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Symptomatology and social support of family of young people with nonfatal suicidal behaviours

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Abstract: Suicidal behaviors are a serious public health problem, affecting individual, family and society. The aims of this study are to identify the effects of suicidal behaviors on different dimensions of family life and to explore differences in depressive, anxiogenic symptomatology, and levels of stress and satisfaction with social support among family members of young people with and without suicidal behavior. Participants were 107 relatives of young people with and without suicidal behavior. Self-report questionnaires were used. Descriptive analyzes and nonparametric tests of comparison of means were used. The components of life most affected by youth suicidal behaviors were family dynamics, considering positive effects and effects in health. There were no differences between family members of young people with and without suicidal behaviors in symptomatology and satisfaction with social support. Results have implications for research in suicidology and for practices and policies to prevent suicidal behaviors of young people, namely in supporting parenting.

Keywords: *Suicidal behaviors; Effects on family members; Youth.*

Sintomatologia e suporte social dos familiares de jovens com comportamentos suicidários não-fatais: Os comportamentos suicidários são um grave problema de saúde pública afetando o indivíduo, família e comunidade. O presente estudo tem como objetivos identificar os efeitos dos comportamentos suicidários na vida de familiares, e explorar a existência de diferenças na sintomatologia e satisfação com o suporte social entre familiares de jovens com e sem comportamentos suicidários. Participaram 107 familiares de jovens com e sem comportamentos suicidários. Usaram-se questionários de autorresposta. Análises descritivas e testes não paramétricos de comparação de médias foram as análises usadas. As componentes mais afetadas pelos comportamentos suicidários foram: as dinâmicas familiares - efeitos positivos e efeitos na saúde. Não se verificaram diferenças entre familiares de jovens com e sem comportamentos suicidários na sintomatologia e na satisfação com o suporte social. Os resultados têm implicações para a investigação em suicidologia e para práticas e políticas de prevenção dos comportamentos suicidários de jovens, nomeadamente na fundamentação do suporte aos pais.

Palavras-chave: *Comportamentos suicidários; Efeitos nos familiares, Jovens.*

Suicidal behaviours are a serious public health problem. Data provided by the World Health Organization indicate that around 800 000 people die by suicide every year and nonfatal suicidal behaviours are thought to be 20 to 30 times more frequent than suicides (WHO, 2018). In young people this ratio is even higher and nonfatal suicidal behaviours are estimated to be 100 to 200 times more frequent than suicide (Bertolote & Fleischmann, 2009).

Suicidal behaviours rate among the leading positions of the ranking of health problems when nonfatal attempts are considered. For 15 to 24 years old suicide is the second cause of years of life lost (YLL). There is an existing consensus in literature indicating that young people find it difficult to ask for help. Peers are usually referred to as the first people they ask for help, but parents and close friends are potential protective factors and mediators in seeking help (e.g., Berger, Hasking, & Martin, 2013; Fortune, Sinclair, & Hawton, 2008). Acknowledging that family's participation can be an important preventive

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factor when it comes to the repetition of suicidal behaviours, some studies try to understand the dimensions of family experience in these situations (Curtis, Thorn, McRoberts, Hetrick, Rice, & Robinson, 2018). This new line of investigation has been focusing on the experience of these families. These studies have mainly adopted qualitative approaches and seek to understand how parents respond and deal with the situation (Buus, Caspersen, Hansen, Stenager, & Fleischer, 2014; Byrne et al., 2008; Ferrey et al., 2016; Greene-Palmer et al., 2015; Kelada et al., 2016; Lindgren, Aström, & Graneheim, 2010; Oldershaw et al., 2008; Stewart, Hughes, Simkin, Locock, Ferrey, Kapur et al., 2016; Trinco, Santos, & Barbosa, 2017).

These investigations consider these behaviours as a traumatic and stigmatising event (Buus et al., 2014; Byrne et al., 2008). They have also identified the presence of depressive symptomatology, anxiety symptoms and sleep problems in the parents (Ferrey et al., 2016; Lindgren et al., 2010). Feelings of guilt, shame, anguish and loneliness (Lindgren et al., 2010), of rage against oneself (Greene-Palmer, 2015) and failure as a parent (Daly, 2005; McDonald, O'Brien, & Jackson, 2007) stand out. These feelings along with the fear of stigma lead to social isolation of the parents and to feelings of loss of social support (Byrne et al., 2008; Lindgren et al. 2010; McDonald et al., 2007). Most of these studies suggest that suicidal behaviours negatively affect several areas of family life (e.g. the relationship with the parents gets more distant and there is a breach in trust after the suicidal behaviour - Kelada et al., 2016; Whitlock et al., 2018). Nevertheless, some - even though fewer - studies suggest that suicidal behaviours may also have positive outcomes in family life (e.g., Kelada et al., 2016; Oldershaw et al., 2008). For example, some parents were able to develop a better relationship with their child (Kelada et al., 2016; Oldershaw et al., 2008; Whitlock et al., 2018).

When a young person has engaged in suicidal behaviours, the process of asking others (family members, friends, health professionals) for help and receiving it can be hard and difficult. Some studies indicate that the parents felt judged and criticized by their relatives (Ferrey et al., 2016). Other investigations reported similar findings concerning friends and neighbours (Asare-Doku et al., 2017; Lindgren et al., 2010; Morgan et al., 2013). This acquires special relevance as it is known that friends and family can represent a fundamental support, especially those who have already experienced similar situations (Ferrey et al., 2016). Some research reports that some parents also felt being blamed by health professionals (e.g., Trinco et al., 2017).

In short, suicidal behaviours of young people can have an important impact (both negative and positive) in several dimensions of family life. Yet, in Portugal there are few studies about these families. There is a need to learn more about these families in order to improve their protective and supportive role.

OBJECTIVES

To identify the effects of suicidal or self harm behaviours in different dimensions of family life (mothers, fathers and other close relatives).

To explore the differences in depressive symptomatology, anxiety symptoms and stress levels in relatives of young people with suicidal behaviours.

To explore the existence of differences in the satisfaction with social support in relatives of young people with and without suicidal behaviours.

METHOD

Participants

A process of convenience sampling has been adopted, and two samples have been used: relatives of young people with suicidal behaviours and relatives of young people without suicidal behaviours. To define suicidal or self harming behaviours the definition of self-harm has been adopted: intentional self poisoning or self harming, regardless of the motive and/or the level of suicidal intent (Hawton, Saunders, & O'Connor, 2012). One hundred and seven relatives participated in the study. The sample comprising the young people with suicidal behaviours was composed of 27 participants reaching from 18 to 80 years (M=47.26; SD=15.25), 18 female (66.7%). Nine of the relatives are mothers (33.3%), six are fathers (22.2%) and 12 are other close relatives (44.4%).

The remaining 80 participants are relatives of young people with no suicidal behaviours reaching from 19 to 63 years of age. Sixty-four of them (80.0%) are female.

Measurements

Scale of Effects of Suicidal Behaviours in Relatives (SESB-R-26). The SESB-R-26 was built in the scope of a broader investigation, comprising this study. The development of the SESB-R-26 was carried out according to the proceedings established in literature (Almeida & Freire, 2008; Gutierrez & Osman, 2008;

Hill & Hill, 2008; Moreira, 2004; Ribeiro, 1999). The items were designed and organized into six theoretical dimensions, based on the results obtained in qualitative studies with samples displaying similar characteristics (e.g., Buus et al., 2014; Ferrey et al., 2016; Greene-Palmer et al., 2015; Kelada et al., 2016). After creating the first version a panel of five judges specialised in Suicidology was consulted. According to the instructions pointed out by Gutierrez and Osman (2008) about the conception of instruments in the field of Suicidology, each jury was asked to rate the items in a 5- point Likert scale, based on the following criteria: relevance, representativeness, specificity, clarity, language and extension. In a second phase, the judges were asked to pair each item with one of the six previously designed theoretical dimensions. In a third phase, the judges were asked to give a technical opinion about the clarity of the instructions, the adjustment of the measuring scale, the global extent and suggestions. The technical opinion was favorable. Some items were altered according to suggestions. The first three times the SESB-R-26 was implemented, the participants were questioned about understanding the items and encouraged to suggest changes, but no suggestions were made. Thus, a final version of the SESB-R-26 was assembled considering 26 items rated on a Likert scale from 1 (Hasn't affected at all) to 5 (Affected very much). The six dimensions of the effects consisted in (a) life in general, (b) negative effects on family, positive effects on family, (d) social life, (e) professional life and (f) health. In 5 components, Cronbach's alpha was between .75 and .88 and in the component displaying Cronbach's alpha below .70, the mean inter-item-correlation (MIC) was .35, thus revealing a good internal consistency. SESB-R-26 revealed a satisfactory sensitivity, answers reached from the lowest to the highest level (1 to 5) in 12 items, from 1 to 4 in another 12 items and from 1 to 3 in only 2 items.

Depression Anxiety Stress Scales (DASS-21; Lovibond & Lovibond, 1995; Pais-Ribeiro, Honrado, & Leal, 2004). DASS-21 is a self-administration scale aimed at assessing anxiety, depression and stress. This scale contains 21 items. In this study it obtained a high total internal consistency (α=.91), as well as its three sub-scales - Anxiety (α=.83), Depression (α=.79) and Stress (α=.81).

Scale of Satisfaction with Social Support (ESSS; Pais-Ribeiro, 1999). It consists of a self-administration scale with the aim of measuring satisfaction with social support. The ESSS contains 15 items. In this study it obtained a good total internal consistency (α=.80) and also in its four sub-scales: Satisfaction with friends (α=.74), Satisfaction with intimacy (α=.57), Satisfaction with family (α=.85) and Satisfaction with social activities (α=.74).

A questionnaire for gathering sociodemographic data was also used.

Data collection and ethical considerations

The study protocol was approved by the Ethics Committee of the Faculty of Psychology and Educational Sciences of the University of Porto, the Hospital Magalhães Lemos, the University Hospital Center of Coimbra and the Regional Board of Health of the Algarve. All the participants signed an informed consent document after the study was explained to them. Anonymity and confidentiality of data were guaranteed.

Data analysis

Statistical analyses were carried out using the Statistical Package for the Social Sciences (IBM SPSS Statistics – Version 24). To calculate the internal consistency of the scales Cronbach's Alpha and the Mean inter-item-correlation (MIC) was used. To explore the existence of differences in the symptomatology and in satisfaction with social support the Mann-Whitney non-parametric test was used.

RESULTS

Effects of young people's suicidal behaviours in the life of relatives.

As displayed in Table 1, the component with more effects as a consequence of suicidal behaviours is *positive effects on the family*, followed by the dimension health, where the increase of family anxiety and changes in sleep stand out.

Table 1. Effects of young people's suicidal behaviours in the life of relatives

Subcategories (Cronbach's alfa and/or MIC; M; SD)	Items	(1) It hasn't affected at all (*N; %*)	(2) Affected slightly and (3) Affected somewhat (*N; %*)	(4) Affected and (5) Affected a lot (*N; %*)	*M (SD)*
Life in general (α=.75; *M*=2.29; *SD*=.88)	1. It affected my life in general.	4 (15.4)	15 (57,7)	7 (26.9)	2.85 (1.16)
	11. It affected my daily life.	8 (30.8)	14 (53.8)	4 (15.3)	2.38 (1.17)
	15. It harmed my relationships in general.	15 (55.6)	11 (40.7)	1 (3.7)	1.70 (.91)
Negative effects on family (*α*=.83; *M*=1.86; *SD*=.65)	2. It affected my family life.	6 (23.1)	12 (46.1)	8 (30.8)	2.92 (1.41)
	4. It affected my relationship with my partner.	16 (61.5)	8 (30.8)	2 (7.7)	1.62 (.94)
	5. It affected my relationship with my relative.	12 (44.4)	12 (44.4)	3 (11.1)	1.85 (.99)
	6. It affected my relationship with my child(ren)/parents.	19 (73.1)	4 (15.4)	3 (11.5)	1.58 (1.07)
	7. It affected my relationship with close relatives.	19 (73.1)	5 (19.2)	2 (7.7)	1.50 (.95)
	12. It affected my family's finances (e.g. paying appointments)	12 (46.2)	10 (38.5)	4 (15.4)	2.08 (1.29)
	13. It affected the siblings.	11 (40.7)	11 (40.7)	5 (18.5)	2.30 (1.33)
	16. It harmed my family relationships.	16 (59.3)	10 (37.0)	1 (3.7)	1.67 (.92)
	20. It made my life as a couple worse.	22 (84.6)	2 (7.7)	2 (7.7)	1.69 (.93)
	24. It put pressure/ discomfort in my life as a couple.	19 (73.0)	5 (19.2)	2 (7.7)	1.81 (1.02)
	25. The relationship with my relative became worse.	22 (84.6)	4 (15.4)	0	1.58 (.76)
Positive effects on the family (*α*=.84; *M*=2.56; *SD*=.97)	21. It strengthened relationships within the family.	14 (53.8)	8 (30.8)	4 (15.4)	2.31 (1.19)
	22. It made my relationship with my relative become closer.	13 (50.0)	6 (23.1)	7 (26.9)	2.65 (1.02)
	23. It made my family more united.	12 (46.2)	6 (23.1)	8 (30.7)	2.73 (1.15)
Social life (*α*=.88; *M*=1.56; *SD*=.93)	3. It affected my social life.	15 (57.7)	9 (34.6)	1 (7.6)	1.77 (1.11)
	9. It affected my relationships with my friends.	21 (80.8)	3 (11.5)	2 (7.6)	1.35 (.85)
Professional life (*α*=.43; MIC=.35; *M*=1.47; *SD*=.53)	8. It affected my relationships with my colleagues from work/school.	22 (84.6)	3 (11.5)	1 (3.8)	1.23 (.65)

	10. It affected my relationships with my superiors at work.	22 (85.6)	3 (11.5)	1 (3.8)	1.19 (.49)
	14. It negatively reflected on my work/school.	12 (44.4)	12 (44.4)	3 (11.1)	2.07 (1.11)
Health (α=.88; *M*=2.43; *SD*=.96)	17. It harmed my mental health.	8 (30.8)	16 (61.6)	2 (7.6)	2.12 (1.03)
	18. It harmed my physical health.	14 (53.8)	10 (38.4)	2 (7.6)	1.77 (1.07)
	19. It changed my sleep routine (e.g. not being able to fall asleep or waking up in the middle of the night)	10 (38.4)	10 (38.4)	6 (23.1)	2.62 (1.20)
	26. It made the levels of anxiety in the family rise.	5 (19.2)	10 (38.4)	11 (42.3)	3.23 (1.14)

Note: MIC = Mean-inter-item correlation; % = percentage; M = Mean; SD = Standard Deviation

Depressive symptomatology, anxiety symptoms and stress levels in relatives of young people with and without suicidal behaviour

As displayed in table 2, no significant statistical differences were found between family/relatives of young people with and without suicidal behaviours.

Table 2. Depressive symptomatology, anxiety symptoms and stress levels in relatives of young people with and without suicidal behaviours

	Relatives of young people with suicidal behaviours (*N*=27)		**Relatives of young people without suicidal behaviours (*N*=80)**		***U***	***p***
	M	*SD*	*M*	*SD*		
Anxiety	2.30	2.54	3.21	3.47	940.50	.308
Depression	3.48	3.49	3.55	3.42	106300	.902
Stress	5.52	3.73	5.25	3.49	1031.50	.727

Note. M=Mean; SD=Standard Deviation; U=Mann-Whitney Test.

Satisfaction with social support in relatives of young people with and without suicidal behaviours

As displayed in table 3, no significant statistical differences were found in the satisfaction with social support in relatives of young people with and without suicidal behaviours.

DISCUSSION

This study is the first to investigate the effects of non-suicidal behaviours in Portuguese families. The only existing study to this day analysing the Portuguese context and in line with this investigation excluded self-harm behaviours with suicidal intent (Trinco, Santos, & Barbosa, 2017). Internationally, there are few quantitative investigations that evaluate the effects of nonfatal suicidal behaviours in relatives. The existing studies do not use specific instruments to assess this event (Morgan et al. 2013).

Results from this study highlight that the dimensions which were most affected were family dynamics in their positive effects and health, namely changes in sleep and increased anxiety. No differences were found between relatives from young people with and without suicidal behaviours concerning depressive symptomatology, anxiety symptoms and stress levels, nor concerning satisfaction with social support. It was also established that the questionnaire SESB-R-26 presented satisfactory psychometric properties, although preliminary, thus encouraging further research.

Table 3. Satisfaction with social support in relatives of young people with and without suicidal behaviours

	Relatives of young people with suicidal behaviours (*N*=27)		Relatives of young people without suicidal behaviours (*N*=80)		*U*	*p*
	M	*SD*	*M*	*SD*		
Total	2.73	.58	2.72	.65	1044.00	.796
Satisfaction with friends.	2.82	.70	3.03	.79	882.00	.153
Satisfaction with intimacy.	2.72	.88	2.62	.87	1006.00	.594
Satisfaction with family.	2.94	.81	3.09	1.01	909.00	.211
Satisfaction with social activities.	2.38	1.02	1.97	1.22	847.50	.094

Note. M=Mean; SD=Standard Deviation; U=Mann-Whitney Test

The results of the effects of young people's suicidal behaviours on their relatives in the Portuguese context are in line with international research (e.g., Buus et al., 2014; Byrne et al., 2008; Ferrey, et al., 2016) showing that an attempted suicide is a disturbing emotional experience and that it can endanger the health and well-being and family relationships (Curtis et al., 2018; Ferrey et al., 2016; Kelada et al., 2016). About 30% of the relatives consider that family life was affected by the young person's suicidal behaviour. Over 40% report an increase in anxiety levels in the family and 23% state that their sleep routine has changed.

Nevertheless, when symptomatology is analysed, there are no differences between relatives of young people with and without suicidal behaviours, and the means obtained are lower than those from previous studies (Lovibond & Lovibond, 1995). These findings seem to indicate that, albeit most relatives experience the suicidal behaviour as an emotionally distressing event, they find resources to adjust and deal with the situation. A different explanation may relate to the psychological support some parents were receiving, enabling the development of skills to deal with the event and to lower psychopathology. These results are encouraging, as parents are identified by young people as potential facilitators of seeking help (e.g., Berger et al., 2013; Fortune et al., 2008). As such, intervention politics should include measures directed at the parents and other potential 'protectors' and informal resources (e.g., friends, social groups). Public health measures promoting an increasing literacy in mental health, including suicidal behaviours, are recommended. Previous studies refer that the parents experience doubts about the best way to help their child and usually do not seek professional help at the proper moment (Berger et al., 2017). Despite the parent's insecurity, if appropriately informed and supported, they can play an essential role in starting treatment and in providing support to young people (Glenn et al., 2015). Results from this research are in line with previous studies that mention positive effects on family dynamics after the suicidal behaviour (Ferrey et al., 2016; Kelada et al., 2016; Oldershaw et al., 2008). Over 30% of the participants in the present investigation remark that the family got more united and 27% that the relationships became closer.

Additionally, results seem to indicate less disturbance in social and professional life, when compared to the data obtained by international investigations (e.g., Byrne et al., 2008; Daly, 2005; McDonald, 2007). One possible explanation for this seemingly lower disturbance level can be the fact that most international studies include mothers and fathers and the present study also includes other relatives. Another explanation might be related to cultural differences of the social support network that overcome the social stigma of this issue. These possible explanations are apparently sustained by the non-existence of differences in the satisfaction with the social support experienced by relatives of young people with and without suicidal behaviours. This result suggests the protective role played by satisfaction with social support that may reduce the negative impact of suicidal behaviours in family dynamics and health. The association between the variables - suicidal behaviour, social support and experience/ impact – and the mechanism responsible for how this association seems to occur, can also help to interpret the absence of differences in psychopathological symptoms. The few existing studies

that include satisfaction with social support (e.g., Asare-Dokar et al., 2017; Byrne et al., 2008; Ferrey et al., 2016; Lindgren et al., 2010; McDonald et al., 2007), suggest that suicidal behaviour may have negative impacts on this variable leading to isolation and making the impact more negative. Other results (Asare-Dokar et al., 2017; Ferrey et al., 2016) suggest that satisfaction with social support rather works as a mediator, increasing or reducing the negative impact. The results gathered by the present investigation provide further arguments consolidating the second hypothesis, thus pointing out the role of satisfaction with social support as a moderating variable and recommending further investigations on this moderating role.

Notwithstanding the limitations of this study, which recommend a broader sample and the use of factor analysis, the results express clues for clinical and psychoeducational practices in order to foster the protective role played by families. Results also suggest that the dimensions of modifications in family dynamics, anxiety and changes in sleep should be addressed in order to prevent health problems and to promote adjustments. Finally, including parents in support groups moderated by health professionals is suggested.

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