consequently, a variety of options for psychological support are available for young people, both in NZ and globally, which utilise the ever evolving changes in technology (Gibson et al., 2016; Hawton et al., 2012; Rickwood, 2012).

Globally, findings suggest that text-based counselling for young people experiencing suicidality is becoming increasingly popular (Nesmith, 2018). Text-based support services have often been developed through crisis helpline organisations, which recognised the changes in digital technology (Mokkenstorm et al., 2016). These services have provided online support through mediums, such as email, text message, chat services, and social networking sites (Martin et al., 2011). Text-based counselling has been delivered through structured sessions, as well as naturalistic, as needed crisis support which is not ongoing (Dowling & Rickwood, 2014; Rickwood, 2012).

Psychological support services that have employed text-based communication technologies have been well-received by young people (Callahan & Inckle, 2012; Gibson et al., 2016; Robinson et al., 2016). Research which examined young people's experiences of online counselling support services found that accessibility, anonymity, confidentiality, and having control over the interaction were valued aspects of these communication mediums (Hanley, 2009; King et al., 2006; Navarro et al., 2019). Moreover, this anonymity is argued to reduce anxiety surrounding social judgement, which is thought to enable more open discussions surrounding sensitive topics, such as suicide (Callahan & Inckle, 2012;

McDermott & Roen, 2016).

Text-based mediums are said to reach young people in distress in ways that were previously not possible (Cox & Hetrick, 2017; Rice et al., 2016). In particular, the accessibility and flexibility of online interventions are thought to provide a unique opportunity for young people, who previously avoided seeking help for their suicidality and distress (Rice et al., 2016; Rickwood et al., 2016). As online support can be accessed at any time and place, it may be especially suitable to the fluctuations in suicidality that young people often report experiencing (Hetrick et al., 2016).

Despite the wide use of text-based counselling, research into the efficacy of this medium in supporting suicidal young people remains relatively scarce (Robinson et al., 2014; Sindahl et al., 2019). There have also been concerns in the literature surrounding how text-based support services can ensure the safety of their service users who are experiencing suicidality (Cox & Hetrick, 2017). However, researchers argue that if adequate safety protocols are followed, text-based mediums should be able to ensure safe and effective practice (Rice et al., 2016).

The ability of text-based mediums to create a safe therapeutic space where young people feel comfortable to disclose suicide has also been called into question (Callahan & Inckle, 2012; Helton, 2003). In spite of these concerns, studies have conversely found that young people may find it easier to communicate their distress through text-based mediums (Gibson & Trnka, 2020; Hassett & Isbister, 2017; Haxell, 2014; King et al., 2006). For example, Hassett and Isbister (2017) found that their young people experiencing suicidality valued being able to use text message and social networking mediums to seek support as they could reflect on what they wanted to communicate before sending a message. Gibson and Trnka (2020) argue that young people may have strong online emotional literacy, resulting in them being more confident and capable of communicating their difficulties online. Text-

based counselling may thus directly target the difficulties communicating that many young people experiencing suicidality are thought to experience.

Academics have also communicated uncertainty surrounding how relational connection can be established between the client and counsellor, especially given the lack of visual and verbal cues with many modes of communication technologies (Callahan & Inckle, 2012; Hanley, 2009; Helton, 2003). Nonetheless, a number of studies suggest that an effective working alliance can be created through a variety of mediums, such as telephone counselling (Gibson et al., 2016; Reese et al., 2002) and online counselling spaces (Cook & Doyle, 2002; Hanley, 2009).

Overall, the findings into text-based counselling for young people experiencing suicidality are promising. However, more research is needed to further understand how suicidal young people use text-based mediums for support (Cox & Hetrick, 2017). In particular, when compared to computer-based text communication, less is known about text message counselling through SMS (Martin et al., 2011). Although there are clear similarities between current smart phones and computers, academics argue that accessing support via text message allows for more flexibility and accessibility, which may influence how and when help is sought (Nesmith, 2018).

The Evolution of Text Messaging among Young People

Text messaging is one of the most frequent forms of communication among youth worldwide (Nesmith, 2018; Thompson & Cupples, 2008). Mobile phone possession is common, with findings suggesting that up to 80% of young people have one (Evans et al., 2013). Text messaging is also a relatively cheap way to connect with others, which is thought to increase young people's accessibly in using this medium (Haxell, 2014).

Interestingly, studies suggest that young people find it easier to communicate with their peers through texting, when compared to calling them or interacting face-to-face (Evans

et al., 2013). Despite concerns that technology may increase feelings of isolation, research indicates that instead, this medium of communicating has been associated with increased social connection among young people (Green, 2003). Developments in technology may therefore challenge how relationships have been traditionally established and maintained (Green, 2003; Turkle, 2011), which is argued to delineate young people from older generations (Ling et al., 2002; Rickwood, 2012).

Text messaging is also thought to increase young people's autonomy through establishing highly valued spaces in which they can communicate privately without adult intrusions (Green, 2003). For example, a NZ study explored general issues surrounding mobile phone use and ownership among young people through focus groups and found that proximal contact was facilitated through mobile technologies. Participants in the study valued how text messaging gave them more control over the communication process and allowed them to escape adult surveillance (Thompson & Cupples, 2008).

Text Message Counselling and Suicidal Young People's Needs and Wants

Text message counselling is a relatively new service development, both in NZ and internationally (Evans et al., 2013; Youthline, 2010). There is consequently limited research into how and why young people use text message counselling, particularly among those who are experiencing suicidality. Although, the efficacy of these services remains unclear, young people continue to use this medium for support in staggering numbers (Nesmith, 2018; Sindahl et al., 2019).

Despite the limited research, findings suggest that this medium may be particularly beneficial in meeting many of young people's needs (Evans et al., 2013; Gibson et al., 2016; Gibson & Cartwright, 2014; Haxell, 2014; Nesmith, 2018). For example, Gibson and Cartwright (2014) examined young people's experiences of text message counselling in NZ through narrative style interviews with 21 young people who had used Youthline's text

message counselling service in the previous 12 months. Their findings suggest that text message counselling was a familiar and accessible medium and young people valued the privacy, anonymity, flexibility, and sense of control associated with the service. In particular, young people who were suicidal described a preference for text message counselling over face-to-face support, as this medium was less of a threat to their autonomy. The youth in the study also voiced the importance of their relational connection with the counsellor, noting they viewed the counsellor as a real person, despite receiving minimal cues or information about them and not being able to speak with the same support person on each interaction. The authors argue that text message counselling may therefore be able to synthesise young people's need for authentic connection, whilst maintaining their autonomy (Gibson & Cartwright, 2014).

These findings are in line with Evans and colleagues (2013), who used focus groups with high school students in a community sample to explore young people's attitudes towards a text-based crisis line. The participants in the study identified that being able to access help without others knowing or intervening was as an appealing aspect of text message counselling (Evans et al., 2013). This provides further support for young people's preference to maintain their autonomy and control when accessing support services, which may contribute to this mediums popularity among young people (Gibson & Cartwright, 2014).

The appeal of anonymity in text message counselling has been demonstrated in a number of studies (Evans et al., 2013; Gibson & Cartwright, 2014; Haxell, 2014). For example, Haxell (2014) reviewed 6,400 messages through Youthline's text message counselling service. Their research suggests that when seeking psychological support, young people may find text messaging appealing as their anonymity may be augmented given that they are not visible or audible to the counsellor. This is congruent with Evans and colleagues (2013), who found the anonymity of text message counselling was not only highly valued by

young people, but it also facilitated the ease at which they would disclose sensitive topics, such as suicidality. However, this study explored the perspectives of youth in general, who had not necessarily used a text counselling service for support, which may have influenced their findings.

Accessibility has also been identified as an important aspect of text message counselling (Evans et al., 2013; Gibson & Cartwright, 2014; Haxell, 2014; Nesmith, 2018). Nesmith (2018) analysed 49 randomly selected counselling transcripts from a text message crisis service, as well as interviewing two text-counsellors. One of their salient findings was that text message counselling allowed young people, who might otherwise not seek or receive help to engage with support (Nesmith, 2018). This accessibility may be particularly beneficial for young people living in rural NZ, who have limited access to psychological support services (Haxell, 2014). Interestingly, research has also found that young people access text messaging counselling services in a range of contexts and situations, suggesting an immediacy in their need for help (Nesmith, 2018; Haxell, 2014).

A small number of studies also suggest that young people experiencing suicidality find text message counselling services helpful (Gibson et al., 2016; Gibson & Cartwright, 2014; Nesmith, 2018; Sindahl et al., 2018). For example, Sindahl and colleagues (2018) completed follow-up online questionnaires among 46 young people who accessed a text message counselling service for suicidality. They found that 35% of youths who used the service felt immediately better after speaking with their text-counsellor (Sindahl et al., 2018).

Although these findings provide valuable insight into text message counselling among young people, more research is needed. There is currently a dearth of understanding into how suicidal youth use text message counselling when they are in crisis. As previous research suggests this medium may be particularly beneficial to those experiencing suicidality, research which focuses solely on suicidal young people is imperative (Gibson et al., 2016).

Moreover, the majority of previous studies have relied on retrospective accounts and community samples where young people might not have used text message counselling before, which may have limited their findings.

Summary of Text Message Counselling

Overall, these findings suggest that text message counselling meets a number of young people's needs and wants. However, there is limited understanding into how and why young people experiencing suicidality use this medium of support when they are in crisis and more research is needed. As young people experiencing suicidality are often reluctant to seek help and engage with psychological support services (Michelmore & Hindley, 2012), certain features of text message counselling, such as its anonymity, accessibility, and the user's sense of control over the interaction may be of particular importance. A greater understanding of how and why suicidal young people use text message counselling services may provide much needed insight into how to increase their help-seeking and engagement with support services.

Overall Conclusion and Overview of the Current Study

Currently, there is limited qualitative research from young people's perspectives surrounding what contributes to them experiencing suicidality, their experience of suicide, and what barriers and facilitators influence their help-seeking and engagement with support, including text message counselling. In particular, there is a dearth of studies, which offer an unrestricted real-time account of young people's experience of suicidality, in crisis. Understanding how young people both experience and make sense of their experience is crucial to elucidate youth suicide. This literature review has argued that young people have useful and important things to say and are active participants in how they make sense of and experience the world. Without considering young people's perspectives and locating these within youth culture and wider cultural understandings, effective suicide prevention may be difficult to achieve.

Accordingly, my research prioritised the insights and experiences of young people experiencing suicidality through a qualitative analysis of their communications on a text message counselling service. This research addressed four questions:

1) What do young people see as contributing to their suicidality?

2) How do young people communicate their experience of suicidality?

3) What prevents young people experiencing suicidality from seeking support?

4) Why do young people experiencing suicidality reach out to a text message counselling service when they are in crisis?

In the following chapter, I outline the research approaches and processes used to conduct my research.

Chapter Two: Research Methodology

In this chapter, I outline the research methodology employed in my study. I will discuss the aims of my study, the theoretical framework that informed this research, ethical considerations, and the method of data collection and analysis.

Study Aim

Through analysing text message counselling interactions between young people who were experiencing suicidality and their counsellors, I aimed to gain an understanding into the following: what young people said contributed to them experiencing suicidality; what young people in crisis text about their experience of suicidality; what young people who were experiencing suicidality text about help-seeking barriers; and why young people experiencing suicidality reached out to a text message counselling service.

Theoretical Framework

Research has previously given less attention to how young people themselves understand and make sense of their experience of suicidality (Claveirole, 2004). I sought to address this gap in the literature by exploring how young people communicate their experience of suicidality to their counsellors on a text message counselling service in NZ.

A qualitative methodology was considered appropriate for this study for a number of reasons. Firstly, qualitative approaches seek answers to questions that focus on how social experience is created and given meaning (Denzin & Lincoln, 2005). Through interpreting or making sense of phenomena and experiences with regard to the meaning people give to them, qualitative research aims to acquire a deeper understanding of the phenomena being explored, as opposed to only examining surface features (Denzin & Lincoln, 2000; Schwandt, 2000). Thus, given that at the core of qualitative research is a focus and interest in meaning (Braun & Clarke, 2013), it was deemed to be an appropriate research framework to explore how suicidality is communicated by young people during text message counselling interactions.

Secondly, qualitative research can be flexible and adaptable in its approach, which can allow for a broader and richer account of phenomena (Good & Watts, 1996; Rohleder & Lyons, 2015). Due to the limited understanding of young people's experiences and perceptions of suicidality, a deeper understanding, which captures the nuances and complexities of how young people communicate their experience of suicidality was considered important.

Thirdly, qualitative researchers argue that knowledge is context specific and thus aim to situate findings within its context (Coyle, 2007). This is of particular importance to my study, given that this research was informed by contemporary conceptions of young people and youth culture, and the findings were located in the social-cultural context. In particular, the data I used was gathered in the context of a counselling interaction using a novel digital medium.

Lastly, qualitative methods allow for young people's experiences to be heard and prioritised (Willig, 2013). As mentioned previously, young people's perspectives have historically been discounted in both general research surrounding young people and in the youth suicide literature (Claveirole, 2004). Allowing young people to voice their personal experiences not only provides rich data grounded in their own language, but also gives an opportunity for new degrees of understanding (Willig, 2013).

Epistemology

Epistemology can be defined as "the study of the nature of knowledge and justification" (Schwandt, 2001, p.71) and can thus be understood as a "justification of knowledge" (Carter & Little, 2007, p.1317). There are a number of theoretical positions underlying qualitative research and the epistemological stance taken by researchers is dependent on their assumptions surrounding how truth and knowledge are conceptualised (Carter & Little, 2007; Chamberlain & Murray, 2008; Crotty, 1998). These assumptions are immensely influential in

shaping the research process, which consequently influences how and what knowledge is generated (Carter & Little, 2007). Braun and Clarke (2013) argue that epistemological positions can be distinguished by whether a researcher thinks reality is *discovered* through or *created* through the research process. Epistemological positions can therefore be differentiated in regards to where meaning resides (Chamberlain & Murray, 2008; Crotty, 1998).

My research adopted a social-constructionist epistemology with an interpretative position informed by contemporary conceptions of young people and the digital world they reside in. From a social-constructionist perspective, humans do not find or discover knowledge, but instead construct it through interpreting or making sense of their experiences (Crotty, 1998; Schwandt, 2000). From this view, the communicated experiences of young people experiencing suicidality are neither absolute representations of 'truth' nor works of fiction, but instead are their interpretations of their socially constructed experience. These interpretations are not constructed in isolation, but instead are located socially, historically and culturally, and are consequently provisional (Schwandt, 2000). Furthermore, a social constructionist epistemology also recognises that my own understandings as a researcher are shaped by dominant discourses (Schwandt, 2000).

Suicide can be understood as a historical and social construct, and as a result, young people's experiences of suicidality are socially and culturally produced (Fullagar et al., 2007; Philo, 1996). From a social-constructionist perspective, the experience of suicide is always constructed by someone, for a particular purpose, in some context. Consequently, when young people communicated their experience of suicidality this was regarded as being done to an audience, in this case their text-counsellor, and they may have constructed a different account to their friends, teachers, or family (Chamberlain & Murray, 2008). Thus, these young people's communicated experience of suicidality was perceived to be contextually and

interactionally constructed (Chamberlain & Murray, 2008).

Interpretivism is a theoretical position linked with constructionism (Grey, 2014). Schwandt (2000) argues that in order to understand the meaning of an action, one needs to interpret what the actor is doing. These interpretations are influenced by our temporal, social, historical, and cultural context (Crotty, 1998). Understanding or meaning-making is consequently unable to be separated from the context (Angen, 2000). As an interpretive researcher, I therefore looked for culturally arisen and historically located interpretations of young people's communicated experiences. This allowed me to venture interpretations of what the young people in my study may be trying to communicate about their own experience (Crotty, 1998; Denzin & Lincoln, 2005).

Youth-Centred Approach

My research took a youth-centred approach to young people's communicated experiences (Braun & Clarke, 2013). Consistent with my over-arching social-constructionist epistemology, the approach to my study was informed by the context and numerous systems of meaning in which young people reside in (Braun & Clarke, 2013; White & Wyn, 2012). More specifically, the theoretical perspectives that informed my research were underpinned by psychological theories of development and current conceptualisations of young people, which emphasise the importance of the social-cultural context and youth empowerment. These perspectives shaped how young people and their experiences were perceived and understood in my study (White & Wyn, 2012).

My research considered developmental understandings of the youth life stage and how this may have shaped their experiences. It also located young people's experiences in a context where there are legitimate concerns surrounding mental distress and suicidality among young people. My study considered the limited power young people have in society and how this may influence how they make sense of and experience their world. However, it

also recognised that young people themselves are able to generate norms and values of their own, which resists or differs from dominant understandings in the wider society (White & Wyn, 2012; Wyn & Harris, 2004). This research thus positioned young people as being active in their meaning-making and identity construction as they negotiated social and cultural changes on their journeys to adulthood, whilst also being influenced by their social-cultural context (White & Wyn, 2012).

My research recognised that young people are in a context where rapid changes in information and communication technology continue to transform people's lives (Green, 2003; Rickwood, 2012; White & Wyn, 2012). The young people of today are argued to be immersed in a digital culture, which challenges previous communication boundaries and offers new ways for them to connect with others and experience communities (Green, 2003; Rickwood, 2012; Swartz, 2014; White & Wyn, 2012). This immersion is thought to be one of the defining characteristics of contemporary youth culture (White & Wyn, 2012). Young people are argued to be 'digital natives' as this context of communication technologies is the only world they are familiar with (Prensky, 2001; White & Wyn, 2012). From this perspective, young people's native tongue is the digital language of text-based communication (Prensky, 2001). Accordingly, my research acknowledged the omnipresence of digital technology among young people and recognised that communicating via these mediums is a natural part of their life (Rickwood, 2012; Turkle, 2011). My study also located young people in a context where developments in digital information and communication technologies have deeply influenced how young people experience social relationships (Green, 2003; White & Wyn, 2012). However, I recognised that young people themselves have in turn contributed to how these mobile technologies have developed and are not passive participants of the digital technology culture (Katz & Aakhus, 2002).

My research not only located young people's communicated experience in youth culture, but also took a youth empowerment approach, which prioritized the perspectives of young people (Wyn & Harris, 2004). Therefore, in addition to valuing their viewpoints, my research argued that they are the most reliable sources of knowledge about their own lives and experiences (Claveirole, 2004; Coyne, 1998). Consequently, my study gave a voice to young people, who have previously been marginalised and discredited in youth research (Wyn & Harris, 2004; Claveirole, 2004).

Researcher Reflexivity

Although researchers have traditionally been viewed as objective and value-free collectors of information, qualitative research acknowledges that the process of data collection and analysis is grounded in subjectivity (Carter & Little, 2007; Morrow, 2005) Social-constructionists frequently position the researcher as a "co-constructor of meaning", who has a vital role in interpreting the data (Morrow, 2005, p. 254). It is argued that how researchers themselves understand the world is shaped by their own values, beliefs, and behaviours, which arise from their own unique history and cultural contexts (Claveirole, 2004; Morrow, 2005). Consequently, researchers are thought to influence each part of the research process, from what topic is chosen to the collection, analysis, and interpretation of the data (Carter & Little, 2007; Russell & Kelly, 2002; Watt, 2007). In order to balance the potential advantage of the active involvement of the researcher with a commitment to portraying the experience of their participants accurately, reflexivity was a critical component in mediating the qualitative research process (Ahern, 1999; Braun & Clarke, 2013; Russell & Kelly, 2002).

Reflexivity is defined as "self-awareness and agency within that self-awareness" (Rennie, 2004, p. 183). It refers to the understanding that both the researcher and their participants have an integral role in shaping the research findings (Morrow, 2005). To be reflexive can therefore be understood as the researcher's open process of critically reflecting

on the knowledge they produce and their role in producing that knowledge (Braun & Clarke, 2013). Through this disclosure, the researcher becomes a visible part of the research process (Carter & Little, 2007; Watt, 2007). Moreover, reflexivity helps facilitate the researcher's awareness of how they themselves have shaped the research process, which allows for a more in-depth understanding of the research outcomes (Elliot, 2005).

Reflexivity was carried out in a number of ways during this research. Keeping a reflexive research journal is argued to be one of the most invaluable ways to actively engage in a process of self-reflection (Morrow, 2005). Throughout the process of research, I kept a self-reflective journal where I recorded my thoughts, feelings and reflections of the research process. By keeping this ongoing record, I became aware of any assumptions or biases that emerged. Once I had this awareness I was able to examine these insights and where possible, set them aside. Another reflexive strategy I used was working closely with my primary supervisor. Discussions with her helped me reflect on my responses to the research process, as well as proposing alternative interpretations to those I had constructed from the data (Morrow, 2005).

As my own experiences and social-cultural context contribute to the research process, it is important to provide the reader with some information about the researcher. My motivation for this research was founded on my experience of working on a suicide crisis helpline and on a text message counselling service for young people experiencing depression. I was thus drawn to this topic not only because of my interest in suicide and suicide prevention, but also because of my curiosity surrounding text message counselling and how young people in crisis use this medium for support. I acknowledge that these experiences and motivations have influenced my understanding and interpretation of the text transcripts. I consequently reflected on how my experience of working with young people through text-based mediums, experiencing first-hand how young people use this service, may have

influenced my interpretation of the text messages. I also considered how my experience of working on a suicide crisis helpline might have shaped how I interpreted the data.

My theoretical motivations have also been influenced by my clinical psychology training and professional roles in youth mental health settings. This may have both facilitated and limited my understanding of how the young people in this study communicated their experience of suicide. The study of psychology has provided me with knowledge and skills surrounding how to support people who are experiencing extreme psychological distress and suicidality. However, there is often a medicalised or clinical focus on the experience of suicide, which may be at odds with how young people make sense of their difficulties and distress. I was thus aware of the dominant medicalised discourses surrounding suicide and instead attempted to interpret the data from the perspectives of how young people see the world by situating the research within youth culture.

Although I have lost friends to suicide, I personally have not experienced suicidality. My understanding of what young people in this study texted could thus be restricted, which may limit the interpretation of the text message counselling transcripts. To aid my understanding of how young people may experience suicidality, I familiarised myself with the literature and reflected on my experiences of working with suicidal clients, both face-to-face and through telephone mediums.

I was also aware that I myself am not a 'digital native' and instead fall into the category of 'digital immigrant' (Prensky, 2001). Although mobile phones and the internet were becoming increasingly popular during my teenage years, my own perspectives and experiences of communicating and connecting with others may differ greatly to the young people of today (Green, 2003; Rickwood, 2012). I was cognisant of how this may influence my interpretations of the data and drew on my experiences of working with young people via text-based mediums to try situate my own understandings within a context where digital

communication is the norm.

I acknowledge my role as a researcher in constructing meaning from my interpretation of the young people's text messages, and that consequently these themes did not emerge from the data. I have played a crucial part in the research process and the theoretical lens I applied to this study has influenced the research outcomes (Carter & Little, 2007). I observed the data with an awareness of dominant understandings surrounding suicide, youth suicide, help-seeking, and what it means to be a young person in today's society, whilst considering how these discourses may have shaped how the young people in the study made sense of and communicated their experience of suicide. Although this may allow for new ways of understanding that data, it may also have limited my interpretations of the text-counselling conversations.

Method

This research was approved by the University of Auckland Human Participants Ethics Committee in November 2016 (Reference Number 018140). All relevant documents, including the participation information sheet (See Appendix A) and consent form (See Appendix B), are in the appendices.

Context of the Study

This research involved the analysis of anonymous transcripts of counselling interactions obtained from a text message counselling service run by Youthline as part of their normal service delivery. Youthline offer a free interactive text message counselling service for young people in NZ (Youthline, 2010). Youthline is a regionally focused and nationally linked youth development organisation. It "operates from an integrated model of evidence-based practice within a community development, training and youth development, and clinical services framework" (Youthline, n.d., p. 2). The text message service can be accessed by any young person in NZ, provided they have mobile phone reception. It is an anonymous service,

which does not require young people to sign up, register, or provide any personal information (Youthline, 2010). However, Youthline has a crisis intervention process, which allows clinical staff to access the client's phone number. This means the young person can be contacted and the appropriate supports, such as emergency services can be provided. This may occur when a young person's risk of hurting themself or someone else is believed to be imminent (Youthline, n.d).

Text message counselling is a comparatively new service development and has been provided to young people in NZ through Youthline since 2004 (Haxell, 2015). Originally, the text message counselling service was designed to be a portal for their other services, such as telephone and face-to-face support (Youthline, 2013). However, between 2006 and 2007, 20% of the text messages received by Youthline were from young people requesting counselling via text message (Haxell, 2014). Furthermore, many of these young people were reluctant to engage with other suggested forms of support. Accordingly, in response to the voice of young people, Youthline's interactive text message counselling service was established (Haxell, 2015).

Youthline's text message counselling service is currently its most popular form of support, receiving more than 20,000 text messages a month and over 385,000 text messages a year (Youthline, 2013). The overall profile of those who text the service are young people of high school age (Haxell, 2014). These young people text Youthline for a number of reasons with the most common relating to emotional difficulties, information seeking, health concerns, and relationship problems (Youthline, n.d.).

The text message counselling service is available every day of the year from 8.00 am to midnight and is staffed by volunteers, who are usually young people themselves (Youthline, n.d.). The volunteers complete an initial 120-hour personal development and basic counselling skills course, followed by a mentoring programme to ensure they are ready

to work independently on the text message service. Youthline counsellors are trained to draw from a strength-based person-centred approach to counselling. The volunteers receive on-going support through regular supervision and training opportunities, as well as having professional support accessible onsite (Haxell, 2014). The counsellors at Youthline work in shifts and thus, most young people who text into the service will speak with a different counsellor each time. However, the counsellors have access to any previous text interactions associated with each client's phone number, which can maintain some continuity (Youthline, n.d.).

Both my primary and secondary supervisors have previously conducted research with Youthline. My primary supervisor put me in touch with the appropriate people at the organisation and we discussed Youthline's potential involvement with my project. After speaking with staff members at Youthline and looking at examples of text-counselling transcripts, the finer details of the research were decided on. Youthline has fully consented to my study and they have consented to be named in this research (See Appendix B).

Data Gathering

The data consisted of previously collected text message counselling transcripts. Text message counselling transcripts were chosen as data as they provide a raw account of how young people in crisis use the service. The data allowed direct access into how young people communicated their experience of suicide during a text message counselling interaction. The advantage of this was that young people's communicated experiences were not restrained by my agenda, allowing them to communicate their experience without limitations.

Young people's use of text message counselling in crisis is an under-researched area. In particular, studies which use data collected from a text message counselling service during its clinical practice is rare. Previous research, which had a similar design analysed 6400 text messages (e.g. Haxell, 2015). However, it was not clear how many text message counselling

interactions this number entailed. Thus, after discussion with staff at Youthline, 200 text message transcripts were agreed to be a suitable number and would be analysed until saturation was achieved. This meant that I analysed the data until no new themes or codes were observed (Saunders et al., 2018), which was achieved at 125 transcripts.

The criteria for a text conversation to be included in the analysis was that the client communicated experiencing suicidality while messaging the service. All references to *current* experiences of suicidality, including suicidal ideation, suicide planning and suicide-related behaviours were included. To distinguish between NSSI and suicidality, only text interactions where the client communicated clear suicidality were included in the analysis. This was determined by the researcher and included explicit references to experiencing suicidality, such as wanting to die or not wanting to live anymore, as well as the counsellor directly asking if the client was experiencing suicidality, a question to which they responded yes. Text message conversations where the client's suicidality was not confirmed by the counsellor asking them if they were experiencing suicidality were excluded.

A member of staff at Youthline was employed by the researcher to collect and anonymise the data. This staff member conducted a search of the word 'suicide' in their database on 7 February 2017 and from this date collected 200 of the most recent text message transcripts that came up. Youthline have regular service users who contact the organisation daily and have a set plan in place for their text-counsellors to support them. These young people's text transcripts were excluded from data collection to ensure that the text transcripts analysed were from a variety of clients and reflect how the service is used when there was no set directives to the text-counsellor.

Of the 200 conversations collected by Youthline, 5 were excluded as they were repeats and 70 were excluded as they did not meet the study criteria. The 70 excluded transcripts included: one conversation where the client texted that they were not a young

person; 17 transcripts where the client was communicating concerns for someone else who was experiencing suicidality; 42 transcripts where the client was distressed but was not experiencing any current suicidality; and 10 conversations where the client's experience of suicidality was unclear and the counsellor did not ask about the client's current suicidality. This resulted in 125 text message counselling transcripts where the client communicated experiencing current suicidality. The data contained all text communication between the counsellor and the client. In total 5,933 text messages were included in the analysis. The text message interactions ranged between 4 and 184 text messages, with the average text conversation consisting of 47 messages.

Data Analysis

Watt (2007) argues that given that each qualitative study is unique, the researcher must determine the most suitable approach to their research project. My research focus was on patterns of meanings across young people's communicated experiences, which would allow for a better understanding of youth suicide. In order to locate recurring themes in the data, my research employed a thematic analysis.

Thematic analysis is a method of analysis, which consists of "identifying, analysing, and reporting patterns (themes) within data" (Braun & Clarke, 2006, p. 79). This form of analysis was appropriate for this study as it is thought to be useful when exploring an under-researched area. Furthermore, as it allows for the latent aspects of the data to be identified by going beyond the semantic content of the texts, it was consistent with a social-constructionist epistemological position (Braun & Clarke, 2006). It is important to note that although I had an idea of the areas I wanted to explore, the research questions were further defined and shaped by the data. Moreover, while the research questions offered a foundation to guide the interpretation of the data, specific themes were not pre-determined, and instead were identified during the analysis process. This method of analysis allowed me to identify the

themes associated with my research questions, whilst also permitting what the young people communicated to inform the findings (Braun & Clarke, 2006).

The data was analysed using Braun and Clarke's (2006) approach to thematic analysis. This provided a flexible method for identifying, analysing, and interpreting themes within the client's text messages (Braun & Clarke, 2006). This approach was a fluid and recursive process and although I have listed the phases chronologically, when I was analysing the text messages I moved back and forth between the phases.

The first step was familiarising myself with the content by reading and re-reading the text message conversations multiple times. By immersing myself in the data, I began to notice patterns throughout the conversations. As I read the text messages, I tentatively noted ideas and patterns in the texts, which I recorded in a Word document. I also numbered each text message conversation. Of note, my focus was on the client's text messages with the counsellor's responses used to provide contextual information.

After multiple readings of the interactions, I generated a list of initial codes to organise the data into meaningful categories, which were informed by the four areas of interest: reasons for suicidality, experience of suicide, help-seeking, and what young people said about using text message counselling. The conversations were coded with as many codes as were relevant. Extracts and quotes from the conversations were added to the list of codes to support the elucidation of content and meaning. In order to keep true to the clients communicated experience, minimal changes were made to grammar and misspellings, and 'text speak' was not altered.

During this process, the research questions were shaped by the data. In particular, the research question surrounding barriers to help-seeking was directed and influenced by what the clients were texting. I initially focused on what the clients messaged about social support in general, but it quickly became apparent that analysing the communicated barriers to help-

seeking was a better fit for the data. Once the research questions were confirmed, I then re-read the transcripts to ensure no themes or subthemes had been missed. Four category headings were then applied, which corresponded to each research question as this allowed for the focus of the findings to be delineated further.

Once all the data had been coded the preliminary themes and subthemes were identified for each research question, with the relevant data placed under each theme. Mind maps were helpful in this process, particularly in recognising and understanding the relationship between the codes.

I then reviewed all the themes to ensure they were internally consistent and discrete from each other. To facilitate this process and ensure credibility, I discussed the themes in-depth with my supervisor. This resulted in combining and revising some themes and subthemes. The themes were then further defined and named, which involved organising the data in a coherent and meaningful manner, as well as including a detailed account of each theme.

The last phase involved a final analysis and write-up of the thematic analysis. This included developing a coherent account of the themes, as well as a discussion of how they linked together and what they meant in regards to the research questions. Of note, the prevalence of themes within the text message transcripts have not been quantified. Although references to prevalence in the data are made (e.g. "many clients messaged"), these quantifiers are not reflective of the salience of the themes in the analysis and instead are applied to add richness to the descriptions of the data (Braun & Clarke, 2006).

Ensuring Quality in Qualitative Research

Once knowledge is assumed to be constructed for a particular purpose, in a particular context and at a particular time, the concept of validity, reliability, and generalisability, which have traditionally been used to evaluate the quality of research are no longer valid or relevant

(Chamberlain & Murray, 2008). Researchers have instead suggested other criteria to ensure 'trustworthiness' and rigour in qualitative research (Lincoln, 1995). The most commonly adopted criteria and strategies to ensure rigour in qualitative research include credibility, transferability, dependability, and confirmability.

Credibility refers to the extent in which the research findings represent the participant's experiences and interpretations (Shenton, 2004). To increase the credibility of the research, I familiarised myself with the literature related to my topic prior to data analysis. The data obtained were raw or 'live' accounts of how young people communicated their experience of suicide during a text message counselling interaction and thus were honest accounts of the phenomena being examined. To preserve the specificity of the text communication, the young people's texts were included verbatim in the analysis, with limited grammatical or spelling corrections (Gibson & Trnka, 2020). I also ensured that I immersed myself in the data and repeatedly reviewed the text-transcripts during both the analysis and writing stages. Furthermore, to ensure that the perspectives of the young people in this study were at the core of the findings, I quoted their text messages throughout the analyses and engaged in reflexive practices.

Transferability can be understood as the extent to which the findings are applicable in other contexts (Shenton, 2004). Given the context-specific nature of qualitative research, the focus is on theoretical generalisability, which refers to the extent to which the theory evolved within one study can be applied to provide a theoretical understanding of a similar phenomenon (Leung, 2015). To increase the transferability of the study, I provided a clear and detailed account of each step of the research process, which included the research design, methods, analysis, and conclusion. This not only ensures the study can be replicated, but also gives the reader the ability to make an informed decision surrounding the ability of the findings to be relevant in other contexts (Shenton, 2004; Morrow, 2005). Of note, this

research was exploratory and had a small scope. The findings are thus not meant to represent all young people who are experiencing suicidality, but instead reflect the communicated experience of suicidality to a text message counselling service by the clients whose transcripts were analysed.

Dependability refers to whether similar findings would be produced if another researcher carried out the research (Treharne & Riggs, 2015). To increase the dependability of this study, the research design, operational details of data collection and a reflective appraisal of the study were well-documented (Shenton, 2004).

Confirmability refers to the steps taken to ensure that the findings represent the conversations of the young people in the study with their text-counsellor, as opposed to "characteristics and preferences" of the researcher (Shenton, 2004, p. 72). To establish confirmability I recognise and acknowledge that qualitative research is grounded in subjectivity and I am an integral part of the research process (Willig, 2013). I therefore practiced reflexivity throughout the research process, one of the most frequently used methods to facilitate confirmability.

Ethical Considerations

This research was conducted in consultation with Youthline staff who manage the text message counselling service and facilitate the organisations research programmes. Youthline's processes and practices, as well as their ethical responsibilities, were taken into account in the design of the study.

It is important to note that while Youthline consented to the research, the young people in this study did not give permission for their text message interactions to be accessed. As I wanted to gain a real-time account of young people's communicated experience of suicide, which was not influenced by the research process, there were concerns that requesting consent at the beginning or end of a text message counselling transaction may

influence what the young person texted. Furthermore, as Youthline provides an anonymous service where client contact details are not sourced, attempting to gain consent from a service user may have disrupted their rapport with Youthline and potentially led to more distress. Therefore, it was decided that the data would consist of transcripts, which had already been collected and stored as part of the services normal delivery. As informed consent is salient in ethical regulation and management in research, there are clear ethical concerns with accessing private text message conversations without gaining consent from both parties (Bhutta, 2004). However, in consultation with Youthline, it was concluded that the benefits of this research outweighed these concerns, and a number of steps were taken to protect the young people who use their service.

In an attempt to protect the young people in my study, I prioritised data sensitivity to ensure anonymity was maintained. I was also aware of the need to protect the reputation that Youthline has for providing a confidential and safe forum where young people can disclose their difficulties. While Youthline's text message transcripts are collected and stored anonymously, there was a slight risk that a client may be identified through the specificity of the experience they described. To resolve this issue, I employed a staff member of Youthline to anonymise all data, so no identifying information was left in the text message transcripts, such as names, locations, or phone numbers of either the young person or their text message counsellor. Furthermore, when writing the research report all efforts were made to ensure the anonymity of the clients who used the service. I therefore made sure that I focused on general subjects, as opposed to highlighting idiosyncratic or individual responses. Although direct quotes from the transcripts were used, I ensured that these did not draw any attention to any individual's specific experience.

I was also conscious throughout my research of the sensitive nature of this topic. I was aware that young people using the service were in crisis and were experiencing extreme

psychological distress. I thus did not see the text message conversations as 'data', but instead viewed each transcript as an experience that deserved respect (Smythe & Murray, 2000). Furthermore, I was aware of the potential emotional and psychological impact of conducting the analyses (Braun & Clarke, 2013). I thus took steps to ensure my own wellbeing was maintained by practicing self-care and communicating regularly with my supervisor. I also encouraged the staff member at Youthline who anonymised the data to practice self-care and seek support if needed (Braun & Clarke, 2013; Rohleder & Smith, 2015). Finally, I was cognisant of my responsibility to build the capacity of the organisation and accordingly, Youthline will be provided with feedback surrounding areas that are important for their practice.

Summary of Methodology

In this chapter, I have highlighted the methodology applied in this research. I used a social-constructionist epistemology, which was informed by a youth-centred empowerment approach. This recognised developmental theory, social-cultural conceptualisations of young people, and located youth in a context where digital technology was ubiquitous and suicide and mental health issues among young people were regarded as a legitimate concern. I conducted a thematic analysis on 125 text message counselling transcripts where the client was experiencing current suicidality. The findings of my analysis are described in the following chapter.

Chapter Three: Findings

In this chapter, I present the findings from my analysis of the text message transcripts. There were 30 themes in total. These were divided into four overarching categories, which were shaped by the research questions: reasons for experiencing suicidality, the communicated experience of suicidality, barriers to help-seeking, and why reach out to a text message counselling service when experiencing suicidality. Of note, spelling errors in the text messages have been corrected where appropriate. However, to ensure the client and the counsellor's accounts are portrayed as accurately as possible, abbreviations or 'text speak' have not been altered and limited changes have been made to grammar.

Category One: Reasons for Experiencing Suicidality

This category explored what young people communicated as contributing to their suicidality. In total, nine themes were identified: unbearable feelings, feeling worthless, feeling powerless, mental health difficulties, feeling alone and uncared for, family relationship difficulties, peer relationship difficulties, experiencing trauma and stressful life events, and it is everything.

Unbearable Feelings: "It hurts too much to live anymore"

A number of clients spoke about experiencing unbearable emotional pain, which contributed to why they were experiencing suicidality. This theme described how the experience of anguish, sadness, and anger was often a contributing factor in the clients' experience of suicidality.

These clients often communicated that they were suffering from high levels of anguish and distress, as one client texted, "It hurts too much to live anymore" (Client 6). They frequently noted that these unbearable feelings had been going on for a long time. For example, one client messaged:

> The only time I wasn't crying in the past two months was when I had a few nights where I drunk myself into a coma. I don't want to be an alcohol abuser to get through the day. But sometimes I just want all the sadness and suffering to end (Client 13).

Clients seemed to be experiencing high levels of distress while texting in. They frequently reported that they were or had been crying and were feeling intense physical distress. For instance, one client messaged, "I'm not cold I'm just shaking I think to my emotions" (Client 63).

Many clients communicated experiencing immense sadness, describing feeling "so low" (Client 108) and "really down" (Client 120). They often texted that they no longer found enjoyment in their life. For example, one client texted, "I've been this way for ages and I always end up feeling horrible every day and just looking forward to being able to sleep. And I don't like living life like that, I hate it" (Client 42). This sadness was frequently described as something that was ongoing and persistent. Clients noted that they had experienced it for months and years, with one client noting it was "too long to measure" (Client 8). They also communicated feeling exasperated at their constant low mood, as this client texted, "I've been so unhappy for over a year and I'm so sick of feeling this way constantly" (Client 78).

They often described feeling angry, as one client texted, "I'm pissed at this whole society and hate it here" (Client 32). This anger was often due to their painful internal experiences and/or in response to interpersonal stressors, such as relationship difficulties. This is highlighted in the quote below:

> Im just ugh i have too much anger built up :/ cant control it, sick of everything and my life sick of everyone and just want to be gone i want to kill myself so i dont have to put up with this bullshit :(i hate it soooo much, no one is there for me (Client 22).

Clients also described detesting their life, as one client texted, "I don't know what to do I hate my life. I'm so angry. So upset. I don't want to live anymore" (Client 15). They frequently communicated resenting being born and having to live a life where they experienced constant emotional pain. This is demonstrated in the interaction below.

> Client 119: I hate my life.
>
> Youthline 119: Could you tell us a bit more about what your having to manage and how come you hate your life?
>
> Client 119: Cause im stupid i never asked to be born nor did i ever ask to breath i didnt ask to pay this pain i never even asked to be born yet im feeling pain

Although some of these clients texted that they wanted to direct this anger towards others, the majority reported that they wanted to direct it towards themselves, noting that it increased their urge to suicide. For instance, one client texted, "I feel angry and I want to hurt myself" (Client 99).

This theme highlighted the unbearable feelings communicated by many clients experiencing suicidality. In particular, clients frequently described feeling high levels of distress, sadness and anger, which contributed to why they were suicidal.

Feeling Worthless: "I don't matter"

A number of clients communicated experiencing feelings of worthlessness, which contributed to why they wanted to end their life. This theme illustrated how clients frequently texted that they experienced low self-worth and viewed their suicidality as being due to their own inherent inadequacies.

These clients described themselves as "pathetic", "weak", and "stupid". They frequently reported feeling that they were "nothing" and offered little value. This is highlighted in the interaction below.

> Youthline 58: Is there anyone you can talk to about how you are feeling?
>
> Client 58: Nah I'll probably just run away and then hurt myself and no one will ever know. But it doesn't matter because I don't matter

Clients often noted they were unworthy of living and deserved to be dead, as one client texted, "I deserve nothing and all I deserve is to rot" (Client 68). They also said that their low self-worth made their suicidality worse, which is shown in the quote below.

> I don't actually know what's causing them [suicidal thoughts]. I have voices in my head telling me I'm useless and whenever I do something wrong the I'm a fuck up. And that makes the suicidal thoughts get worse. And they are really serious (Client 48).

Clients also described themselves as a burden on their family and friends, as one client messaged, "I'm just a burden and a fuck up I ain't worth shite" (Client 40). In particular, they frequently noted that they were a hindrance to their family. This is shown in the quote below.

> I've messed everything up. Everyone would be better if I was gone…I don't want to make my mum sad because she has given up so much to try and make me happy again but I think she will find it easier without me (Client 89).

Clients repeatedly communicated that if they took their life, their family would be better without them. This is highlighted in the interaction below:

> Youthline 43: How do you predict people would feel if you killed yourself?
>
> Client 43: Better off... I am a burden to my father and a leech to others I would think my departing would set them free and they could do anything they wanted with their lives.

Many clients saw themselves as being "defective" (Client 25) and described feeling like something was wrong with *them*. They communicated that their way of being and thinking was faulty and deficient compared to others. As this client texted, "It gets worse by the year and I don't think I belong in this world, everyone else seems like it is nothing to them but it is all too difficult to me" (Client 3). Clients repeatedly expressed that their experience of suicidality was due to there being something faulty about them. For example, one client texted, "It's just me and my head, thoughts, feelings that I still need counselling on" (Client 18). They thus attributed their distress as being due to their own worthlessness and 'negative' thoughts and feelings. As one client messaged, "My mind is really messed up at the moment. I can be okay sometimes, but then something triggers in me, and I am right back to feeling like I just don't want to be here anymore" (Client 109).

This theme illustrated how feelings of worthlessness contributed to why clients wanted to take their life. Many clients communicated experiencing low self-worth, believed they were a burden on others, and understood their suicidality as being due to their own inner faultiness.

Powerlessness: "I'm powerless over everything"

Clients described feeling powerless over their thoughts, feelings, and situational stressors, with many of them texting high levels of hopelessness and helplessness. This theme explored how clients often communicated feeling stuck, with limited control over their internal difficulties and external world, which contributed to why they were feeling suicidal.

These clients communicated feeling powerless over what they could do to help themselves. This is highlighted in the quote below.

> I just want all the pain in my life to end as it's so unbearable. I'm just caged up and I can't see a way how things can get better. I live with a muzzle on every day and I'm powerless over everything. I can't solve anything at all. Like nothing (Client 68).

They frequently described feeling helpless and often communicated that they felt like they had little power or control to change how they were feeling. This is demonstrated in the interaction below.

> Youthline 79: U mentioned earlier that u feel like ur stuck in place u don't want to be. Could u say a little more about wat u mean by that?
>
> Client 79: I just feel I'm in a place I would never have imagined I would be. I feel like I'm stuck in a cycle of sadness and self-harm. And no matter how hard I try to change things. They always end up being the same.

These clients often expressed that they had tried to change what they were experiencing, for example, through seeking support and distracting themselves. However, when this had been ineffective, their feelings of powerlessness increased. As this client texted:

> I just feel like things are starting to get worse again and no one understands and I've tried all medicine and I'm so hopeless and done with everything. :(I don't know what to do anymore :(everything is so so hard (Client 50).

Clients also described having little control over their ability to change their circumstances. For instance, one client described having no control over their family being verbally abusive to them and recently finding out they were pregnant (Client 57). This powerlessness occurred in a range of contexts and environments, with a number reporting they felt "forced" to attend school and medical appointments when they did not want to. For example, one client explained that they felt "trapped" when they were seeing a clinician through community mental health and texted "it feels like I'm being forced to do something" (Client 93). Some clients also texted that they had limited say over having to take medication for their mental health issues. As one client messaged, "It's not my choice… it's not up to me whether or not I'm still on these meds" (Client 55).

Clients also described feeling "stuck" and communicated experiencing feelings of hopelessness. For example, this client messaged, "I am at a point where I cannot think of reasons to live. I mean what is the point in living when all you do is cry, and think about everything negatively. I live life so miserably" (Client 106). They often described seeing little chance of things improving and communicated having little hope for the future. This is highlighted in the interaction below.

> Youthline 46: With the suicidal feelings, do you think you will do anything?
>
> Client 46: I want to so bad but I just know I can't but I feel like I will one day, I don't see me having a future

This theme highlighted the immense powerlessness clients communicated as contributing to their suicidality. Many clients texted about experiencing helplessness, with limited control over their ability to influence what they were experiencing, both internally and externally. They also frequently communicated feeling hopeless with little hope that their difficulties would improve.

Mental Health Difficulties: "I'm just really fed up and exhausted of trying to get better all the time"

A number of clients communicated that they were experiencing mental health issues. This theme illustrated how clients frequently described experiencing mental illness and understood their suicidality as being due to their mental ill health.

These clients frequently described enduring mental health difficulties, such as depression, anxiety, panic attacks, obsessive-compulsive disorder, and eating disorders. They often communicated experiencing more than one mental health issue. As one client messaged, "I struggle with depression and anxiety :/ and also had a tough childhood growing up and still currently and have Post traumatic stress disorder" (Client 50). Clients also

described experiencing mental ill health for a prolonged period. For example, one client texted, "I've been suffering with depression and anxiety my whole life" (Client 67). It was often unclear whether these diagnoses were made by a clinician or if the client had self-diagnosed.

For many of these clients, they communicated that their suicidality was a direct result of their mental illness. For example, one client messaged, "I'm struggling with my eating disorder so much that I wanna just end my life" (Client 85). Clients also described their suicidality as being a symptom of their mental illness, which meant that they were 'sick' and needed to get 'better'. For instance, one client texted, "I'm just really fed up and exhausted of trying to get better all the time" (Client 39).

From this medicalised understanding of suicide, getting better often involved taking medication. Clients frequently communicated that they were taking medication, with some noting that if they took their medication they expected their suicidality to decrease. For example, in response to the counsellor asking if they were suicidal, the client responded with, "I've been clinically depressed since (year), sometimes yes but other times no. Right now kind of even though I've taken my anti-depressant" (Client 50).

This theme illustrated that a number of clients were experiencing mental health issues and saw this as a reason for this suicidality. They often communicated that their suicidality was thus a symptom of their mental illness and as they were 'sick', they required medication to get better.

Feeling Alone: "I literally have no one who cares"

A number of clients talked about feeling alone and uncared for, which contributed to why they were experiencing suicidality. This theme explored how clients frequently texted feeling isolated and unloved. Feeling lonely and isolated occurred among clients who had no support available to them, as well as among those who had support people around them.

Clients repeatedly communicated feeling alone, noting they had felt this way for long and prolonged periods. For instance, one client texted, "I feel really alone all the time" (Client 39). They often reported that they felt unsupported, as one client messaged, "no one really has my back" (Client 98). Interestingly, even though clients said they had support people around them, they still frequently described feeling disconnected. For example, one client texted, "I just feel so alone, even though I'm surrounding by people who want to help. And that's why I just can't seem to find the point of living anymore" (Client 93).

For a number of clients, however, there seemed to be little support or care available to them, as this client texted, "I literally have no one who cares" (Client 70). They also communicated feeling unloved by their family and friends. For example, one client messaged, "I just wanna be important to someone and have someone here for me" (Client 46). When counsellors tried to deter their clients from suicide by encouraging them to think about the impact it would have on loved ones, this carried little weight for some. This is shown in the interaction below.

Youthline 101: How do you think your loved ones would feel?

Client 101: I doubt they would care

Youthline 101: What makes you say that?

Client 101: They don't really care about me now so why should they once I'm gone.

At times, clients also communicated that feeling alone and uncared for was a direct reason for their suicidality. For example, one client texted, "I've got no one I feel safe to talk to and then I start wanting to hurt myself cos it hurts" (Client 99).

This theme highlighted how clients reported feeling alone and uncared for, which contributed to their experience of suicidality. Clients frequently described feeling isolated and alone, despite having support people around them.

Family Relationship Difficulties: "Me and my mum are fighting"

Many clients described experiencing relationship difficulties within their family, which contributed to why they were feeling suicidal. This theme highlighted how these interpersonal difficulties, particularly surrounding establishing autonomy, were influential contributing factors to clients experiencing suicidality.

These clients frequently communicated about having arguments with their parents. For example, one client texted, "Me and my mum are fighting because she can't handle me" (Client 66). They often reported that their disagreements with their parents were related to not having enough autonomy at home or in their life decisions. For instance, this client was struggling with her family's involvement in her romantic relationship: "My family are trying to force me to break up with my boyfriend. And I'm so unhappy at the moment I'm seriously going to kill myself" (Client 64). Clients also described experiencing constant difficulties with their parents or step-parents arguing. As one client texted, "My mum is always going off at my dad and I can't stand it anymore" (Client 49).

Clients noted that these interpersonal conflicts had impacted their relationship with their parents. For instance, this client described growing up in a home where conflict and domestic violence was the norm. In regards to their relationship with their mum they messaged, "I hate her. It sounds harsh but I really do" (Client 106). A number of clients also described feeling unhappy and unsupported at home. As one client texted, "Home doesn't help me" (Client 67).

This theme illustrated how family relationship difficulties contributed to why many clients were experiencing suicidality. Clients described experiencing difficulties with arguing with their parents, as well as their parents arguing with each other. In regards to conflict with their parents, tension over navigating client's independence was found to be a salient issue.

Peer Difficulties: "People let me down"

Many clients communicated experiencing relationship problems with their peers, which contributed to why they wanted to take their life. This theme explored how interpersonal difficulties with peers, such as rejection, feeling let down, and bullying contributed to clients experiencing suicidality.

Clients often talked about feeling rejected and "hurt" by their peer group or a friend. This is highlighted in the interaction below:

> Youthline 122: Hi, do you want to tell us a bit more about what's going on at the moment?
>
> Client 122: Ok well few days ago couple of people let me down one of them said that that she doesnt wanna be my friend anymore and I felt hurt and the other person says stuff isnt true and they both let me down. My mind thinks i wanna do something bad this week and get in trouble with the police or kill myself. my life is hard.

For many, it was the school environment in particular where things were difficult for them. This is demonstrated in the quote below.

> Over the weekend I was okay but then today with school, and friendship issues between me and a mate and then exams coming up and then I ditched my last period class right at the end and I thought about how dumb it was to and I don't know. At school is when everything really gets to me (Client 102*)*.

Clients reported that they were being "bullied", noting that it had gone on for a long time and it often occurred at school. Although a few noted experiencing immense pressure to do well academically at school and university, most communicated experiencing more pressure related to the social aspect of school.

At times, clients explicitly made a direct link between their peer difficulties and wanting to suicide. For example, one client texted, "I have a person who relies on me too much…and she always puts me down if I don't help…the best way for me get out of this is kill myself" (Client 83). Interestingly, they rarely spoke about experiencing difficulties in regards to romantic relationships.

This theme explored how peer difficulties contribute to clients experiencing suicidality. Clients frequently discussed feeling rejected and let down by their peers. A number of clients noted that they struggled with the social aspect of school and reported experiencing bullying.

Stressful Life Events: "I've never really had a time were everything was okay"

Many clients communicated experiencing stressful life events and trauma. This theme explored how these difficulties contributed to why they were experiencing suicidality.

These clients often described experiencing stressful experiences in their life, such as the death of a loved one, their parents separating, and growing up in a broken home. For example, one client described being "destroyed" after their mother left their family and found a "new family". This is illustrated further in the interaction below.

> Youthline 44: Is there anything happening in your life which finding difficult at the moment?
>
> Client 44: My mum, she left me 2 years ago and it's just hard
>
> Youthline 44: Sorry to hear that, sounds like you felt let down by someone you cared a lot about?
>
> Client 44: Very much so, I just want to go

Clients also described their homes as being high-stress environments where there was always tension and conflict. For example, one client explained the impact that the ongoing and

constant family stress had had on them, noting that their "life has been shit from the time I was born*"* (Client 79). This is demonstrated further in the interaction below.

> Client 79: I guess thinks have always been kinda of strange for me. I've never really had a time were everything was okay
>
> Youthline 79: That must be difficult and quite exhausting :(What do you mean by strange, like things not working out at school or home or with friends?
>
> Client 79: My family isn't exactly drama free
>
> Youthline 79: If you want to, would you like to talk about the kind of dramas that have been going on?
>
> Client 79: The worse of it is over. But it still hurts

These clients communicated experiencing difficult home environments where there was financial stress and poor living conditions. For example, one client who was working full time while studying, communicated experiencing high-stress with supporting their family financially since both their parents were unable to find work:

> Well I've had no money to go anywhere or do anything cause I've been helping with groceries now my parents have become reliant on my brother and I. I've become a bit house crazy and depressed it's been to a point where nothing looked like it was going to get any better so suicide was an option I was going to take (Client 9).

Some clients noted experiencing historic and current physical, verbal and/or sexual abuse. For example, one client messaged, "To be honest I get told to kill myself (Client 94). Many of the clients, who had or were experiencing trauma, reported that their home was not a safe space for them. This is highlighted in the quote below.

> Basically my dad has been and is still currently abusive. He has hit me, pushed me, thrown me, he has threatened me and recently I left the house so that I was safe.

> Ended up at a mate's house for a week…yeah, my dad's mood swings from very happy to crazy and insane to angry depending on what went on that day (Client 106).

These clients frequently communicated how difficult they found living in these environments and how immensely "let down" they felt. As this client texted, "It's just distressing everything that's happening at home here also" (Client 68). Of note, only two clients reported a suicide or attempted suicide of someone they knew and no clients referred to the suicide of a public figure.

This theme explored how stressful life events and the experience of trauma contributed to why clients experienced suicidality. Clients often described living in difficult circumstances and experiencing stressful life events. At times, clients reported experiencing emotional, physical and/or sexual abuse.

It is Everything: "I guess everything is getting too much for me. I just don't know what to do anymore"

The majority of clients communicated experiencing multiple and cumulative difficulties, which contributed to why they were experiencing suicidality. This theme discussed how the reasons for suicidality were multifaceted, with clients frequently describing feeling overwhelmed and unable to cope with these difficulties.

Although a number of clients gave a specific reason for their suicidality, such as having a mental illness or conflict with their family, the majority of them described experiencing multiple stressors, which contributed to why they wanted to take their life. This is highlighted in the text below.

> I don't know, there are so many things to talk about a small list being: abuse in the past, friendship losses, my ex who keeps on making rumours, school who literally made me do therapy, everyone being concerned about me, depression and anxiety

> constantly getting in the way of my daily life, I hate school and the stress it puts on me, I hate home and my family, I hate everything and everything hates me right back. honestly you name it, I have been through it (Client 106).

These clients communicated experiencing the factors discussed above for prolonged periods and often described complex, cumulative, and interconnected relationships between these difficulties. For example, one client described experiencing "depression" and said that this had negatively influenced their peer relationships. They noted experiencing high levels of distress and disconnection due to these relationship difficulties and described feeling powerless over what they were experiencing, both internally and externally. All these factors appeared to contribute to why this client wanted to end their life (Client 39). In particular, clients often noted experiencing cumulative stressors with their peer difficulties and school pressures, which they were struggling to cope with. As one client texted, *"*If this is how it is going to be like for the rest of the year [in regards to peer difficulties] in addition to exams I feel like I want to kill myself" (Client 3).

Clients often talked about feeling overwhelmed by the multiple difficulties they were experiencing. For example, one client texted, "I guess everything is getting too much for me. I just don't know what to do anymore" (Client 79). They repeatedly described their life as a constant "struggle", which they were unable to cope with. As one client texted, "I just want to press like a pause button, so I can figure everything out. I just want everything to stop" (Client 42). Clients often conveyed a sense of being trapped by the multiple sources of stress in their lives, which they frequently portrayed as being inescapable and out of their control. This is demonstrated in the text message below.

> It's just had a breakdown today after seeing my sister was going to jail... and then having an argument with my friend just took over me a little bit.. then I was starting to

> get bullied at school. And then going home. I hate it here. I don't wanna be here but I have nowhere else to go because of school (Client 67).

This theme highlighted that the majority of clients were experiencing multiple stressors, which contributed to why they were experiencing suicidality. Clients reported feeling overwhelmed by these stressors and described being unable to cope, with many of them seeing these difficulties as being inescapable.

Summary of Reasons for Suicidality

Clients described a range of difficulties that contributed to them experiencing suicidality. These included unbearable feelings, worthlessness, powerlessness, mental health difficulties, loneliness, family relationship difficulties, peer difficulties, and stressful life events. However, the majority reported experiencing multiple difficulties and clients frequently described a complex relationship between these factors, as well as a cumulative impact. They often noted that they felt overwhelmed and unable to cope with the multitude of stressors they were experiencing. In conclusion, the experience of suicidality among these clients was not due to one risk factor, but instead was the result of a complex interaction between multiple stressors.

Category Two: The Communicated Experience of Suicidality

This category intended to capture young people's communicated experience of suicidality. Eight themes were identified, these included: suicidality as a normal part of life, a form of coping, ambivalence about suicide, a way to communicate distress, increasing intensity, it's out of my control, planning suicide, and recognising that help was needed.

A Normal Part of Life: "Thoughts are becoming part of an everyday thing now"

Many clients described experiencing persistent and ongoing suicidal thoughts that were marked by an ongoing feeling of hopelessness. This theme illustrated how suicidality was

communicated as being a chronic and pervasive experience, which had become a re-occurring part of these clients' lives.

Clients texted that they thought about suiciding all the time. They frequently communicated experiencing suicidality for days, weeks, and even years. As one client messaged, "I'm always thinking about it these days" (Client 109). Clients talked about their suicidality as being a highly pervasive experience, describing their suicidal thoughts as "really loud" (Client 117), "really strong" (Client 68), and "oppressive" (Client 85). Due to the chronic nature of their suicidality, clients communicated feeling like they were in a constant struggle. For example, one client messaged, "Every time I close my eyes for more than like 5 minutes I imagine myself dying" (Client 59). They messaged that they had little hope in no longer experiencing suicidality. As one client texted, "They've calmed down but there's always going to be that thought in my mind" (Client 67).

Clients also messaged that their experience of suicidality was re-occurring in nature. As this client texted, "this is a very common occurrence for me" (Client 115). They noted different experiences of suicidality in the past, such as suicidal ideation, suicide attempts, and periods in respite and hospitalisation. Of concern, clients often reported having attempted suicide multiple times. For some of these clients, these attempts were very recent, such as the day before they messaged the service.

These clients communicated that as their experience of suicidality was so frequent and persistent, suicide had become a constant option and normal part of their life. As this client texted, "Thoughts are becoming part of an everyday thing now" (Client 104). For many, their experience of suicidality had become part of how they saw themselves, as one client texted, "I want to kill myself. Which is kind of normal for me and I'm bored with distracting myself. So I thought I'd text" (Client 25). They often conveyed that their experience of suicidality had become part of their identity. For example, when asked about the frequency of their suicidal

thoughts, one client replied with, "Most of the time. Nobody is even surprised anymore more cause I have "chronic" suicidal ideation" (Client 117).

This theme highlighted that the clients' experiences of suicidality were persistent and ongoing. Due to the recurring and chronic nature of their suicidality, being suicidal was understood as being a normal part of life and had become part of their identity.

A Form of Coping: "Death is a better option"

A number of clients described suicide as being an understandable response given what they were experiencing, as well as a logical way to solve their problems. This theme described how suicidality was often understood as a way of coping.

These clients communicated seeing suicide as being a reasonable response given their emotional pain. Suicide was seen as a way to relieve their distress and escape from their painful emotions. This is shown in the interaction below.

> Client 39: I'm just really fed up and exhausted of trying to get better all the time
>
> Youthline 39: Getting better can be a slow process and understandable that you're feeling discouraged
>
> Client 39: Yeah, it just seems like death is a better option
>
> Youthline 39: Do you think death is a better option or do you want the pain to stop, just trying to understand where you're at
>
> Client 39: Both. I want the pain to stop and I think death is the best chance of that happening

Clients often did not speak of the finality of taking their life and instead described it as a way to gain "instant relief" (Client 68) and peace from their strong and unwanted emotions.

Clients also communicated that suicide would solve their problems, often conveying the idea that it was a logical and reasonable option. For example, one client texted "the best

way for me get out of this is kill myself" (Client 83). They conceptualised suicide as being a coping strategy in itself, which was viewed as accessible and understandable. For instance, when asked by their text message counsellor what coping strategies they had used in the past, one client gave attempting suicide as an answer (Client 87). Furthermore, clients frequently described suicide as being their only option, as this client text, "It seems like the only way to escape everything" (Client 117).

This theme highlighted how clients viewed suicide as an understandable response to their difficulties and a logical way to solve their problems. Suicide was thus regarded as a coping strategy in itself, which was accessible and reasonable, and in many cases was their only perceived option.

Ambivalence about Suicide: "Part of me wants to and part of me doesn't"

Many clients conveyed feeling ambivalent towards taking their life. This theme highlighted the uncertainty and internal life-or-death debate that clients frequently texted experiencing.

These clients talked about feeling ambivalent about taking their life and texted that despite not wanting to be dead, suicide was always an option. For example, one client messaged, "There's obviously a part of me that doesn't want to die but all my other problems just seem to overrule the small part of me that wants to live" (Client 117). A number described experiencing a constant internal conflict, where they were unsure or did not want to take their life, but felt unable to cope with their painful emotions and/or current demands or situation. For example, one client messaged, "I don't really want to commit suicide, I just want the pain to end (Client 57). Clients frequently said that it was not that they wanted to be dead, but they wanted to solve their problems. As this client messaged, "I want to leave this world. But I don't want to die" (Client 112). They described being afraid of taking their life and did not want to do it, but could see no other option. For instance, one client texted, "I'm scared to do it. I know deep down I don't want to but I can't see any other way out" (Client

89). Clients communicated being confused and uncertain about taking their life, and frequently texted that they did "not know what to do". For example, one client messaged, "I don't know what to do because I just want everything to end" (Client 113).

Clients also communicated ambivalence in regards to having a plan to suicide and what means they would use. They often used words, such as "maybe", "not yet", and "probably" when answering questions surrounding intent. For example, in response to being asked about the likelihood of them acting on their suicidal thoughts, this client texted, "Part of me wants to and part of me doesn't at the moment I'm just sitting at a riverbank thinking. It's just a difficult decision but I just feel really down" (Client 83).

This theme highlighted how clients experienced inner tension and confusion about suiciding, with a number of clients communicating feeling ambivalent towards taking their life.

A way to Communicate Distress: "I just don't have anyone I can talk to"

For many clients, their suicidality was a way of communicating their distress and pain. This theme discussed how suicidality was often used by clients to convey their anguish and connect with others.

Clients repeatedly said that suicidality was a way to express their pain. For example, one client texted, "Sometimes I have outbursts where I cry and say stuff but I never actually have intentions of doing it you know?" (Client 73). Often, when a client's desire to suicide was explored further by their counsellor, it was found that their suicidality was a way to express their distress and they did not want to take their life. This is highlighted in the interaction below.

Client 78: I wanna die

Youthline 78: Hey hearing that you you want to die. Just wanting to check your safety

do you currently have a plan to end your life?

Client 78: No I just sick of being me and hurting

These clients appeared to express suicidality as a way to receive support from others. An example of this is shown in the text message interaction below.

Client 14: I really want to die, I have no reasons to live anymore

Youthline 14: We r concerned for u Are u intending to suicide tonight?

Client 14: No, I just don't have anyone I can talk to

At times, clients also seemed to use their suicidality as a way to maintain control of the text conversation or get their needs met. For example, one client texted, "Lets only talk about killing myself" (Client 64) and one client asked what would happen if they were higher on the suicide intent scale, "If I said 10 would you answer back faster?" (Client 108).

This theme illustrated that many clients used suicide as a way to communicate their distress, which was often an attempt to connect with their supports. Suicidality was also used by clients as a way to assert their control over the text interaction or meet their other needs.

Increasing Intensity: "It's getting worse"

A number of clients communicated that although they always experienced some kind of suicidal ideation, the intensity of their suicidality varied over time. This theme highlighted how clients described their experience of suicidality to be dynamic, with clients noting a gradual worsening as well as fluctuations in intensity over short time periods.

These clients communicated that their suicidal ideation was increasingly getting "worse" and "stronger". They frequently texted that their suicidal thoughts were continuing to increase in frequency and intensity over days and weeks. This is highlighted in the text interaction below.

Client 100: I just don't really know what to do.... it's getting worse..

Youthline 100: When you say it's getting worse what do you mean?

Client 100: Like the whole suicide thing.. it's on my mind more and more each day

For many, as their suicidal ideation increased in intensity, so too did their behaviours that could increase their risk to themselves, such as not taking their medication and planning how they would take their life. For example, one client messaged, "Well ever since feeling like killing myself last Friday I've just felt odd and it's kind of been getting worse and worse every day which is why I don't feel like taking my antidepressants" (Client 47).

While most clients noted that their suicidality as a whole was worsening over time, clients also described the intensity of their suicidality increasing and decreasing over a short space of time, such as over hours or days. This is highlighted in the quotes below.

Client 60: My thoughts are very violent

Youthline 60: What sort of violent thoughts are you having, just concerned for your safety

Client 60: I don't know they've gone back to being murmurs in my head

It was often unclear what exacerbated or alleviated these clients' distress. At times, they communicated increased suicidality in response to arguments with parents and friends, and when they were experiencing strong emotions, such as anger and sadness. While other clients noted their suicidality increased when they were by themselves, particularly at night. For example, one client messaged, "It usually happens at night. When I'm alone it's just being alone makes me feel worse because that's when my mind goes crazy" (Client 100).

This theme explored how the intensity of suicidality varied, highlighting the dynamic nature of suicidality both within and between clients. Clients often messaged that their

suicidality was gradually worsening, whilst also describing experiencing a more labile pattern of increased and decreased suicidality over a shorter period of time.

It's out of my Control: "My head takes over"

A number of clients described their experience of suicidality as being out of their control. This theme explored how clients communicated having limited control over their experience of suicidality, highlighting the helplessness many described experiencing.

These clients conveyed a sense of their suicidality as being an external force that had consumed them. This is shown in the interaction below.

> Client 7: My head takes over and I can't get away from it
>
> Youthline 7: Can u tell us more about what u mean about your head taking over?"
>
> Client 7: I try distract myself but my thoughts just win. They always come back so much worse and they get so unbearable to the stage where I'm hurting myself, taking pills, drinking and more

Clients frequently described having no control over this force, often conveying a sense of helplessness. As one client texted, "I can't make it stop" (Client 59). They communicated feeling like they had very little or no perceived control over their risk of attempting suicide. For example, one client messaged, "I'm scared because I don't know what's going to happen next or whether suicide will get to me first before the help starts working mainly" (Client 91). Clients repeatedly texted that they were unsure if they could keep themselves safe. They also had difficultly answering questions regarding the likelihood of them acting on their suicidal thoughts and often responded to questions regarding intent with "I do not know". For instance, one client messaged, "No one knows...one day I might actually go too far with my attempts or self-harm. Even I don't know. Till the time comes" (Client 19). They also communicated being frightened that they would take their life. As this client texted, "I'm

scared of what i might do to myself" (Client 72).

Clients frequently described experiencing a constant battle with their experience of suicide. For example, one client messaged, "It is very hard :'(I don't know how much longer I can fight :(" (Client 50). They texted saying they felt "tired" and described feeling defeated with the constant struggle with their suicidality. As this one client texted, "I've given up trying and I'm already gone" (Client 37).

This theme illustrated how many clients described having no control over their experience of suicidality, and thus reported having limited control over their risk of taking their life. They frequently communicated experiencing an ongoing struggle to "fight" their suicidal thoughts and feelings.

Planning Suicide: "I have made a plan on how. Several plans. In case others fail"

Around half of the clients communicated having thought of how they would suicide, while the other half described experiencing suicidal thoughts with no plan or intent to act on their thoughts. This theme discussed the different levels of suicidal intent communicated by clients, highlighting that many had thought about how they would suicide, some were in the process of taking their life, and the remaining clients were experiencing suicidal thoughts with no intent.

The analysis suggested that around half of the clients communicated having thought about how they would suicide. These clients frequently talked about having very specific and detailed plans to end their life. They described having put a lot of thought into how they would suicide and reported thinking about their plan for a long time. Clients discussed leaving suicide notes for their loved ones and described researching ways to suicide online. For example, one client texted,

> Um so it would probably be about 1 or 2 in the morning and a Saturday and I'll be at my uncles. I'd have a note for my parents when they come to pick me up to tell them why. But I'd probably hang myself in the shed with a belt (Client 101).

Often, clients noted multiple ways they could suicide and consequently had more than one suicide plan. For example, one client messaged, "I have made a plan on how. Several plans. In case others fail. It'll just happen when the time and day is right" (Client 23). These plans involved jumping off buildings or bridges, hanging, overdosing on a range of substances, cutting, and running into traffic. For instance, one client texted, "Well my school is in town so I figured at break I'd wonder off find some rope and hang myself. Or jump off a building" (Client 118).

At times, clients said they had started preparing and carrying out their suicide plan, such as stockpiling medication. For instance, one client messaged, "I have taken like 5 anti-depressants from my brother every month for the past year and a bit. They are in my drawers" (Client 113). A small number messaged that they planned to take their life right then. For example, one client texted, "Yip before I go to bed I am going to use all my sister's sleeping pills and hope I don't wake up in the morning" (Client 110). Some clients were already attempting suicide before or while messaging in to Youthline. This is shown in the interaction below.

> Client 119: Im hurting myself!!
>
> Youthline 119: What do you mean?
>
> Client 119: Im cutting and i feel like it
>
> Youthline 119: Is that really going to help?
>
> Client 119: Yep cut deepier and deeper

The majority of these clients said they did not want other services to get involved, such as emergency services or the mental health crisis team. This is highlighted in the interaction below.

> Youthline 52: We are really concerned for ur safety right now. Can u please text us with ur address?
>
> Client 52: Why do you want my address?
>
> Youthline 52: We are concerned about u. U have said u have cut urself, taken pills and alcohol & we want to help u by getting u support right now. We can do this together. If u need the ambulance, we can call them. If we know where u r we can contact ur local crisis team to help
>
> Client 52: No. I just want to die

These clients often declined Youthline's offer to call them and did not answer when their text message counsellor tried to call them. However, at times they did eventually engage with supports, such as the mental health crisis team or emergency services, and/or agree to speak with Youthline over the phone. For instance, in the above example (Client 52) the client gave their contact details and Youthline was able to connect them with further support.

Interestingly, clients infrequently described their suicidality as being impulsive. They rarely communicated carrying out suicidal behaviours that appeared spontaneous. For those who described their behaviour as being impulsive, this was often in response to interpersonal difficulties, such as a fight with a family member or a peer. Of note, these clients still described experiencing ongoing and persistent suicidality. However, as opposed to having well thought out suicide plans, they often messaged that they planned on using whatever means they could find first or whatever was most accessible. For example, one client texted, "I'm alone and on the streets upset and I don't care how I'm just going to find a way jump in front of a speeding truck, train, buildings, bridge, cliff anyway I find first" (Client 56).

The remaining half of the transcripts suggested that clients experienced suicidality with no intent to act on their thoughts. These clients communicated experiencing frequent suicidal thoughts, but had not thought about how they would take their life and had no plan to suicide. As this client texted, "I'm not suicidal. Passively wanting to die and being actively suicidal are different things" (Client 32).

This theme highlighted the heterogeneity among clients in regards to their suicidal intent. Around half of the clients communicated having a plan to suicide, while the remaining clients described experiencing suicidal ideation with no plan or intent. Of those who had thought about how they would take their life, many reported having well thought out and highly detailed suicide plans. A few clients reported that they planned to suicide right then, with some already carrying out behaviors with the aim to suicide before or while messaging in to Youthline.

Recognising Help was Needed: "I need to get help"

A number of clients acknowledged needing "help" and support from others for their suicidality. This theme discussed how clients recognised that they needed help for their suicidality and what help they communicated wanting.

These clients acknowledged they needed support from family and/or friends, and more formal supports, such as the mental health crisis team, respite, and school counsellors. For example, one client texted, "I actually want to kms [kill myself], it's just idk [I don't know] I hate living I need to get help :/" (Client 22). However, at times, clients said they did not want support from others, which included talking to family, friends, or professionals. For instance, one client messaged, "No i DONT WANT HELP (Client 56). Clients also oscillated between wanting and receiving support on the service. These clients refused to answer their counsellors' questions or responded in a manner that was challenging. This is reflected in the interaction below.

Youthline 28: Do u have a plan 2 end ur life?

Client 28: Yeah

Youthline 28: Can you please share more about your plan?

Client 28: No…You don't need to know

In regards to the help they wanted, clients repeatedly communicated wanting "someone to talk to" and support people who would listen to them. As one client texted, "My suicidal thoughts are back and I need help and no one's listening to me" (Client 48). They described wanting their support people to "care", try to understand what they were feeling without judgement, and not minimise their experience. For example, one client messaged, "I just need someone who understands me and would let me open up" (Client 22). Clients often said they did not want to be told what to do, and instead wanted space to talk and be heard. As one client texted, "I know people care but I feel like I just need a friend. Who doesn't try and fix me or doesn't get it, but is just there" (Client 93).

This theme highlighted that the majority of clients acknowledged they needed help for their suicidality. The help they wanted was to have someone to talk to and listen to them without judgement. However, some clients reported that they did not want help from others.

Summary of the Communicated Experience of Suicide

Many clients communicated that their experience of suicidality was persistent and ongoing, viewing it as being a normal part of life. They talked about suicide as being an understandable way of coping, which was frequently perceived as being their only option. However, clients also noted ambivalence and uncertainty surrounding taking their life. A number used suicide as a way to communicate distress, often in an attempt to connect with others. Clients described their experience of suicidality as being dynamic, which was gradually worsening over time. They also conveyed that their experience of suicidality was out of their control. In regards to their intent to act on their suicidal thoughts, heterogeneity

was present, with around half the clients describing having a suicide plan, while the remaining half denied having thought of how they would suicide. Lastly, clients repeatedly acknowledged that they needed help for their suicidality.

Category Three: Barriers to Getting Help

In this section, I focus on what young people said about what stopped them from getting support for their suicidality. Seven themes were identified, these included: no one to talk to about their suicidality, keeping suicidality private, difficulties communicating, people will not understand, fear of negative judgement, suicidality places a burden on others, and mental health services are unhelpful.

No One to Talk to about their Suicidality: "I have no one to turn to"

A number of clients reported having no one that they could talk to about their suicidality. This theme discussed how clients communicated that they had no one they could disclose to, even if they had support people around them.

These clients talked about feeling alone and lonely in their experience of suicide. As one client messaged, "I am completely isolated in my struggle" (Client 62). They described this isolation as pervasive and ongoing, with clients noting that coping by themselves was becoming more and more difficult to manage. For example, one client texted, "Its getting harder and harder everyday to have to carry this all by myself. Im exhausted" (Client 109).

Clients also described having no one to talk to even when they had support people around them. This included informal supports, such as family, friends, and church, as well as professional supports, such as school counsellors, therapists, and mental health teams. For example, although this client had both professional and family support, they texted, "I have no one to turn to when I feel like this" (Client 68). Clients often conveyed the idea that it was not just about having people they could talk to, but it was important to find the right supports to confide in. This is highlighted in the interaction below.

> Youthline 31: Have you talked to anyone in your life about how you're feeling? You mentioned that people don't understand?
>
> Client 31: Yeah but I just haven't found the right people I feel comfortable in talking too and I don't want support they have in [place]

These clients talked about the importance of having support people who they trusted and felt safe to talk to about their suicidality. This is depicted in the interaction below.

> Youthline 81: Are there any other people you talk to or can spend time with?
>
> Client 81: Not really any that I trust enough or feel comfortable enough around to talk to them about these kind of things

Clients also spoke about difficulties trusting that others would be able to provide reliable and dependable support. For instance, one client messaged, "Yeah I've just learnt that the more vulnerable I am the more I get hurt" (Client 68).

However, a small number of clients noted that they had spoken with their parents, friends, and/or professional support people about feeling suicidal, with most of them using their peers as their main source of support. These clients frequently reported that they found their support people unhelpful and at times, they had caused more problems for them. As one client texted, "And to be honest the first time I was depressed I went through it alone and that went much better" (Client 12). They often described an unsupportive family environment where their parents did not understand their experience of suicidality, and in some cases were abusive. For example, one client messaged, "Mum just laughs at me when I say I want to suicide" (Client 3). These negative experiences with seeking help resulted in them being reluctant to seek support in the future. As this this client messaged, "I'm just confused and not sure how to deal to it. I feel as though I wanna talk to someone but I don't have the courage to do so with past experiences" (Client 100). Moreover, clients repeatedly communicated that

they felt unable to get the support they wanted and needed from others, and consequently had stopped seeking it. This is highlighted in the text below.

> Support = listening and being nice to me = trusting that I know what is best for me = getting someone safe to talk to until I don't need it no more. None of that's going to happen so I stopped asking (Client 45).

This theme explored how many clients communicated having no one that they could talk to about their suicidality. Clients described feeling this way even when they had support people around them, including professional support services. Of the small number of clients who did speak to someone about their suicidality, the majority found disclosing unhelpful. Having a negative experience with seeking support negatively impacted the likelihood of them pursuing help in the future.

Keeping Suicidality Private: I haven't said anything to them

The majority of clients said that no one knew about their suicidality. The following theme illustrated how clients described not wanting others to know about their suicidality and maintaining their confidentiality was important to them.

Although clients frequently acknowledged the need to talk to someone, at the same time, they described not wanting others to know about their suicidality. For example, one client messaged, "I just about want to secretly take more pills to give me relief and not tell anyone as if I tell anyone about it would be dire - literally dire" (Client 68). In particular, they communicated not wanting their parents and more formal supports, such as the crisis team or emergency services to know about their suicidality. It seemed clear from the transcripts that many of these clients would have had supports around them who did not know what the young person was experiencing.

These clients said that their family were unaware they had attempted suicide in the

past, the severity of their suicidality, or that they were even experiencing suicidality. For example, in the quote below, one client explained why their parents were unaware of their current suicidality and why they no longer told anyone about their distress:

> I haven't said anything to them. Because they think that suicidal people are wimps and attention seekers and just want to take the easy way out. so I haven't been able to say anything to them because of that and I've tried talking to my best friend. But he also just doesn't understand. So I kind of just stop talking to people about it (Client 100).

Clients also reported being at home with their parents at the time they were texting Youthline, with their family being unaware of their distress. In some cases, they had started harming themselves with the aim to suicide and their parents did not know. For those clients who had spoken with their parents about their difficulties, they often said they had not disclosed everything. As one client texted, "my mum knows about my self-harm, but not about how bad I feel" (Client 53).

Of the clients who were getting professional support, they frequently said that they did not talk to them about their suicidality. As a result, many of these client's formal support people were unaware of their suicidality or the true nature of what they were experiencing. This is shown in the text interaction below.

> Youthline 12: Sounds like you're feeling pretty low atm. Who do you see about your depression?
>
> Client 12: I have previously been to a councillor but don't really go into details about it with her (I'm quite shy before I get to know people and have been known to hide things well). My doctor but again not in detail.

In regards to previous suicide attempts, at times, clients reported that they had received medical attention, and their parents and mental health team knew about it. However,

most communicated that no one knew about their previous attempt or attempts to take their life. For example, one client messaged that they hid their overdose from others, "no one knew I had tried :'(I didn't want to hurt my family" (Client 50).

Clients often gave the sense that confidentiality was immensely important to them. They frequently asked their counsellors questions about privacy and confidentiality. For example, after disclosing their suicidality one client messaged, "I don't like telling you that. Are you going to tell anyone?" (Client 59). Many spoke about being anxious about the consequences of getting help, such as getting in trouble and making their parents angry. As one client messaged after disclosing to their counsellor, "Please don't tell anyone :'(I'm scared" (Client 50). Clients frequently communicated being fearful of information being used against them for something they did not want, such as being hospitalised or taking medication. Due to concerns over what would happen if others found out, a number of them expressed immense anxiety and distress when Youthline asked them to engage with the mental health crisis team or speak with their parents. This is shown in the quote below.

> No no no…Because you're going to get me to tell someone. I can't do that. I won't kill myself tonight. Just please don't make me tell anyone. Please I'm fine. I promise I won't hurt myself please just stop (Client 79).

Clients often stopped replying to their text-counsellor when they were told to speak with their parents or that emergency services needed to be called. For example, this client did not respond to their counsellor, as they were worried Youthline would contact emergency services, "I ended up taking pills. that's why I feel funny and bit sick but I am keeping an eye on myself. I didn't reply earlier as I didn't want an ambo [ambulance] to come" (Client 104).

Clients also messaged about previous experiences where their privacy was breached, resulting in them being reluctant to trust people again. For example, one client described feeling "betrayed" by their psychologist after they spoke with the client's parents about their

suicidality and found it difficult to trust professional supports again (Client 7).

This theme illustrated how most clients did not want others to know about their suicidality and keeping their experience private was important to them. As a result, their support people, including professional supports, were often unaware of their current and previous experiences of suicidality. Clients also spoke about concerns with their sensitive information being used against them and often asked about confidentiality on the service.

Difficulties Communicating: "I don't know how to word everything"

Many clients reported that difficulties communicating were a barrier to them seeking support. This theme explored how clients' difficulties conveying their experience of suicidality and emotions in general, negatively influenced their help-seeking with both formal and informal support sources.

These clients often said they did not know how to bring suicide up and were unsure about how they would say it to others. For example, one client texted, "Like what do I say to them?? And stuff?? I'm so bad at talking about my emotions…No like I said I'm not someone to talk about my emotions and how I feel" (Client 46). They communicated that because they did not know how to talk about their difficulties they felt "overwhelmed" and "anxious" about seeking support. This often resulted in them avoiding speaking with others. For example, one client did not want to see the school counsellor because "I don't know how to word everything…I'm just scared. I'm not very good at like talking to people I get really shy" (Client 120).

Clients also conveyed difficulties with talking about their experience with others, saying they found it hard to talk not only about suicide, but about their emotions and problems as well. In particular, they described disliking talking about their emotions, whilst also communicating not knowing how to express and convey what was going on for them. This is highlighted in the text interaction below.

Client 27: What do I do to stop my feelings?

Youthline 27: It can be hard to just stop feelings but it can help to talk about them, some times that can help stop them feeling so over whelming

Client 27: But I don't know how to talk about my feelings I just can't put it into words

Clients often expressed difficulties communicating within their family. For example, when Youthline asked if this client had spoken with their family about their suicidality, they responded with, "Not really we're not close and we don't talk much in general" (Client 115). They also described being in a family where emotions were not spoken about, and they thus did not know how to bring up their difficulties with their family members. As one client texted, "we aren't really an emotionally open family, we don't talk about that stuff (Client 62).

Of the clients who were seeing formal supports, they often described experiencing difficulties communicating how they were feeling to their clinicians. As one client texted, "Yea I usually just answer the questions that she [their counsellor] asks me I don't really talk much" (Client 74). These clients reported specific difficulties with talking about their suicidality with their clinicians. This is highlighted in the interaction below, where the client had wanted to take their life that morning.

Youthline 39: Does the therapist know how regularly you feel how you felt this morning?

Client 39: Not really

Youthline 39: What do you think is preventing the therapist knowing or understanding that?

Client 39: I don't really know how to describe what I'm thinking about most of the time, so it always gets interpreted the wrong way when I try to talk about it. And then

> when it goes direction I don't try again because it feels like no matter what no one can understand

Due to difficulties communicating, clients said they did not talk about what they wanted or needed to when they saw their support people, and if they did, they struggled to effectively convey what was actually going on for them. This is illustrated in the interaction below.

> Client 36: I started forgetting things and then I couldn't remember why we were talking about what we were talking about and nothing made much sense to me
>
> Youthline 36: Sounds like that was kinda frustrating? Did you and the therapist end up talking about your forgetting?
>
> Client 36: No because I kind of drifted off and then I ended up just going along with everything they were saying just to get out of there because I really wanted it to be over

This theme explored how difficulties communicating was a barrier to seeking support. Clients described not knowing how to communicate both their experience of suicidality and general emotions with others. They frequently reported feeling anxious communicating their difficulties to their support people. The majority of clients who were seeing professional supports noted that difficulties communicating influenced their disclosure and general level of engagement.

People will not Understand: "No one gets how I feel"

Many clients spoke of being fearful of others not understanding them. This theme discussed how their fear of being misunderstood acted as a barrier to help-seeking.

These clients described believing no one understood their experience of suicidality, which prevented them from seeking support. As this client texted, "If you're not going through it. It's not something simple to understand" (Client 100). They also communicated

believing that no one understood their emotional difficulties and situational stressors. For example, one client messaged, "Not everyone gets through tuff times and I don't believe people will understand me" (Client 19).

Clients often said that when they had tried to share their difficulties with others, people did not understand and this made them feel worse, leading to them isolate themselves. For example, one client texted, "No one gets how I feel so I don't even bother saying anything" (Client 68). In particular, they communicated that when they had tried to talk to their parents they had overreacted or "freaked out" (Client 39). These clients then avoided disclosing their suicidality to their parents in the future.

Clients also described experiences where they felt their family did not take their suicidality seriously. They communicated feeling that their parents were not listening to them and minimised their experience. For example, one client texted, "Normally I go see my mum and she will just say go to sleep so I'll self-harm until I'm tired" (Client 30). When one client was asked how their parents would respond if they knew the young person was experiencing suicidality they messaged, "I've tried to tell my mum but she doesn't listen. They'd just tell me to go to bed" (Client 49). Consequently, clients frequently communicated that they felt their family did not understand the extent of the pain they were in. As one client texted, "I think they've given up on me to be honest :(And no one notices how much worse I've actually gotten :'(" (Client 50).

Clients noted similar experiences with professional support services, messaging that they often felt that they were not taken seriously. When clients said they had disclosed suicide attempts and suicidal thoughts to their clinicians, they said their formal support people "dismissed" them (Client 40) and "nobody cared" (Client 68). As this client texted, "they [mental health service] actively try to provide as little support as possible. They just take their chances that I won't kill myself" (Client 18). These negative experiences appeared

to prevent them from using these services in the future.

Many clients communicated that feeling misunderstood was a reason why they did not want to seek support for their suicidality. This theme explored how clients' fear of not being understood and previous experiences where they felt misunderstood negatively influenced the likelihood of them seeking support. A number of clients described experiences where their parents and professional support people had not taken their suicidality seriously and did not understand the extent of their distress.

Fear of Negative Judgement: "They think of me differently"

Many clients communicated concern over what others would think of them if they told them about their suicidality. This theme illustrated how fear of negative judgement acted as a barrier to many clients in seeking support.

These clients said they feared if they told people about their suicidality they would be labelled as "crazy" or unstable. In particular, they described worrying that their peers would reject them, as one client texted, "I've completely shut out all of my friends from high school and don't feel like letting them in because I'm scared they won't like me" (Client 47). At times, they communicated having negative experiences in the past, such as friends and family treating them differently after disclosing their suicidality, and this prevented them from talking to anyone again. For example, one client messaged, "The couple people I've told. They think of me differently and they see me as someone else. And I don't like it" (Client 100).

In an attempt to avoid being judged by others, clients often described putting on a "fake smile" (Client 13) and "pretending everything is okay" (Client 105). They repeatedly spoke about societal pressure to not express 'negative' emotions and to always be 'happy'. For example, one client texted, "I should put on my smiley mask. Sorry about my negative. Emotions are forbidden so I shouldn't be negative" (Client 68). These clients communicated

that hiding their difficulties made them feel worse and often intensified their problems. As one client texted, "The reason I got into this mess in the first place was because I muffled up my emotions and tried to be this perfect person all the time" (Client 39). They often messaged that hiding their experience from others prevented them from getting the support they needed. This is depicted in the interaction below.

> Client 104: I.am not the best…but ill b fine
>
> Youthline 104: Thanks for letting us know that you will be fine. Still concerned about you not feeling the best
>
> Client 104: It's my cover up quote

Interestingly, these clients said if they did speak to someone, they often felt misunderstood or were not taken seriously because they had previously hidden their distress. For example, one client explained their friend's reaction when they told them they were feeling suicidal and depressed, "they just thought I was making it up simply because whenever they see me, they see me with a smile on my face." (Client 105)

This theme highlighted how clients feared being negatively judged for their suicidality. A number of clients described experiencing pressure to be happy and not express 'negative' emotions, which not only prevented them from getting support, but also increased their difficulties.

Suicidality Places a Burden on Others: "Any time that this kinda thing happens she gets really angry and disappointed"

Many clients communicated feeling like a burden on their family and friends. This theme focused on how this perceived burdensomeness acted as a barrier to help-seeking among these clients.

Clients often noted that being a burden prevented them from seeking support from

others. As one client texted, "I don't want my mum to get angry with me. Because any time that this kinda thing happens she gets really angry and disappointed" (Client 20). This was particularly evident if they had already tried to seek support from their family. For example, one client messaged, "No one knows how to help. That's why I tried to run away. So no one had to anymore" (Client 70).

These clients communicated that they did not want to cause any problems for their family and peers, and consequently would hide their suicidality and distress. For example, one client messaged, "I'm trying to not make it hurt my boyfriend or my family but it takes a lot of energy to be happy for them." (Client 59). They frequently conveyed a sense of shame surrounding what they were experiencing, which contributed to them feeling like a burden and reduced the likelihood of them seeking support. For instance, one client explained that they did not want to talk to their family about their suicidality as "I'm already enough of a disappointment" (Client 79).

Not wanting to burden others was identified as being a reason many clients gave for not wanting to seek support. This theme highlighted how a number of clients hid their suicidality from others and did not want to put any pressure on their family. For many clients, not causing stress for their family seemed especially important if they had already sought support from them in the past.

Mental Health Services are Unhelpful for Suicidality: "I'd never call the crisis team again"

Clients often communicated finding mental health services unhelpful in reducing their suicidality. This theme considered the adverse encounters with mental health services that clients described experiencing and how this reduced their likelihood of seeking support in the future.

Clients frequently described finding mental health clinicians ineffectual. One client

noted, that despite seeing a therapist regularly and taking medication, "it's not really doing anything" and what their therapist told them to do when they are suicidal "never works" (Client 39). At times, clients communicated that mental health services made them feel worse and exacerbated their suicidality. For example, one client texted, "Both myself and my support people are aware that talking to the mental health services increases my risk. My friends try to keep me away from them" (Client 18). Clients also spoke about negative experiences with mental health professionals where they were treated with disrespect and not listened to. This is highlighted in the interaction below.

> Youthline 45: Is your GP aware of what's been going on for you?
>
> Client 45: Yea. But he can't do nothing except give me drugs. He can't do nothing.
>
> Youthline 45: Having people who are aware and know a wee bit about what's happening is supportive. Have you spoken to your GP about your thoughts?
>
> Client 45: Yeah. But he can't do anything. He sends me to the DHB and they treat me like shit worse than an animal so I leave. Now I don't go near anyone whose supposed to help not counsellors not doctors not anyone in that fucked up place

Clients who had had interactions with professional support services often spoke about poor communication surrounding their treatment, such as not knowing who their doctor was or that they had been discharged. For example, one client texted, "Then when I was admitted they said they'd refer me to this other place but they turned me down so I'm stuck with no counsellor and a psychiatrist who won't even see me" (Client 7).

These negative experiences appeared to make clients unwilling to seek support from professional support services in the future. As one client texted, "I'd never call the crisis team again cos I've been treated like I was less than human" (Client 5). When a service had provided ineffective support, this too seemed to reduce the client's likelihood of seeking professional help again. This is highlighted in the interaction below:

Youthline 56: How come you're so against getting the help you need?

Client 56: Cause it doesn't help

Youthline 56: Have you tried before?

Client 56: Yeah a lot

Youthline 56: Okay, who's tried to help you?

Client 56: Mental health and police they just don't help. I'm sick of trying

Of concern, if professional support had been unhelpful, clients often described feeling let down and communicated beliefs that no one could help them. As this client texted, "Yeah, but they can't help me. No one can. They've tried" (Client 70).

This theme illustrated that the majority of clients who had received professional support found their clinician unhelpful in reducing their suicidality and in some cases had exacerbated their difficulties. These clients spoke about adverse experiences with mental health services, which made them reluctant to seek support from them in the future.

Summary of Barriers to Getting Help

Many clients communicated having no one to talk to about their suicidality despite having family, friends, and professional supports around them. They often said that they did not want anybody to know about their suicidality. Consequently, most clients reported that no one knew about what they were experiencing and maintaining this privacy prevented them from disclosing their difficulties to others. Clients also identified difficulties communicating, concerns about being misunderstood, fear of negative judgement, not wanting to burden others, and beliefs that mental health professional were unable to help as salient help-seeking barriers. Across the themes, it was found that negative experiences of help-seeking had a detrimental impact on future help-seeking behaviours. In conclusion, there were a number of barriers that reduce the likelihood of clients seeking support, which were reflective of their unique needs and wants.

Category Four: Why Reach out to a Text Message Counselling Service when Experiencing Suicidality?

The final category looked at why these young people experiencing suicidality had chosen to reach out to a text message counselling service when they were in crisis. Six themes were identified, these included: easier to talk through text, it's anonymous, it's private, it's accessible, feeling connected through texting, and limits on availability of text message counselling.

Easier to Talk through Text: "I find it hard to express myself like voice to voice"

A number of clients messaged that it was easier for them to talk over text, compared to telephone and face-to-face interactions. This theme discussed how texting was a more comfortable and fluid way for clients to communicate their distress.

Clients frequently described finding it easier to talk about their suicidality and general difficulties via text message. For example, one client texted, "I won't ring if I was in serious trouble or in a harmful situation I would only be able to text" (Client 19). These clients said they preferred to have time to think about what they want to say before they respond to someone. As one client messaged, "I find it hard to express myself like voice to voice, I kind of just need time to think about it and re-think what I am saying/typing" (Client 101). One client who was experiencing difficulty talking to their therapist about their suicidality even reported that they showed the therapist the messages that they had been sending Youthline.

Clients also said they preferred texting to talking over the phone and they often declined when Youthline suggested they call them. This is shown in the text interaction below.

> Youthline 66: Would u be ok to call us? We can keep texting if that's more comfortable for you. What works better for you?
>
> Client 66: Texting please I don't like talking on the phone....

As with this example, clients communicated difficulties with speaking over the phone and frequently said that calling was not an option for them. For instance, one client said they were unable to speak with the crisis team over the phone, "Will they only text me. I can't talk on the phone" (Client 44).

At times, they gave reasons for not wanting to call Youthline, such as concerns with who they would speak with, having to re-explain their situation, being too upset to talk, being uncomfortable with initiating the call, experiencing high anxiety, and difficulties communicating over the phone. For instance, one client texted "Is it bad that I'm way too nervous to accept the call? My stomach shuts up and I get really nervous. I feel stupid for not being able to talk over the phone" (Client 67). These clients sometimes elaborated on why they preferred texting over face-to-face support. This is shown in the quote below.

> I can't be in the same room as people when I first meet them so can't see a therapist cos phones are the enemy of counsellors. They want me to go but I can't. I feel too sick…So I hide and text you guys (Client 44).

Clients frequently described feeling uncomfortable and experienced high anxiety with face-to-face interactions. This often created difficulties in communicating what they were experiencing. For example, one client said that despite experiencing depression and suicidality for three years they had not spoken to a counsellor or a doctor as, "I can't really talk about things face to face" (Client 100). However, clients repeatedly noted that they felt less anxiety and found it easier to open up through text message counselling, as one client texted, "I'm a more open person thru txt rather than face to face" (Client 74).

This theme highlighted that clients preferred communicating through text message, compared to over the phone and face-to-face interactions. Clients noted that they favoured texting, as it was easier to communicate via this medium and reduced their anxiety

surrounding seeking support. This seemed to allow clients to open up about their suicidality more easily than they had been able to in other interactions with professionals.

It's Anonymous: "It's so much easier to talk to someone I don't know"

Many clients expressed liking the anonymity of text message counselling. This theme illustrated how anonymity was appealing to a number of clients and helped them communicate more freely.

These clients noted that they valued the anonymity of text message counselling. As one client messaged, "It's so much easier talking to someone I don't know" (Client 7). They frequently described feeling that they could be more honest and open due to this anonymity. For example, one client texted, "I don't like to talk to people about how I feel. I go to [school name] but I don't talk but I feel like I can talk to you because you don't know who I am" (Client 89). Clients also spoke about it being easier to talk to people they did not know as they did not have to worry about the impact they would have on others. As this client messaged, "Whenever I talk to someone I do know, they get hurt and it makes things worse" (Client 77).

This theme demonstrated how clients communicated valuing the anonymity of text message counselling. Clients frequently described feeling that they could be more open due to this anonymity and in particular, did not have to worry about the impact of what they said affecting others.

It's Private: "I'm having to do secret texts right now"

Clients often messaged that they liked to be able seek support with no one knowing. This theme discussed how many clients valued being able to get help through text message counselling, whilst maintaining their privacy and confidentiality.

As has already been discussed, most clients did not want others to know about their suicidality. A number described text message counselling as a way that they could get

support without other people finding out, such as one client who texted, "I'm having to do secret texts right now :/" (Client 68). Being able to maintain their confidentiality and privacy, particularly from their parents, was thus a crucial aspect of the appeal of text message counselling to these clients.

Clients often said their family did not know they were texting Youthline and wanted to conceal this from them. For example, one client messaged, "How long does it take to reply because I need to go to sleep soon before my mum comes in then yeah don't want that" (Client 96). They also declined to call Youthline when asked, as they did not want their parents to hear them. This is demonstrated in the interaction below.

> Youthline 98: We are concerned about you. Would you be comfortable calling us this evening?
>
> Client 98: Probably not
>
> Youthline 98: Thanks for your honesty. Are you at home this evening/is there anyone close by tonight?
>
> Client 98: My mum. Which is why I wouldn't be comfortable calling

Clients also communicated that they did not want adults to intervene. They frequently asked Youthline to not involve emergency services and expressed anxiety surrounding engaging with other support services. For example, when Youthline suggested they contact the mental health crisis team, one client texted, "What will they do, I can't have them come to my house or anything" (Client 44). Often, Youthline would still call emergency services or keep attempting to contact the client over the phone due to their duty of care regardless of whether the client wanted the support.

This theme highlighted that text message counselling was a way clients could get help for their suicidality, whilst maintaining their confidentiality and privacy, especially from their

parents. Consequently, clients could get support from Youthline without others finding out and adults intervening.

It's Accessible: "I really need to talk to someone"

The accessibility of text message counselling was identified as another reason the clients used the service when in crisis. This theme illustrated how text message counselling was available immediately to clients when they needed support and offered a relaxed and informal way to access help.

Clients often communicated an immediate need to speak with someone, as one client texted, "I really need to talk to someone" (Client 52). They did not have to wait for an appointment or arrange a time to talk to someone, and instead could message Youthline right when they needed some help. Clients were thus able to text whenever they needed it from wherever they were. For example, this client was texting Youthline while waiting for further support:

> Right now I'm in hospital and I guess [mental health services] can decide what they want to do and I'll do my best with the resources I have. Honestly. There isn't much more you can do. Thanks for texting though (Client 18).

Clients frequently communicated that they were texting Youthline while they were doing other things and when they were with other people, such as their friends and parents. They described being in a range of environments when they messaged in, such as at school, in their room, and on the bus. Some of them were also able to text in while in a high-risk situation or environment. For example, one client messaged in while they were sitting on top of a building and were contemplating jumping off (Client 56).

The nature of text message counselling also appeared to influence the accessibility of the service. Clients always initiated the first message and could choose what messages they

responded to, and if they responded at all. Counsellors also encouraged continued engagement with the clients. For example, one counsellor texted, "Awesome, and we are here tomorrow too, so can talk then again :) You are doing really well in texting :)" (Youthline 19). This appeared to create an environment where clients felt they could message in at any time in a relaxed and informal context.

Clients appeared familiar and comfortable with the service, and were often messaging for further support, as this client texted, "I need some help again" (Client 48). At the end of the conversation, clients frequently communicated that they would text for more support if they needed it. For example, one client messaged, "I might text again either tomorrow or the next day, depending on how I feel" (Client 60). At times, the text message conversations went on for long periods, with long gaps in between messages as if the young person were texting a friend.

This theme showed the accessibility of text message counselling from both practical and functional levels. Many clients noted that they needed help right away and thus could receive support from Youthline without having to wait for a scheduled appointment. Clients frequently accessed the service in a range of different environments and while with other people. The process of text message counselling, where the interactions were observed to be informal and relaxed, and clients were encouraged to message in at any time, appeared to increase the services' accessibility.

Feeling Connected through Text Messages: "I feel so much better I have your support"

The analysis of the transcripts suggested that many of the clients felt a personal connection with their text message counsellor, which enabled them to talk more easily about feeling suicidal. This theme discussed how clients and their counsellors formed a genuine connection, where clients felt safe and trusted the counsellors.

Despite not knowing the counsellors names or any other personal details about them,

and getting a different counsellor each time a client texted the service, a genuine and real relationship was observed between clients and their counsellors. This is shown in the interaction below.

> Client 10: I feel so much better I have your support
>
> Youthline 10: U r welcome, and yes, u definitely have Youthline's support. Take care and make sure u let us know how u r getting on tomorrow- even a text would be gr8 [great]

Moreover, these clients communicated having a special or unique relationship with the service. For example, one client texted, "I only feel safe talking to Youthline" (Client 109).

For many of the text message interactions, there appeared to be an egalitarian relationship between the client and their counsellor. Clients often texted with their counsellors as if they were messaging a peer and the counsellors frequently responded with informal language, smiley face emoticons, and talking about clients' interests, such as the television shows they watch and what they were doing at school. An example is shown below.

> Youthline 50: Awwww, there's a lot going on for you, takes courage to reach out so well done!"
>
> Client 50: Thank you it was hard but I had no one else to talk to :(
>
> Youthline 50: Yeah, it's very challenging :(

Clients also communicated feeling safe when using the service and that they trusted their counsellor. For example, one client texted, "I haven't told anyone else all of this. I don't trust anyone else enough" (Client 109). A number of clients said that they trusted Youthline and no other support services. As one client messaged, "I just don't trust face to face counsellors anymore. Or anyone other than Youthline, to be honest" (Client 121). Feeling

safe appeared to contribute to creating a space where clients could be honest and open about their suicidality. They frequently described being able to talk to their text message counsellors about things that they were unable to talk to with anyone else. As one client texted, "I can't tell anyone how I feel, that's why I texted you guys" (Client 4).

Clients often asked their counsellor specific questions about suicide and their distress, which they may have not felt comfortable or safe enough to ask other people. For example, one client texted, "Can u tell me how to deal with suicide" (Client 84). They also sought guidance and advice from their counsellor to manage their suicidality as they were struggling to cope with it alone. As this client messaged, "I just needed someone to care, to help me figure out how to deal with this" (Client 30).

Clients frequently talked about finding text message counselling useful. They often messaged that talking with their counsellor had been helpful and described feeling grateful for their support. This is highlighted in the interaction below.

> Youthline 63: If you do struggle remember we are always here to support you when things seem dark or difficult
>
> Client 63: Yeah I know thank you. I will probably text you again tomorrow because it's helping me

This theme explored how clients often had a personal connection with Youthline. In many text message interactions, an egalitarian relationship between the counsellor and the client was observed. Clients frequently described text message counselling as being a safe and trusting medium, where they could speak freely and talk about things they did not discuss with others. Many clients reported that they found text message counselling helpful.

Limits on Availability of Text Message Counselling: "Why is no one replying?"

While most of the themes reflect a positive experience of text message counselling, one theme conveyed unhelpful encounters with the service. This theme illustrated how Youthline was not always available when clients needed them.

The analysis of the transcripts indicated that delays in responding to clients were common, as this client messaged, "Why is no one replying?" (Client 13). The counsellors frequently apologised for these delays and were transparent with the wait times. Youthline has an automated message, which is sent out when the service is busy. This was texted frequently and is shown below.

> Hey this is Youthline =) None of our txt counsellors are available atm. U can call 0800376633 or reply HOLDING for the nxt available counsellor 2 txt u back

Many clients replied with "HOLDING" and waited for a counsellor to respond to them. There were a small number of conversations where the young person disclosed that they were suicidal and they received automated messages in response. This is shown in the interaction below, where the last two messages from Youthline were automated texts.

> Youthline 52: Thanks for holding. We should have some text counsellors free after 6pm. Are you able to wait until then?
>
> Client 52: Yeah. But this is quite urgent. I'm at risk
>
> Youthline 52: If you're having thoughts of hurting yourself, we encourage you to call us, contact your local crisis team, or 111 for emergency.
>
> Client 52: Im really suicidal
>
> Youthline 52: Please call us on 0800 376633

As a result of there not being enough available counsellors and the text service not operating through the night, there were often times that the conversations ended when the

client still wanted or needed more support. For example, when one client was told the service was closing they responded with, "Do you have to go now? Is there anyone else available through the text service? Please?" (Client 19). Of concern, some conversations closed before the client's risk was resolved or their distress was alleviated. This is highlighted in the interaction below where an automated message was sent to the client when the text service was closing. It was unclear from the transcripts if Youthline had organised third party support or had called the client in these interactions.

> Client 35: I'm suicidal
>
> Youthline 35: Hey this is Youthline. Were sorry we have no txt counsellors available tonight. You can try calling us on 0800 376633, or txt again tomorrow for support. If you're having thoughts of hurting yourself, we encourage you to call us, contact your local crisis team, or 111 for emergency. This will be our last txt today.

Due to these service limitations, a number of clients communicated feeling unsupported by Youthline. For example, one client messaged, "U have texted me once, but thanks for letting me know that this is another service I can't talk to" (Client 5). Moreover, despite Youthline's apologies and transparency with wait times, the delays in replying sometimes resulted in the client disengaging with the service and did not respond when the counsellor got back to them.

This theme highlighted that Youthline was not always available. The data revealed long wait times, the service closing when clients still needed support and the frequent use of automated messages when counsellors were unavailable. These service issues often resulted in clients feeling unsupported by Youthline and at times they disengaged.

Summary of Text Message Counselling

In conclusion, text message counselling was an appealing and helpful source of support for clients experiencing suicidality. Many clients described finding it easier and more comfortable to communicate via text message, as opposed to face-to-face or over the phone. They noted that they valued being able to get help without others knowing and frequently communicated that the anonymity and accessibility of the service appealed to them. The analysis also suggested that clients formed a genuine connection with their counsellors. It therefore differed from other mediums of support in that it meets a number of the specific needs and wants of these clients when accessing and engaging with support. However, Youthline was not always available when clients needed the service.

This chapter has reviewed the key findings from my research. It discussed the themes for each of the four categories, which were shaped by my research questions. In the following section, I discuss these themes further in relation to the literature.

Chapter Four: Discussion

The purpose of my study was to explore young people's real-time experience of suicide as they used a text message counselling service for support. I was interested in capturing open communication about suicide, amongst young people who were experiencing suicidality during a moment of crisis. More specifically, my study aimed to elucidate what young people said contributes to them experiencing suicidality, how they described their experience of suicide, the barriers they communicated for getting support, and why they were reaching out to a text message counselling service for help. In this final chapter, the key findings from these four areas of interest are discussed in detail, in the context of previous literature. Following this, the clinical implications of this research are reviewed before the strengths and limitations of the study are outlined. Finally, directions for future research are considered.

Reasons Young People Give for their Suicidality

Although considerable empirical attention has been given to the risk factors surrounding youth suicide, studies from the perspective of young people themselves are limited (Hjelmeland & Knizek, 2010). Moreover, research which has sought to understand young people's experience of suicide has often relied on psychological autopsy studies, retrospective recalls of people who have attempted suicide, or general population samples where young people have not experienced suicidality (Hjelmeland & Knizek, 2017; Owens et al., 2008). My study addressed limitations in the existing literature by offering insight into the factors that young people themselves identify as impelling them to suicidality. As my analysis provided a real-time account of their communicated experience of suicide, the findings also contribute to understandings of the difficulties that might be uppermost in young people's minds during a suicidal crisis.

Young people in my study frequently noted experiencing strong and unwanted emotions, with which they had difficulties coping with. This suggests that young people may

struggle with unbearable feelings during a suicidal crisis (Cha et al., 2018; Esposito et al., 2003; Grimmond et al., 2019; Jeglic et al., 2007; Lachal et al., 2015; Pisani et al., 2013; Wolff et al., 2018). Although the young people in my study did not pathologise their experience, their communicated sadness was consistent with depression being a well-established risk factor in the youth suicide literature (Beautrais, 2000b; Cash & Bridge, 2009; Evans et al., 2004; Gould et al., 2003; Pelkonen et al., 2011). In line with previous findings, anger was commonly described in the texts analysed in my research (Esposito et al., 2003; Jang et al., 2014; Lehnert et al., 1994; Park et al., 2010). Interestingly, the young people in my study communicated an increase in their suicidality when their anger increased, but noted that they wanted to direct this anger towards themselves. This finding highlights the way internalised anger may contribute to them experiencing suicidality.

These findings provided further support for emotional dysregulation being a contributing factor to suicidality among young people (Esposito et al., 2003; Jeglic et al., 2007; Pisani et al., 2013; Wolff et al., 2018). However, my analysis has gone further by highlighting how the social-cultural context influenced these young people's experience. Young people in my study frequently spoke about how expressing 'negative' emotions went against normative expectations. They described family homes where emotions were not discussed and responses to their distress were often punitive and unhelpful. Young people's difficulties with emotional competence may therefore not always be an individual pathology, but instead may be better understood as a reflection of the norms and expectations of their family and wider society (Gilchrist & Sullivan, 2006). This may be particularly relevant in the NZ context, where stoicism and self-reliance is highly normalized (Judd et al., 2008).

The importance of interpersonal factors has been well-recognised in the youth suicide literature (Cash & Bridge, 2009). Although connection is regarded as an essential human need across the life-span, young people may be especially vulnerable to the adverse impact of

limited support because of the challenging social environment they inhabit (Heinrich & Gullone, 2006). In my study, young people frequently described feeling uncared for and alone. This suggests that chronic disconnection and isolation may contribute to why young people experience suicidality, a finding that is consistent with previous studies (Ali & Gibson, 2019; Cash et al., 2013; Holliday & Vandermause, 2015; Jeglic et al., 2007; Schinka et al., 2012; Westerlund, 2013). Furthermore, feeling alone and uncared for meant that families could not serve as a protective factor in my study (Fleming et al., 2007). Disconnection and isolation may consequently be a particularly important risk factor for this demographic (Orri et al., 2014).

In line with feeling socially disconnected, young people in my study frequently spoke about difficulties in family relationships, such as conflict with their parents and witnessing their parents arguing. These findings suggest that young people experiencing suicidality may experience familial relationship difficulties and conflict within their family (Beautrais, 2000b; Brent et al., 1996; Gould & Kramer, 2001; Hawton et al., 2012; Hedeland et al., 2016; Lachal et al., 2015; Sinclair & Green, 2005). Some of the tension that young people experienced within their families related to difficulties navigating independence from their family unit. Although this is regarded as a developmentally appropriate task, this suggests that some youth who experience suicidality may be struggling to establish autonomy from their family (Sinclair & Green, 2005).

Interpersonal difficulties were also apparent in young people's peer relationships. Relationship issues with their peers, such as bullying, and feeling rejected and let down, were commonly described experiences in my study (Czyz et al., 2012; Grimmond et al., 2019). These findings give greater insight into how peer connectedness may contribute to suicidality among young people, which has historically received less attention in the literature (Czyz et al., 2012). Interestingly, in contrast to previous research, difficulties in romantic relationships

did not emerge as a theme (e.g. Cash et al., 2013). It is unclear why romantic relationships did not feature in my study, highlighting an area that may benefit from further exploration.

Many of the factors that young people identified as contributing to their suicidality reflected a sense of their powerlessness to change their circumstances or help themselves. This marginalisation of young people from mainstream society has been widely recognised (White, 1994). Young people in my study often communicated having limited influence over decisions in their lives, such as having to go to school and having a say in their treatment, which may reinforce their beliefs of being unable to change their circumstances (Evans, 2007). This may give further insight into why agency and autonomy is so highly valued by this demographic (Gibson & Cartwright, 2013). My analysis also indicates that hopelessness and helplessness were integral factors in young people's suicidality (Williams, 1997). When they attempted to change things and it was ineffective, this appeared to increase their beliefs of having limited control. These findings support previous research, which suggests that suicidal young people often feel stuck and trapped in their experience (Ali & Gibson, 2019; Czyz & King, 2015; Grimmond et al., 2019; Hedeland et al., 2016; Lachal et al., 2015; Orri et al., 2014; Westerlund, 2013; Wilson et al., 2005). This also provides further support for the Cry of Pain perspective of suicide (Williams, 1997).

In line with previous findings, stressful life events, financial difficulties at home, and poor living conditions contributed to young people experiencing suicidality (Beautrais, 2000b; Gould et al., 2003; Heled & Read, 2005; Jakobsen & Christiansen, 2011; Page et al., 2014). Enduring historic or current physical, emotional, or sexual abuse was also communicated in my study, indicating that young people who experience trauma may be at increased risk of experiencing suicidality (Evans et al., 2005). Although feeling safe at school has been identified as a protective factor in the youth suicide literature (Fleming et al., 2007), in my analysis, the school environment was identified as a particularly difficult environment

for many young people. Of note, contagion did not emerge as a theme. This is a notable inconsistency with the literature, which often places emphasis on contagion as being a pertinent risk factor in suicide (Insel & Gould, 2008).

From a developmental perspective, young people are at a crucial stage of making sense of who they are, within a context where social acceptance, competence, and autonomy are highly valued (Wisdom et al., 2006). Disruptions or breakdowns in identity formation is thought to be an important factor in youth suicide (Rasmussen et al., 2018; Törnblom et al., 2015). Supporting this, young people in my study frequently communicated feeling worthless (Ali & Gibson, 2019; Grimmond et al., 2019). My findings indicated that young people felt both incompetent and unworthy of living, highlighting how poor self-esteem and high self-criticism contributed to their experience of suicidality (Rasmussen et al., 2018). Moreover, my analysis suggested that they saw themselves as a burden on others. This is consistent with Joiner's understanding of the role of 'perceived burdensomeness', which not only contributed to young people's experience of suicidality in my study, but also appeared to reduce their likelihood of seeking support from their family (Joiner, 2005).

From a social-constructionist perspective, the social-cultural context is vital in furthering our understandings of youth suicide. When the young people in my study talked about the reasons they were experiencing suicidality, there were clear links between their understandings and dominant discourses surrounding suicide (Bourke, 2003). My analysis showed that young people may view their experience of suicide as being due to their mental ill health. Although this is in line with previous research findings (Ali & Gibson, 2019; Stubbing & Gibson, 2018), it contrasts with other studies, which suggest that young people do not always associate suicidality with mental illness (Heled & Read, 2005; Issakainen, 2014; Lake et al., 2013). Given the current dominance of the medical model in the conceptualisation of suicide, it makes sense that young people applied the pervasive

discourses, which connect distress with biologically based mental illness to their understanding (Bennett et al., 2003; White et al., 2016). Conceptualising suicide as a product of mental health problems may also be an attempt by young people to legitimise their distress (Ali & Gibson, 2019). This may be particularly relevant for young people who struggle to communicate their experience effectively or have had encounters in the past where they felt misunderstood or were not taken seriously.

Young people in my study also utilised moral discourses in their conceptualisation of suicide, attributing their experience of suicide to something being wrong or faulty about *them* (Bennett et al., 2003; Roen et al., 2008). Consequently, they viewed their suicidality as being a personal weakness or failure, of which they were the sole cause. This suggests shame may be an important emotion to consider as young people experiencing suicidality may blame themselves for their difficulties (Fullagar, 2003; Törnblom et al., 2015).

Suicide was also conceptualised by the young people in my study as being an understandable response given the emotional pain they were in and a logical way to solve their problems. Although this finding is consistent with previous studies (Bourke, 2003; Everall et al., 2006; Fullagar et al., 2007; Stubbing & Gibson, 2018), positioning suicide as normative conflicts with the pervasive discourses of suicide being immoral and diseased (White et al., 2016). Young people experiencing suicidality may consequently experience tension between conceptualising suicide as an understandable response, whilst simultaneously viewing it as something to be ashamed of (Bennett et al., 2003; Roen et al., 2008; Stubbing & Gibson, 2018). Navigating this discursive tension may negatively influence their help-seeking and engagement with support (Fullagar et al., 2007).

My analysis suggested that suicidal young people may experience a range of difficulties discussed above, for prolonged periods. This indicates young people's suicidality may be due to a complex interaction between factors, with a noted cumulative effect

(Beautrais, 2000b; Esposito-Smythers et al., 2014; Gould et al., 2003; Grimmond et al., 2019; Speckens & Hawton, 2005; Stubbing & Gibson, 2018). Moreover, despite the dominance of the bio-medical model of suicide, my study suggests that mental illness alone may not be able to account for suicidality among young people (Hjelmeland & Knizek, 2017; McDermott & Roen, 2016; Roen et al., 2008; White, 2012).

In summary, the findings from my study suggested that in moments of crisis, young people are able to recognise the factors that are contributing to their suicidality. This insight into their difficulties highlighted how they are active participants in their experience and thus can provide invaluable insight into what contributes to them experiencing suicidality. These findings indicated that conceptualising suicide among young people is complex. Although aspects of current models of suicide applied to these young people, such as Interpersonal Theory and the Cry of Pain model, these conceptualisations of suicide have not been fully adapted to fit the context of young people's lives and thus may not be culturally appropriate (McDermott & Roen, 2016). Instead, there is a need for a developmental social-cultural framework, which takes into account young people's position in society, their developmental stage, and how suicide itself is constructed to fully elucidate suicidality among young people. Moreover, particular importance should be paid to the social-cultural conceptions of emotional states, interpersonal factors, powerlessness, and identity construction to ensure that models of suicide are developmentally informed. Acknowledging the social-cultural factors that contribute to young people's experience of suicide not only delineates their experience further, but also offers a more comprehensive understanding, which no longer solely locates suicide within the individual.

Young People's Communicated Experience of Suicide

The second area of interest in this study was young people's communicated experience of suicide. Due to the limited research in this area, there is a paucity of knowledge surrounding

what young people in crisis experience. Furthermore, given that much of the existing research has relied on non-suicidal samples and retrospective recall, it was important to capture the trajectory of young people experiencing a suicidal crisis in real-time.

Young people in my study frequently portrayed their suicidality as being a persistent and ongoing experience, with many describing it as a constant struggle. Their suicidal ideation was often expressed as being relentless and inescapable, with many communicating little hope of escaping these thoughts (Everall et al., 2006). My findings highlighted the chronic nature of suicidality (Czyz & King, 2015; Hedeland et al., 2016), as well as how the suicidal state is marked by overwhelming despair (Everall et al., 2006).

In line with these findings, many of the text messages suggested that the intensity of young people's suicidality was gradually worsening over time (Nock et al., 2008, 2013). Within this steady worsening, young people in my study also described experiencing fluctuations in their suicidality over short periods of time. This is congruent with previous research and allowed for greater insight into the dynamic nature of the experience of suicide (Czyz et al., 2019).

Supporting the finding of epidemiological studies, young people in my study frequently described their suicidality as a reoccurring experience, noting previous episodes of suicidal ideation and multiple suicide attempts in the past (Cash & Bridge, 2009). As their experience of suicide was so frequent and chronic, suicide was often communicated as being a normal part of their life. These findings suggested that many young people, who experience suicidality, conceptualise suicide as being accessible and normative. Consequently, they may view suicidality as being ubiquitous (Bourke, 2003; Fullagar et al., 2007; Roen et al., 2008; Westerlund, 2013).

Moreover, my analysis indicated that suicidality had become part of these young people's identity. As adolescence is argued to be a critical period of identity construction

(Erikson, 1968), there may be detrimental consequences of this identification for a young person's self-worth and self-efficacy (Moses, 2009). This may influence their ability to adaptively cope, whilst also potentially hindering their ability to thrive (Bostik & Everall, 2007).Young people may internalise the stigma, judgements, and shame associated with suicide, and as a result, become 'suicidal' as opposed to it being a phenomena they experience. However, the youth suicide literature has given little attention to how experiencing suicidality impacts young people's sense of self.

The functions of suicidality among young people are argued to be complex and difficult to delineate (Gair & Camilleri, 2003; Holliday & Vandermause, 2015). Interestingly, in my study, young people did not speak about the finality of ending their life, and instead conveyed that suicide would bring them peace and salvation. These findings gave some insight into how young people in crisis may conceptualise suicide and what they believed their suicide would achieve. For many young people in my study, their motive was not solely to die, and other functions of their suicidality appeared to be to solve their problems, escape from emotion pain, and/or communicate distress. Although having multiple motives for suicidality has been demonstrated in previous research (Jacobson et al., 2013; Madge et al., 2008), these studies have relied on retrospective accounts. My study therefore adds to the literature by having a real-time account of the motives young people give for their suicidality, whilst in distress.

One of the most interesting findings of my study was how young people viewed suicidality as being a coping strategy in itself. Thinking about or acting on suicidality was often conveyed as being the only way they could cope with their difficulties and solve their problems (Orbach et al., 1999, 2007). Everall and colleagues (2006) argued that difficulties with emotional regulation were salient in young people's reliance on this maladaptive form of coping. However, my study goes further by suggesting that whilst limited problem-solving

and emotional regulation skills may be a contributing factor for youth suicide, it is also imperative to consider the actual powerlessness young people have over their lives and circumstances. This provides further support for models of suicide, which acknowledge the social-cultural factors that contribute to young people experiencing suicidality.

Young people in my study also conveyed that suicide was a way for them to communicate pain and distress (Holliday & Vandermause, 2015; Jacobson et al., 2013; Orri et al., 2014; Scoliers et al., 2009; Stubbing & Gibson, 2018). This is in line with research, which suggested that suicidality among young people often serves an interpersonal function (Orri et al., 2014). Academics have argued that revenge was a critical aspect of this communication (Orri et al., 2014). However, my findings did not support this, and instead indicated that the motivation behind suicidal young people's behaviour was to alleviate their suffering (O'Connor et al., 2006; Scoliers et al., 2009; Williams, 1997). While it appeared that some youth may use suicidality as a way to control the text message counselling session, this seemed to be a product of believing that their distress would not be taken seriously and people would not listen to them. Consequently, young people may perceive communicating suicidality as being their only way to connect with others and get their needs met (Lachal et al., 2015). This combination of findings underline young people's need to assert their control in a social-cultural context where they constantly felt powerless, as opposed to being an expression of anger or revenge. Using suicide as a means to communicate pain also indicates that young people might lack the language to effectively convey their experience (Everall et al., 2006; Gribbon et al., 2019). However, it may also highlight that they view suicide as a reasonable and valid way to communicate their distress (Stubbing & Gibson, 2018). This may cause tension and misunderstandings between young people and adults (Lachal et al., 2015).

One of the most pertinent findings of my research was that suicidal youth may experience ambivalence and uncertainty surrounding taking their life. Young people in my

study often communicated feeling afraid and confused. They frequently noted that they did not want to suicide, but could see no other option. This suggests that many young people who experience suicidality may not want to be dead, but instead, want things to be different. Although these findings support earlier qualitative research and ambivalent intent has been demonstrated among young people who attempt suicide (Bergmans et al., 2009; Holliday & Vandermause, 2015; Miranda et al., 2008), ambivalence has received limited empirical attention.

Although young people in my study communicated experiencing immense uncertainty and confusion about taking their life, they frequently described having no control over their experience of suicide. They also texted that they had limited control over their risk of taking their life and often conveyed a sense of suicide being inevitable. This is in line with the findings of Lachal and colleagues' (2015) meta-synthesis of qualitative studies, which suggested that young people experiencing suicidality experience a loss of self-control. It also indicated that suicidal youth may have an external locus of control (Beautrais et al., 1999).

Around half of the clients in my study described having thought of how they would take their life, while the remainder communicated experiencing suicidal ideation with no plan or intent. This was somewhat consistent with previous research, which found that suicidal ideation among young people was more common than planning suicide and suicide attempts (Nock et al., 2008, 2013). However, that half of the young people in my study had thought about how they would end their life, with or without a detailed plan, was higher than previous findings (Kokkevi et al., 2012; Nock et al., 2008, 2013). This indicates that rates of planning suicide may be higher among young people in crisis. Young people in my study frequently described having multiple plans of how they would take their life and communicated having a variety of methods of suicide (Beautrais, 2000a; Hawton et al., 2012). These means and methods were often accessible, such as overdosing on over the counter medication and

hanging themselves.

Suicidal behaviour among young people is commonly conceptualised as being impulsive (Bridge et al., 2006). However, in my study, their suicidality was infrequently described as being a strong emotional response to something, where they had not thought out clearly what they wanted to do. Instead, they often described having well thought out and highly detailed plans of how they would suicide. This suggests that suicidal young people may spend prolonged periods thinking about ways they could take their life, which indicates that their experience of suicidality may precede any noticeable 'at risk' behaviours (Czyz & King, 2015; Hedeland et al., 2016). Accordingly, suicidality may not always be an impulsive and incongruent act among youth. Moreover, even those in my study who communicated about behaviours, which might be regarded as being more impulsive and reactive, appeared to have been thinking of suicide for extended periods before their behaviour escalated. Although my findings contrast with many of the dominant understandings of youth suicide, they are congruent with studies, which have found premeditation is a stronger predictor of suicidality than impulsivity (Nock et al., 2013; Jacobson et al., 2013). This finding may, however, also reflect a particular subsection of the youth population who can avert a suicidal impulse long enough to reach out for help.

Although less common, young people in my study also texted an immediate intent to suicide and noted carrying out suicidal behaviours before and while messaging the service. This suggests that, although some youth may be ambivalent about suicide, others experiencing suicidality do experience imminent intent and attempt suicide (Cha et al., 2018; Pelkonen et al., 2011). Although these young people frequently communicated not wanting emergency support, it is important to emphasise that they did message in for help. This indicates that young people experiencing suicidality may want support at their critical or heightened moment of distress, but it may be a specific kind of support that meets their

individual needs and wants (Gilchrist & Sullivan, 2006).

My analysis suggests that young people experiencing suicidality often acknowledged that they needed help, indicating they had some insight into their difficulties. Although this finding is in line with earlier studies (Holliday & Vandermause, 2015; Saunders et al., 1994), it contrasts with previous research, which found suicidal youth do not recognise the need for help (Arria et al., 2011; Czyz et al., 2013; Freedenthal & Stiffman, 2007). As young people in my study were already seeking help through texting a support service, this may account for this conflicting finding. However, they also communicated not wanting support from anyone and at times appeared to oscillate between wanting help and withdrawing from their counsellor within an interaction. This highlights the complex relationship between recognising the need for help and getting support for suicidality (Rickwood et al., 2005; Saunders et al., 1994). In support of previous research, young people in my research noted that the help they desired was to have someone to talk to and to listen to them without judgement (Fortune et al., 2008b; Wilson & Deane, 2001).

In summary, my study offered invaluable insight into real-time expression of suicidality among young people, which facilitated the identification of crucial opportunities for intervention. These findings provided further support for the heterogeneity and dynamic experience of suicidality both within and among young people, whilst also highlighting the chronic and persistent nature of the phenomena. My research allowed for greater insight into young people's motives for suicide, finding that suicide was conceptualised as a normal response to life's difficulties, which along with ending one's life, had the function of solving their problems, escaping from emotional pain, and/or communicating their distress. My analysis found that young people may experience ambivalence and uncertainty as they struggle over their inner turmoil of choosing life or death. However, participants in my study also noted experiencing limited agency over their experience of suicide. Lastly, many young

people in my research acknowledged that they needed help in managing their suicidality, but complexities in seeking and engaging with help were apparent.

Barriers to Getting Help

My research provided new insights into barriers young people experience in accessing help. As this study had an unstructured account of young people's communicated experiences, this not only delineated barriers for both formal and informal sources of support, but also meant that young people's perspectives were not influenced or confined by previous research findings.

Despite having multiple support people around them, young people in my study frequently described feeling isolated, with no one that they could talk to about their suicidality. This suggests that while those experiencing suicidality may acknowledge that they need help, talking to the 'right' people, who they felt safe with and trusted was critical in facilitating their help-seeking (Freedenthal & Stiffman, 2007; Fullagar, 2003; Gibson et al., 2019; Gilchrist & Sullivan, 2006). As young people at times described abusive family environments, home may not be a place where they can get adequate support. Similarly, those experiencing familial relationship difficulties may also be less likely to seek support from their family (Yakunina et al., 2010).

My findings suggest that young people experiencing suicidality may not want others to know. This echoes previous findings (Freedenthal & Stiffman, 2007; French et al., 2003; Gilchrist & Sullivan, 2006; Holliday & Vandermause, 2015) and provides further support for suicide in itself being a barrier to help-seeking (Carlton & Deane, 2000; Michelmore & Hindley, 2012; Saunders et al., 1994). Young people in my study often communicated that they had not told anyone about their current or previous experiences of suicidality, including attempts at taking their life. These findings highlight the extent to which youth may conceal their suicidality from others (Gould et al., 2004; Hawton et al., 2012; Holliday &

Vandermause, 2015; Madge et al., 2008; Wang et al., 2003). However, in line with the literature, if they had sought support, it was most likely to be from a peer (De Leo & Heller, 2004; Nada-Raja et al., 2003). As previous suicidality is one of the major predictors of future suicide-related behaviors, the desire for suicidal young people to hide their experience is a concern (Beautrais, 2000b).

Confidentiality and privacy was therefore conveyed as being important. The young people in my study repeatedly communicated fears over how their support people would react if they disclosed suicidality. Getting in trouble or having to do something they did not want to do, such as being hospitalized or taking medication, were often cited as concerns. Although these findings highlight the salience of confidentiality and privacy among young people experiencing suicidality, they also illustrate their powerlessness, which may be particularly evident in help-seeking relationships (Binder et al., 2011). It thus makes sense that young people may be sensitive to disclosing suicide as they fear their autonomy and agency will be compromised (Gibson & Cartwright, 2014).

In line with maintaining their privacy, my analysis indicated that young people experiencing suicidality may not want adults to intervene, particularly their parents (French et al., 2003; Gibson et al., 2016). Self-reliance and the developmental task of establishing autonomy have been well-documented barriers to help-seeking in the youth suicide literature (Rickwood et al., 2005, 2007; Wilson et al., 2011). As this study and others have demonstrated, young people experiencing suicidality may recognize the need for help, whilst simultaneously displaying low rates of help-seeking (Saunders et al., 1994). Their desire to hide their suicidality, whilst concurrently recognizing that they need help, highlights a dialectic that many young people may face. Consequently, they may experience difficulties with synthesising their need for help and loss of autonomy by asking for support. These opposing needs may contribute to the complexities in help-seeking and engagement among

young people experiencing suicidality (Gibson & Cartwright, 2013).

The young people in my study frequently described difficulties in communicating as a barrier to seeking support (Ciarrochi et al., 2003; Cigularov et al., 2008). A number said they did not know how to bring suicide up with others or what to say. They also noted difficulties in talking about their emotions in general and thus avoided seeking support. This suggests young people experiencing suicidality may want to talk about what is going on for them, but lack the vocabulary to describe their experiences (Cigularov et al., 2008; Everall et al., 2006). Surprisingly, my analysis also found that young people who were getting formal support often did not know how to talk to their clinicians about their suicidality. This frequently resulted in their therapist being unaware of the extent of their distress. Difficulties communicating may therefore also affect young people's engagement with professional support services and worryingly, their suicide risk might not be addressed. Although these findings are in line with previous research, it may be that the true extent of non-disclosure among young people experiencing suicidality, particularly with their therapist, is not recognized (Cigularov et al., 2008).

My analysis also suggests that young people experiencing suicidality may avoid seeking support out of fear of burdening others, particularly their family. This was especially evident if the young person had already sought support from their family, as they did not want to worry or disappoint them again. This indicates shame may negatively influence help-seeking among those experiencing suicidality (Everall et al., 2006; Freedenthal & Stiffman, 2007; Törnblom et al., 2015). Although some studies have demonstrated that perceived burdensomeness is a barrier to help-seeking among young people experiencing suicidality, it has received comparatively less empirical attention (Burton Denmark et al., 2012; Fortune et al., 2008b; Freedenthal & Stiffman, 2007; Grimmond et al., 2019). Given perceived burdensomeness is a key component in theoretical understandings of suicide, the limited

research surrounding this barrier is surprising (Joiner, 2005). Due to young people's relative dependency on the adults in their lives, it may be particularly important to consider how burdensomeness might affect this group.

One of the most disturbing findings from my study was that when young people experiencing suicidality did disclose, it often proved unhelpful and caused them more problems (Hedeland et al., 2016; Sweeney et al., 2015). This resulted in them being reluctant to seek support in the future and suggests that poor responses to disclosure may be a salient factor in future help-seeking among youth (Lachal et al., 2015; Owens et al., 2016; Rickwood et al., 2005).

My findings provided a number of examples of young people having had experiences which reinforced their feeling that their suicidality could not be understood (Everall et al., 2006; French et al., 2003; Gilchrist & Sullivan, 2006; Lachal et al., 2015). They often talked about previous experiences where parents and professional support people had not taken their suicidality seriously and had minimised their difficulties. Feeling understood, and in particular, being heard and listened to without judgement, may be especially important to young people who are experiencing suicidality (Hedeland et al., 2016; Lachal et al., 2015).

It was particularly worrying that young people in my study often texted that mental health professionals could not help them (Radez et al., 2020; Rickwood et al., 2005, 2007). These young people said that formal support services were unhelpful and in some cases, had worsened their suicidality. Adverse experiences with mental health services where youth felt they were treated poorly and disrespected were also described. This may account for why professional support in previous studies did not prevent young people from experiencing an escalation in suicidal behaviours (Nock et al., 2013). Of concern, due to their negative experiences with support services, many young people in my study communicated believing that no one could help them. This suggests that when a service does not meet a young

person's needs or is a punitive experience, they may not only be reluctant to seek help in the future (Rickwood et al., 2005), but may also see themselves as being beyond help. This is a concern as it may exacerbate their feelings of powerlessness, which in turn could worsen their suicidality (Owens et al., 2015).

The stigma surrounding suicide, mental health issues, and getting help for these difficulties are widely recognized attitudinal barriers to help-seeking among youth (Michelmore & Hindley, 2012; Rickwood et al., 2005, 2007). In support of this, young people in my study frequently texted that they were concerned others would judge them if they disclosed their suicidality, with many of them not wanting to be seen as mentally unwell (Freedenthal & Stiffman, 2007; Gilchrist & Sullivan, 2006). My findings suggested that although young people may position suicide as a normal response to their difficulties, the dominant discourses that conceptualise suicide as something to be ashamed of continue to negatively influence their help-seeking (Bennett et al., 2003; Fullagar, 2005). Moreover, those experiencing suicidality may actively resist an 'illness identity' by concealing their difficulties and avoiding seeking help for their distress (Biddle et al., 2007).

Due to societal pressures to be happy and not show 'negative' emotions, young people also described putting up a façade to hide their true self (Everall et al., 2006; Grimmond et al., 2019; Holliday & Vandermause, 2015). This highlights the pressure and immense efforts young people experiencing suicidality go to to position themselves as normative (Bostik & Everall, 2007; Everall et al., 2006). This investment in appearing 'normal' appears to increase their suicidality, as opposed to alleviate their distress (Bennett et al., 2003).

In summary, my study suggested that young people experiencing suicidality are active participants in the help-seeking process, with the identified barriers reflecting their unique needs and wants. By having an unrestricted and real-time account of young people's perspectives of help-seeking, my study provided an affirmation of previously supported

barriers, whilst also allowing further insight into how they experienced these barriers. The findings also highlighted how perceived burdensomeness, feeling misunderstood, and discursive tensions influence help-seeking, which have received less attention in empirical research on youth suicide.

Why Reach out to a Text message Counselling Service when Experiencing Suicidality?

The following category explored what young people experiencing suicidality communicated valuing about text message counselling and how it differed from other sources and mediums of support. This research provided important insights into young people's decision to disclose their suicidality via a text service. As rates of help-seeking and engagement are low among young people experiencing suicidality, gaining further understanding into their needs is imperative (Michelmore & Hindley, 2012).

Although previous research suggests that practical barriers to help-seeking and engagement with formal support are less influential compared to individual determinants, the youth in my study indicated that a number of the structural aspects of text message counselling were appealing (Michelmore & Hindley, 2012). My study found that young people communicated finding it easier to talk over text message, compared to interacting with others via face-to-face and over the phone (Evans et al., 2013; Gibson & Cartwright, 2014; Haxell, 2014). As youth experiencing suicidality may struggle to communicate their difficulties, text message counselling may be a favourable option as texters have time to think about what they want to say and how to word things (Hassett & Isbister, 2017; Haxell, 2014; King et al., 2006). This suggests that young people might find it easier to disclose their suicidality via text message counselling as they feel more comfortable and competent talking over text (Gibson & Trnka, 2020). Communicating over this medium may also help reduce their anxiety surrounding talking to others due to the proximal separation, as well as the lack of visual feedback and nonverbal cues from their counsellor (Cook & Doyle, 2002; Evans et

al., 2013; King et al., 2006). Text message counselling may consequently allow young people, who would previously not seek help, to access the support they need (Nesmith, 2018).

Texting also appeared to be a natural and fluid way for young people to connect with their counsellors. This supports current conceptualisations of young people, who are thought to be immersed in a digital world where their norms of communication differ from those in older generations (Rickwood, 2012; White & Wyn, 2012). Young people experiencing suicidality may consequently find this mode of communication less threatening as it fits within their normative way of conversing and connecting (White & Wyn, 2012).

The accessibility of text message counselling was also communicated as being important in my study (Evans et al., 2013; Gibson & Cartwright, 2014). Young people experiencing suicidality used text message counselling to access support right away (Nesmith, 2018; Haxell, 2014). They did not have to wait for a scheduled appointment or specific time, and could talk to someone when they needed to. This need for accessibility among young people experiencing suicidality has been highlighted in previous research (Williams et al., 2018). Due to the dynamic experience of suicide, accessibility may be particularly appealing to young people experiencing the phenomena. My study also demonstrated that youth used the service in a range of different environments and while with other people, indicating that text message counselling fitted into their everyday lives. As previous research has suggested that finding time is a barrier to seeking professional support among young people experiencing suicidality (Czyz et al., 2013), this may be a key benefit of text message counselling.

The services accessibility was also apparent in that the text message counselling interactions were informal and the young person had some control over the counselling process. This may be particularly appealing to those experiencing suicidality as they can close down the conversation when they choose. Furthermore, what it means to seek support

may carry less weight if a young person can engage without any ongoing or long-term commitment (Creed & Kendall, 2005; Zack et al., 2007). This flexibility in regards to both accessibility and how they engage with services may be an important need for young people experiencing suicidality (French et al., 2003; Gibson et al., 2016).

My analysis highlighted the importance youth placed on being able to get help through text message counselling with nobody knowing (Evans et al., 2013). They were also able to choose what messages they responded to, and in fact if they responded at all. Text message counselling may therefore provide an opportunity for young people experiencing suicidality to access and engage with professional support, whilst maintaining their agency and autonomy (Gibson & Cartwright, 2014; Gibson et al., 2016). This medium may also meet their opposing needs as they can get the help they recognize they need, while preserving their confidentiality and privacy. As previous research has demonstrated difficulties with synthesizing these conflicting needs (Gilchrist & Sullivan, 2006), text message counselling may provide a vital medium to work with young people who are experiencing suicidality.

Young people in my research communicated liking the anonymity of text message counselling (Gibson & Cartwright, 2014; Evans et al., 2013; Haxell, 2014). They frequently said that they could be more open due to this anonymity and did not have to worry about what they said influencing or impacting others. This suggests that text message counselling may directly target identified barriers to help-seeking, such as privacy concerns, stigma, and being a burden on others. This was consistent with previous studies, which found young people are more comfortable discussing sensitive subjects, and are more likely to disclose suicidality, through mediums where they can remain anonymous (Callahan & Inckle, 2012; McDermott & Roen, 2016).

Along with the structural benefits of providing support through this medium, my findings indicated that young people also valued the process of text message counselling.

Despite the young people in my study not knowing their counsellors and having a different counsellor each time they messaged the service, the interactions between them conveyed authentic relationships. This adds to the growing body of evidence that the therapeutic relationships in text message counselling mediums are perceived as genuine by service users (Gibson & Cartwright, 2014; Gibson et al., 2016). It also suggests that young people experiencing suicidality may value having a personal connection with their counsellor, which may facilitate their engagement (Everall & Paulson, 2002; Gibson et al., 2016; Wilson & Deane, 2001). This calls into question how those who use text-counselling services may respond to automated messages that form part of other suicide crisis services, as they may feel less personal connection through them (e.g. Larsen et al., 2017).

My analysis indicated that the therapeutic relationship was often egalitarian, where the young person messaged their counsellor as if they were texting a peer. Previous research has identified that young people experiencing suicidality value this style of relationship (Gair & Camilleri, 2003; Hassett & Isbister, 2017). As egalitarian relationships are argued to reduce power differentials, this style of relationship may be less challenging to their autonomy (Hanna & Hunt, 1999; Hollidge, 2013). Consequently, when a young person experiencing suicidality engages with text message counselling, their opposing needs for connection and autonomy may simultaneously be met (Binder et al., 2011; Gibson & Cartwright, 2014). An egalitarian relationship may also reduce misunderstanding and judgement, facilitating suicidal youth to feel heard and understood (Hassett & Isbister, 2017). As engaging young people experiencing suicidality with support services has historically been difficult, further understanding of this relationship style in professional support contexts is important (Binder et al., 2011).

Young people in my study frequently communicated finding text message counselling helpful, suggesting that this medium may be effective in supporting those experiencing

suicidality (Gibson et al., 2016; Nesmith, 2018). Interestingly, my findings suggested that young people felt safe and trusted the text service, which meant they could speak more openly with their text message counsellors. Text message counselling may therefore address the help-seeking barrier of not having the 'right' people to talk with. My findings also showed how young people used the service to get information about suicide and asked questions they may not feel comfortable to ask their support people (Wisdom et al., 2006). This may be related to the overt discouragement of openly discussing suicide in NZ (Gibson et al., 2019) and provides further support of their trust in the service. Although it was not clear specifically what helped these young people trust Youthline, it may have been due to their anonymity, their egalitarian relationship with their counsellor, or finding the service to be helpful (Everall & Paulson, 2002; Hollidge, 2013). As young people in my research often described finding services ineffective, and in some cases damaging, having a form of support that young people respond well to is critical.

Lastly, young people in my study frequently conveyed that the text message counselling service was too limited to meet their needs. More specifically, the long wait times to speak with a counsellor and not being available through the night were clear issues. This is likely to be a function of the broader Non-Governmental-Organisation environment in which Youthline operates. Funding has become increasingly difficult to obtain and many services lack the resources to service they need (Hoyle, 2016). These limits in availability not only negatively impacted young people's experience of the service, but some clients may not have received adequate support to manage their suicide risk. As well as being a safety concern, these adverse experiences may reduce the likelihood of young people seeking help in the future (Rickwood et al., 2005). As my research has found that young people access text message counselling when in crisis, which can occur at any time, having a service that operates within limited hours may be ineffectual. Moreover, recent research has highlighted

that suicidality risk increases at night (Tubbs et al., 2020), providing further support for services to be available at all hours.

Overall, my findings suggested that there are a number of factors that make text message counselling unique from other forms of support. This research highlighted that text message counselling meets many of the needs and wants of young people who are experiencing suicidality. Importantly, my study indicated that text message counselling is able to meet young people's opposing needs. This medium of support may thus be able to specifically target many of the barriers to seeking support, which are commonly cited in the literature, as well as addressing young people's low rates of engagement.

Conclusion

A number of overarching findings from my study have been identified. Firstly, young people experienced multiple difficulties, which contribute to why they experience suicidality. These stressors were cumulative and the relationships between them were complex. This provides support for models of suicide, which do not rely solely on medical explanations for youth suicide.

Secondly, young people's experience of powerlessness was evident in the reasons they gave for their suicidality, their experience of suicidality, barriers to help-seeking, and why they reached out to a text message counselling service. Young people's powerlessness was thus a critical aspect in elucidating youth suicide. Their powerlessness also highlighted the importance of taking the social-cultural context where young people felt pressure to conform to normative expectations, suicide was difficult to talk about, and their families did not model adaptive emotional expression into account.

Thirdly, these findings underlined the heterogeneity and dynamic experience of suicide both within and among young people. In particular, the complexity and heterogeneity in motives for suicidality was apparent. For many young people experiencing suicidality,

suicide was conceptualised as a coping strategy in itself. Along with ending one's life, suicide may be seen as a way to solve problems, escape from emotional pain, and communicate distress.

Fourthly, ambivalence and uncertainty was identified among many young people experiencing suicidality. For many youth it may be that they do not want to die, but cannot see any other option to cope with their distress. Ambivalence not only provides a critical window of opportunity in regards to time, but may also give clinicians something to work with.

Fifthly, young people experiencing suicidality frequently acknowledged that they needed help. However, there were a number of barriers to getting support, which were related to their unique needs and wants. While the findings provided support for previously identified help-seeking barriers, they also suggested that perceived burdensomeness and feeling misunderstood, which have received less empirical attention, may be important barriers for young people experiencing suicidality.

Sixthly, young people conceptualised suicide as a normal response to life's difficulties, while also applying immoral and medicalised discourses to their understandings. Thus, young people experiencing suicidality may experience a dialectic of suicide being an understandable response and something they are ashamed of. Navigating these contrasting conceptualisations of suicidality may also influence their help-seeking as they may fear judgement, rejection, and misunderstanding.

Seventhly, difficulties communicating emerged as a salient factor among young people experiencing suicidality. Suicidal young people may struggle to communicate their experience. This not only contributed to suicidality having an interpersonal function, but also limited their ability to adequately help-seek and engage with supports. However, these difficulties communicating may be alleviated through conversing over text message.

Finally, text message counselling met many of young people's needs when seeking and engaging with support for suicidality. It was a preferred source of support among young people experiencing suicidality and they noted valuing the anonymity, privacy, accessibility, and genuine connection that the medium provided.

Clinical Implications

My research has a number of important implications for working with young people experiencing suicidality, which can also inform youth suicide prevention strategies. Increasing young people's power is a core clinical implication. Young people's beliefs of having no power to change their experiences or situation may be exacerbating their difficulties by keeping them in a position where they feel trapped and stuck. Interventions that target these belief systems, such as fostering an internal locus of control and understanding learned helplessness, may increase young people's perceived power (Beautrais et al., 1999). Moreover, developing problem-solving skills to improve self-efficacy and cultivating mastery for adaptive coping skills may also be helpful (Speckens & Hawton, 2005). If young people believe they have more options and have different beliefs surrounding their own self-efficacy and resilience, suicide may not be viewed as their only choice and something that is out of their control.

The feelings of powerlessness communicated by young people also highlighted the limited options available to them in society (White, 1994). Therefore, their powerlessness was also valid and interventions need to acknowledge and address this (Fullagar, 2005). Consequently, it is essential that young people's power is increased, so that they are given more opportunities to take charge of their circumstances and also to determine the kind of support they want.

It was clear from my study that youth are active participants in managing their own mental health and finding appropriate support. Young people themselves should be utilised to

inform the development of youth suicide prevention strategies (Cox & Hetrick, 2017). By prioritising their own experiences and giving them a voice, this will help ensure that these initiatives meet their needs and are accessible (Gibson & Cartwright, 2013). Moreover, the young people in my study showed insight into their difficulties, which could be usefully employed in the development of suicide prevention strategies.

Clinical interventions with young people who are suicidal may benefit on focusing on identity work. These interventions may involve developing self-efficacy and self-worth, which in turn may modify the self-concept of young people who experience suicidality, so they no longer see themselves as someone who is 'suicidal' or a 'burden'. This may positively influence a number of areas in a young person's life and mitigate other stressors that contribute to suicidality.

This research highlighted the importance of having a systemic approach to youth suicide intervention and prevention. At the family level, clinicians should work on family relationships and how they communicate within this system to help ensure young people feel safe at home, both physically and emotionally. This may strengthen the likelihood that young people will turn to their family for help and importantly, their family will know how to listen and provide effective support (Hedeland et al., 2016). Young people and their family may benefit from psychoeducation on suicide. This may help normalize the re-occurring nature of suicidality and ongoing journey to wellbeing, so young people feel less shame and concern with being a burden, and the family feel more equipped to cope with the young person's suicidality. As this research suggests that suicidality among youth is pervasive and dynamic, it is essential to not just provide systemic support in times of crisis and highlights the importance of ongoing interventions and support (Czyz & King, 2015).

At the community level, interventions need to target making school a less punitive and challenging environment for young people. As some young people's home environment

may be abusive and unsupportive, the need for support services in the community and schools is crucial.

This study supports previous recommendations for interventions that target the development of emotional competence among young people experiencing suicidality in both clinical and community settings (Pisani et al., 2013). This may support young people in managing their distress more effectively, as well as facilitating the development of a vocabulary to help them convey what they are experiencing, which may increase their help-seeking and engagement with support. However, this research extends previous recommendations by arguing that a cultural shift surrounding how emotions are understood and expressed in western society is also needed. The young people in my study described a culture where emotions and suicidality were not discussed, 'negative' emotional expression was forbidden and no one knew how to respond to the presence of strong affect. Thus, instead of solely locating suicidality within the individual, the social-cultural context where youth do not feel safe to express emotions and are not taught or modelled emotional competence must be taken into account (Bourke, 2003; Gilchrist & Sullivan, 2006; White, 2012). This highlights the need for broader public education on the importance of talking about difficult emotions and suicidality with young people, as well as developing the skills to do so (Grimmond et al., 2019).

The barriers to help-seeking communicated in this study also provide rationale for suicide prevention initiatives to concentrate on modifying the dominant norms and attitudes in society surrounding suicide and mental illness. If suicide continues to be understood through medicalised and moral discourses, young people will remain reticent to seek support for their suicidality (Fullagar et al., 2007). Clinicians working with suicidal youth must attempt to work within young people's worldview, while simultaneously supporting them in negotiating the tension between positioning suicide as 'other' and normative. This will

require a delicate balance of attempting to lessen understandings of suicide as a viable option, whilst also subverting the fear of stigma and ostracism that is associated with suicide (Roen et al., 2008). Not only will working within young people's worldview facilitate help-seeking and engagement, but it may also reduce the stigma, misunderstanding and judgement associated with suicide (Fullagar et al., 2007).

It is critical that the dynamic nature and heterogeneity of young people's experience of suicide informs clinical practice. Consequently, a one-sized-fits-all approach will be ineffective and instead, a thorough assessment of what each person is experiencing is needed. In particular, delineating young people's motives for suicidality is important. However, youth experiencing suicidality may want to conceal their difficulties and clinicians need to be aware of this.

When working with young people who are experiencing suicidality, three windows of opportunity to intervene became apparent. Firstly, my study suggests that for many young people, their experience of suicidality preceded any outward 'at risk' behaviors. Thus, the experience of suicidal ideation with no plan or intent provides a crucial opportunity to provide intervention. As this study indicated that suicidality worsens over time, this intervention is timely and critical. Moreover, this study suggested that premeditation among young people who experience suicidality is common. This also presents a crucial period where clinicians can provide support and disable any suicide plans. Secondly, young people's ambivalence towards taking their life provides an opportunity to intervene in terms of time, whilst also offering something to work with by giving clinicians a chance to build on the young person's own wish to continue living. Thirdly, the means and methods of suicide disclosed by youth in this study were often highly accessible, which can cause challenges in restricting access to them (Beautrais, 2000a). This stresses the importance of working *with* a young person and their system to keep them safe, as opposed to focusing on punitive

measures that remove access to means.

When young people experiencing suicidality sought support, they feared judgement and misunderstandings. Clinicians working with this group must thus ensure that young people feel heard and understood. Furthermore, young people's suicidality must be taken seriously and their experience should never be minimized. From a clinical perspective, a non-judgemental and understanding approach, which takes suicidality seriously may sound like a minimal requirement. However, of great concern, this study suggests this is not what young people are experiencing, especially within mental health services.

Previous suicide intervention strategies have predominantly relied on programmes developed for adult populations, which have made few adaptations to meet the needs of young people (Hawton et al., 2015). This study identified that when suicidal youth seek and engage with support they value anonymity, privacy, accessibility, and genuine connection. This highlights areas where adaption in support services can occur to ensure clinical practice and suicide prevention initiatives are more developmentally appropriate.

Furthermore, young people's difficulties in communicating affected if and how they engaged with professional supports, including disclosing their suicidality. Clinicians supporting youth who are experiencing suicidality must therefore adapt their style of working to facilitate communication, not only to increase engagement, but also to ensure the young person is safe. Moreover, clinicians need to be aware that communicating suicidality may be a form of help-seeking and respond appropriately to reduce tension that can arise from misunderstandings (Lachal et al., 2015).

Lastly, this study suggested that young people experiencing suicidality use text message counselling as it met a number of their needs when seeking and engaging with support. Text message counselling was also congruent with the dynamic experience of suicide, where times of heightened suicidality might not fit within a scheduled appointment

time or occur during typical nine to five office hours. Therefore, this medium should be utilised when working with young people experiencing suicidality and text message counselling services need to be recognised as an effective way of engaging suicidal youth. However, service limitations may result in young people feeling unsupported and importantly, may not be able to ensure their clients are safe. Text- message counselling services, which operate through the night and have enough available counsellors, are thus essential to ensure the service is meeting the demands of young people who are experiencing suicidality.

Limitations and Strengths of the Current Study

There are three important areas of limitation in this study. Firstly, due to the young people being anonymous their demographic data was unknown. Consequently, important information, such as the client's age, gender, ethnicity, and sexual orientation remained undetermined. However, the aim of this research was not to generalise these findings to all young people in NZ. Instead, the focus was on gaining an in-depth understanding of what these young people communicated on the text message counselling service.

Secondly, as the young people in my study were already seeking help by messaging in for support, this may have been a biased sample for elucidating barriers to help-seeking. Furthermore, a number of young people had sought professional support previously and were already engaging with mental health services. Thus, this sample might have been more confident with seeking help, compared to those who have never interacted with professional support services. It is also important to note that given the context of this study, the young people in my research can be assumed to be comfortable in communicating via text and this may not be reflective of all youth (Green, 2003).

Thirdly, due to the study design, the context of the text messages were unable to be explored further than what the text message counsellor asked and what the young person

disclosed. Thus, although this study allowed a unique and unrestricted access into young people's communicated experience, the context was limited by the counselling agenda.

Despite these limitations, there are a number of strengths in this research. Firstly, as the majority of research in the youth suicide literature has utilised quantitative methods, which rely on structured survey questions, this qualitative study was able to get a richer account of young people's experience of suicidality. Moreover, their perspectives may have been further captured as their communication was anonymous and they could talk more openly and comfortably through this medium.

Secondly, my study did not rely on retrospective recall from young people or people close to them where information could have been lost or altered over time. Instead, it provided a real-time account of young people's experience of suicidality and consequently, direct insight into their world. Due to the stigma associated with suicide and young people's reluctance to seek support for their difficulties, direct access into their experience of suicidality has previously been restricted. Although recent studies of internet forums have also captured real-time accounts of young people's experience (Owens et al., 2015), this study gained more insight into young people's experience of suicidality as they were messaging while in crisis. Thus, the young people in my study were not talking generally about suicide, but were experiencing suicidality whilst messaging in. Moreover, as the data was counselling interactions, this may have allowed for deeper disclosure and insights into the communicated experience of suicide among youth.

Thirdly, as this research analysed text-transcripts from normal service delivery, it was unstructured. This ensured that the young people and their counsellor could message freely, with no limitations or bias influencing what was texted.

Lastly, the focus of this study was on young people's experience of suicidality. Previous researchers have highlighted the importance of researching suicidality and NSSI

separately to further understand the phenomena (Chapman & Dixon-Gordon, 2007; Jacobson et al., 2013) Thus, by solely concentrating on suicide, as opposed to a wider definition of self-harm, a richer account of suicide was provided.

Directions for Future Research

The current study highlighted a number of areas where further research is needed. Although my analysis confirmed previous findings, in regards to factors that contribute to young people experiencing suicidality and what prevents them from seeking support, it also drew attention to areas that have previously received less empirical attention. In particular, the youth suicide literature has given little consideration into how experiencing suicidality impacts young people's sense of self and this area warrants further investigation. Interestingly, my study found that young people did not talk about romantic relationship difficulties as contributing to their experience of suicidality. As interpersonal difficulties were apparent in their other relationships, it may be beneficial for future research to explore romantic relationships among those experiencing suicidality further. More research into perceived burdensomeness and feeling misunderstood is also needed. Further understanding into how shame influences both young people's experience of suicidality and help-seeking may be paramount. This may also provide greater insight into why text message counselling is a popular medium among young people.

It is imperative that future research considers the social-cultural context youth suicide is located in. In particular, young people's powerlessness may be especially important. Accordingly, more research from young people's perspectives is needed to determine how to best increase their power. A better understanding of the pressures young people experience at school is also essential. Future studies should utilise the voice of young people to explore what changes could be made at school, so it is an environment of growth, as opposed to being challenging and punitive.

There is currently a dearth of research on the experience of therapy among young people experiencing suicidality. Of concern, my study found that young people who were seeing professional support services were not disclosing their suicidality to them. Therefore, more research is needed on young people's experience of engaging with formal support when they are suicidal. Moreover, future studies should explore what young people experiencing suicidality want and need from their therapist to facilitate their disclosure and overall engagement.

More research is needed on young people's experience of suicide from their own perspective. In particular, ambivalence and uncertainty among young people experiencing suicidality warrants further attention. Given the opportunities for intervention that ambivalence can provide, a further understanding of uncertainty among young people who experience suicidality is essential.

This research has identified that text message counselling was a preferred source of support for young people experiencing suicidality and it met many of their needs. However, further research is needed into the efficacy of text-based counselling services in reducing suicidality. Future studies should also ascertain what else suicidal young people want and need from a text message counselling service. As there are a number of developments into text-based interventions, which utilise automated messages, this style of intervention may be less effective and demands further attention.

Concluding Comments

Youth suicide has been identified as one of the most common causes of death among young people worldwide (Pelkonen et al., 2011). Although considerable empirical attention has been given to the risk factors that contribute to youth suicide and barriers to help-seeking among young people experiencing suicidality, there is limited research from the perspectives of young people themselves. My study provided further understanding of suicidality among young people by focusing on how they themselves communicated what contributed to them experiencing suicidality, their experience of suicide, the barriers that prevented them from seeking support, and what it was about text message counselling that they valued. The study highlighted that young people are active agents, who have insight into their difficulties and have clear needs and priorities for support in managing their suicidality. It is critical that young people's voices continue to be prioritised in research as they provide invaluable and unique understandings into youth suicide. To ensure that future research into youth suicide does justice to young people's experience, the social-cultural context, which considers their developmental needs, power differentials and dominant societal discourses, must be taken into account.

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Appendix A

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PARTICIPANT INFORMATION SHEET

Project title: An analysis of young people's suicide conversations on a text counselling service.

Name of Researcher: Jeanne van Wyk
Jeanne van Wyk is a Doctoral of Clinical Psychology student. Her supervisor for this research is Kerry Gibson, who is a Senior Lecturer in the School of Psychology.

What is this research about?
This research aims to explore how young people in New Zealand (NZ) communicate their experience of psychological distress and suicidality to Youthline's text counselling service. By analysing the conversations during a text counselling interaction between young people who are experiencing suicidality and their counsellors, we aim to gain a greater understanding into how these young people talk about suicide and the reasons they give for wanting to end their life. As text counselling is a relatively new service development, the research will also explore what young people who are experiencing suicidality say about the kind of help they need and how they respond to different responses from their text counsellors.

This research will involve the analysis of 200 anonymous transcripts of text counselling interactions gathered by your organisation during the course of normal service delivery. This material will analysed to explore how young people communicate their experience of psychological distress and suicidality on a text counselling service.

What will taking part in the research involve?
The researcher would like the consent of your organization to provide us with the required number of transcripts of text counselling for analysis. This will require a member of your staff to type "suicide" into Youthline's database and supply the researcher with 200 of the most recent text interactions that meet this criteria. The researcher will employ a member of staff at Youthline to anonymise the provided text transcripts, so that there are no identifying features

in the data, such as the names of the service user and the counsellor. The transcripts will be given to the researcher in electronic form.

What will happen to the research?
The researcher will use this research for her doctoral thesis, which will contribute to knowledge by increasing our limited understanding surrounding how young people communicate their experience of psychological distress and suicide to a text counselling service. The researcher may publish this information in academic publications and at conferences.

The researcher would like to name Youthline in the research as the organization providing this service.

What will happen to the text transcripts after the research is completed?
The researcher is obliged to keep the data as well as the Consent Form you will be asked to complete for this research. This information will be kept in a locked cabinet in the School of Psychology for 6 years and then will be destroyed.

What are the benefits for your organisation?
The researcher hopes that the research will inform the development of your text counselling service. You will be provided with you a report on the research when it is finished and the researcher would also be happy also talk with your organisation about the findings.

Are there any risks for your organisation?
The researcher believes that there are very few risks for your organization as the data is collected and stored anonymously, and the data will be anonymised further by a member of your organisation to ensure there are no identifying features in any of the transcripts. However, the researcher is aware of the need to deal sensitively with the data to protect the reputation that Youthline have for providing a confidential and safe forum for young people to confide their difficulties. In reporting the data the researcher will ensure that the focus is on general issues rather than highlighting idiosyncratic or individual responses. The researcher will use direct quotes from the transcripts, but will ensure that these are reported without any information that might identify a participant through name or specific circumstance.

Youthline is able to withdraw their consent to participate in the research within six months of signing the consent form.

Jeanne van Wyk can be contacted via email on jvan106@aucklanduni.ac.nz

Kerry Gibson can be contacted at the above address in School of Psychology at the University of Auckland or telephone 09 373-88556

William Hayward (Head of Department) can be contacted via email on w.hayward@auckland.ac.nz or telephone 09 373 7599 extn. 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 ext. 83711. Email: ro-ethics@auckland.ac.nz

Approved By The University Of Auckland Human Participants Ethics Committee On November 7th 2016 For Three Years. Reference Number 018140.

Appendix B

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CONSENT FORM

THIS FORM WILL BE HELD FOR A PERIOD OF 6 YEARS

Project title: An analysis of young people's suicide conversations on a text counselling service

Name of Researcher: Jeanne van Wyk

I have read the Participant Information Sheet and have understood the nature of the research and why I have been asked to assist with this. I have had the opportunity to ask questions and have them answered to my satisfaction.

- I agree to assist with this research
- I agree that the required material from Youthline's text counselling file data can be made available to the researchers.
- I agree that one or more of my staff members can assist with the extraction of the required data for this research.
- I understand that that the data will be anonymised by a Youthline staff member before being analysed and that the researchers will ensure that any direct quotes used in the research outputs will not include any information that might identify a service user.
- I understand that I may be asked for advice and feedback on the research as it develops.

- I agree that Youthline can be named as the organization involved in any publications arising from the research.

- I understand that Youthline can withdraw their consent to participate within 6 months of signing the consent form if I am concerned about the process.

- I am aware that the researchers will provide me with a report on the research findings.

- I agree that the research may be published in academic articles and conference presentations at the researchers' discretion.

Name _____

Signature _____

Date _____

Approved By The University Of Auckland Human Participants Ethics Committee On November 7th 2016 For Three Years. Reference Number 018140.