2010

Experiences and perceptions of how community-based interventions can promote young adults' resilience to suicide within rural/regional communities

Tracy Evans
Edith Cowan University

Edith Cowan University

Copyright Warning

USE OF THESIS

The Use of Thesis statement is not included in this version of the thesis.

Experiences and Perceptions of How Community-Based Interventions can Promote
Young Adults' Resilience to Suicide within Rural/Regional Communities

Tracy Evans

A report submitted in Partial Fulfilment of the Requirements for the Award of
Bachelor of Science (Psychology) Honours,
Faculty of Computing, Health and Science,
Edith Cowan University.

Submitted (June, 2010)

I declare that this written assignment is my

own work and does not include:

(i)   material from published sources

used without proper acknowledgement; or

(ii)   material copied from the work of

other students

Signature   (Tracy Evans)

Experiences and Perceptions of How Community-Based Interventions can
Promote Young Adults' Resilience to Suicide within Rural/Regional Communities

In the literature, both statistics and studies have noted that suicide in rural/regional young adults' is an important concern. Recent research suggests, that to facilitate a primary approach to suicide prevention in young people, there is a need to promote the protective construct of resilience at a community level, highlighting strategies such as connectedness, and decreasing the stigma related to mental illness and health-seeking behaviour (Commonwealth Department of Health & Aged Care, 2005; Injury Control Council of Western Australia, 2006). However, there is a need to investigate and identify the links or mediating factors that promote individual resilience within a person, in relation to broad community-interventions (Niner et al., 2009). Therefore, this phenomenological study undertaken within a rural/regional context, explored resilience and how this may protect in regard to the problem of suicide among young adults'. Specifically, the experiences and perceptions of young adults' and those that work with youth in a rural setting were explored, to aid identifying how young adults' define resilience to the problem of suicide, and discover what community strategies are needed within rural/regional areas, to promote resilience for young adults'. Ten informants, 7 young adults (4 female and 3 male) and 3 older adults, located in rural/regional areas in the South West of Western Australia; volunteered to participate in a semi-structured interview, exploring the construct of resilience and how this may protect in regard to the problem of suicide. The semi-structured interviews were analysed at both an individual level for each informant and a higher level of generalisation, to aid in the identification and extraction of themes and sub-themes from the complete data (Becker, 1992). Five major themes were identified as a result, which informants' perceived to be important to defining or promoting resilience within the context of suicide. These included; support, awareness of internal processes, stepping stones, acceptance, and suicide education. These findings suggest that individual, relational, contextual and cultural aspects are important factors for rural young adults' experiences and perceptions of resilience, especially when considered within the context of suicide. Thus, supporting Ungar and colleague's (2007) perspective of resilience, which emphasises the importance of both an individual's abilities, and the capacity of an individual's ecology to provide the resources needed to promote resilience and well-being.

Author: Tracy Evans

Supervisor: Dr. Andrew Guilfoyle

COPYRIGHT AND ACCESS DECLARATION

Signed...

Date...29th July 2010.............

Acknowledgements

Table of Contents

Introduction

In Western Australia in 2006, suicide accounted for 17% of the deaths for both male and female individuals in the 15 to 24 year-old age group (Australian Bureau of Statistics, 2008a). Emotionally and financially, the costs associated with suicide are substantial. For instance in Australia in 2005, there were over 8,000 young adults hospitalised due to suicide attempts and related intentional self-harm (Australian Bureau of Statistics, 2008b). Whilst researchers (Pirkis, Burgess, & Dunt, 2000) utilising Australian national survey data reported that 43 respondents out of a sample of 10,641 adults (i.e., .004% of sample), self-reported attempting suicide over a one year period. By extrapolating Pirkis and colleague's (2000) .004% figure, this equates to an estimated 6251 individuals in Western Australia's approximate adult population of 1.56 million (Australian Bureau of Statistics, 2007a) who may potentially attempt suicide in a given year. Moreover, in a study (Wilburn & Smith, 2005), which explored the relationship between young adults' stress, self-esteem and thoughts of suicide, it was reported that the majority of participants (86%) had experienced thoughts of suicide at some time in their lives. While in another study (Mission Australia, n.d.) which surveyed young Australians in 2007, it was found that approximately 1 in 5 respondents aged between 15 and 24 years old, perceived suicide to be an important concern personally.

Primarily, suicide is a preventable problem (Vijayakumar, Pirkis, & Whiteford, 2005), and as purported by Judd, Cooper, Fraser and Davis (2006) suicide is not caused by any one single factor, but potentially from a combination of psychosocial (e.g., personal, social and situational) stressors interacting with an individual's vulnerability at a specific time and place. It has been reported in the literature that "coping with stress" is a major source of concern among young-adults (Mission Australia, n.d.). Essentially, this finding may be understood in relation to recent research (e.g., Mroczek & Almeida, 2004; Tusaie-Mumford, 2001), which has demonstrated that there are age differentials in how stressors may be appraised and/or experienced. For instance, Stawski, Sliwinski, Almeida and Smyth (2008), explored the differences in self-reported exposure and emotional reactivity to daily stressors between younger and older adults. It was reported that on any given day throughout the duration of a two-week study, younger adults where four-times more likely than older adults to report a stressor. While, on the days when individuals reported a greater number and/or severity of stressors, it was found that younger adults in comparison to older adults, perceived significantly greater levels of negative affect. Furthermore, a study conducted by Wilburn and Smith (2005), reported a

positive association between increases in negative stressors and increases in suicidal thoughts ($r = .33$, $p = .002$) in a sample of young adults, highlighting a potential cumulative effect of negative stressors. Consequently, the identification and study of factors that may decrease young adults' vulnerability towards current and possible future psychosocial stressors that may preclude suicidal thoughts and behaviours, is an important area to be researched (Commonwealth Department of Health & Aged Care [CDHAC], 2005).

Specifically, the contemporary discourse surrounding suicide prevention efforts, highlights the importance of understanding two factors related to psychosocial stressors. Firstly, the factors to inform the 'who' or 'what population' may be at risk for suicide (Rutter & Behrendt, 2004); and secondly the protective-factors, which make-up an individual's capacity for resilience in times of adverse stress (CDHAC, 2005). Essentially, resilience is a dynamic process that takes place between the characteristics and abilities of an individual and qualities of their environment (Tusaie & Dyer, 2004). It refers to the capacity of an individual to flexibly cope with demands or demonstrate positive behavioural adaptation, in the face of significant stress and adversity (Haglund, Nestadt, Cooper, Southwick, & Charney, 2007).

However, there seems to be a paucity of literature specifically focused within the area of suicide research related to what makes youth resilient to suicide. Thus, the critical review of the literature that follows will initially identify the potential suicide risk factors associated with young adults. It will identify the differing conceptions of resilience and the quantitative and qualitative research undertaken with both youth and other cohorts that has facilitated towards the current understanding of this construct, in respect to stress and suicide. Leading to an analysis of how the promotion of the protective factor of resilience may be beneficial as a primary prevention approach towards the problem of suicide in the peer-group of young adults.

Young Adults and Risk Factors of Suicide

Young adulthood, or the years between 18 and 25, is regarded as a relatively healthy physiological period (Arnett, 2007; Porth, 2002). However in this age cohort, it has been reported that deaths caused by suicide, account for the greatest proportion of deaths than all other causes (Australian Bureau of Statistics, 2007b). Notably previous research, which has utilised epidemiological data of completed and/or attempted suicides, has identified several psychosocial stressors comprised of individual and environmental risk factors that are associated with suicide in young adults.

Specifically for youth, individual suicide risk factors encompass biological, psychological and social aspects. These include, depression or significant psychological distress (Burns & Patton, 2000; Carter, Issakidis, & Clover, 2003); feelings of isolation (CDHAC, 2005); perceptions of hopelessness associated with negative beliefs about the future (Lalonde, 2006; Rutter & Behrendt, 2004); or a diagnosed mental health condition, such as an affective, anxiety or substance-use disorder (Carter et al., 2003; Pirkis, Burgess, & Dunt, 2000). While a personal history of physical and/or sexual abuse (Injury Control Council of Western Australia [ICCWA], 2006; Stone, 1992); previous suicide attempt(s) and/or deliberate self-harm (Livingworks, 2004; Taylor, Page, Morrell, Carter, & Harrison, 2004); or a significant experience of personal loss, such as death of a loved one, a relationship breakup, or a life-changing physical disability (Lipschitz, 1995; Livingworks, 2004) have also been identified as potential individual suicide risk factors. Furthermore, the non-responsible media representation of suicide, such as reporting the actual method(s) used, and/or sensationalising or romanticising the individual who completed the suicide (Baume, Cantor, & Rolfe, 1997; CDHAC, 2005; Patterson & Pegg, 1999), has been associated with contagion effects or copy-cat suicides (Gould & Kramer, 2001). For instance, it has been posited that misrepresentation of suicide in the media may influence psychologically vulnerable individuals who are struggling with seemingly insurmountable problems, to potentially view suicide as an alternative option (Baume et al., 1997; CDHAC, 2005).

The 'help-negation effect' is another individual risk factor also noted in the literature, which has been shown to have a pervasive influence upon young adults' help seeking behaviours in times of extreme psychological distress associated with suicide. This factor refers to the phenomenon that in the context of suicide, individuals are more likely to withdraw socially (Carlton & Deane, 2000), and less likely to seek help from formal (e.g., doctor, counsellor, psychologist) or informal (e.g., family or friends) supports, for suicidal thoughts (Rickwood, Deane, Wilson, & Ciarrochi, 2005). For instance, in a study conducted by Carter and colleagues (2003), which utilised Australian national survey data, it was reported that 12.5% of young adults in the sample, had either attempted suicide or considered suicide and had not sought formal or informal help.

Specifically, in a study of young adults, Harris, McLean and Sheffield (2009), reported that a 'suppressive-coping style' related to an avoidance orientation of problem solving and social withdrawal, and increases in 'depressive thoughts' were negatively associated with intentions for seeking help for suicidal thoughts ($r = -0.29$, and $r = -$

0.42, respectively; $p < .05$). While, cognitive inflexibility and rigidity has been noted among youth who were placed in care shortly after a suicide attempt (e.g., Lalonde, 2006), it was found that these youth were unable to envision conceptions or hopes related to a future self. In addition, several other factors accounting for the 'help negation effect' have been identified through qualitative investigation. These include, a potential lack of competency in communicating emotions, more so among males than females (Niner et al., 2009; Quine et al., 2003; Rickwood, Deane, Wilson, & Ciarrochi, 2005); a lack of personal awareness and/or knowledge of the signs and symptoms associated with depression (Gorman et al., 2007; Rickwood et al., 2005); the stigma associated with suicide and mental health within society (Botha, Guilfoyle, & Botha, 2009; Niner et al., 2009; Rickwood et al., 2005); and, the predominant Australian male social role encouraging self-reliance, such as the stereotype of the 'stoical, strong macho male' (Niner et al., 2009; Quine et al., 2003).

Importantly however, in conjunction with the aforementioned individual suicide risk factors associated with young adults universally; researchers who have explored suicide risk factors among Australian youth have noted there are specific environmental circumstances (e.g., Cantor & Neulinger, 2000; Judd, Cooper, Fraser, & Davis, 2006; Patterson & Pegg, 1999) that may potentially contribute to an increased risk of suicide for young adults living in rural communities, compared to those living in urban areas. These consist of, limited opportunities in education and employment (Cantor & Neulinger, 2000; Gerber, 2004; Quine et al., 2003); limited availability of transport and affordable non-alcoholic recreational activities (ICCWA, 2006; Patterson & Pegg, 1999; Quine et al., 2003; Robertson & Chapman, 2004); and, an increased familiarity and availability of lethal methods such as firearms, which are used for pest control on rural farming properties (Judd et al., 2006; Patterson & Pegg, 1999; Tomborou et al., 2000). Whilst critically, other factors also play apart, such as limited accessibility and use of mental health services in country areas (Cantor & Neulinger, 2000; Judd et al., 2006; Quine et al., 2003) inclusive of the fear of stigma and embarrassment, related to seeking professional-help for emotional problems associated with concerns of limited confidentiality and the high visibility of professional mental-health services within rural/regional areas (ICCWA, 2006; Rickwood, Deane, Wilson, & Ciarrochi, 2005).

Notably, it has also been reported that young adults are one of the most frequently identified groups that are 'excluded' within rural/regional communities (ICCWA, 2006), which may potentially lead to heightened feelings of isolation for these young

individuals. Whilst specifically, it has been reported in Australia, that rural areas demonstrate higher suicide rates compared to urban areas (Australian Bureau of Statistics, 2007b); and although this pattern for young adults' is generally more prominent for males (Cantor & Neulinger, 2000), there have been reports of a similar pattern for females within Western Australia (WA). For example, it has been reported that in the South Western region of WA, female suicides were also greater than those reported at the state and national levels between 2000 and 2004 (ICCWA, 2006). Subsequently, it appears that rural young adults may experience a greater number of contextual pressures than their urban counterparts in view of their specific environmental circumstances, which may potentially affect their life choices and put them at an increased risk of suicide.

Thus as aforementioned, suicide is not caused by any one individual factor, it is a complex problem involving multiple individual and environmental risk factors or psychosocial stressors (CDHAC, 2005; Judd, Cooper, Fraser, & Davis, 2006), that interact with an individual's vulnerability at a specific time and place (Judd et al., 2006). Importantly, risk factors such as those associated with suicide, do not predict a negative outcome with certainty, they simply increase an individual's exposure to the circumstances that have been associated with a higher incidence of that outcome (Carbonell, Reinherz, & Giaconia, 1998). It is the protective factors associated with resilience however, that may potentially buffer or operate to protect those who are at risk from the negative effects of risk exposure (Carbonell et al., 1998; CDHAC, 2005). For instance, consider those rural young adults who demonstrate resilience, by way of everyday competence when facing perceived considerable stress or threats to their well-being (Ungar, 2008). They do not alter the individual and/or environmental risk factors that may concomitantly contribute to the reported higher rates of suicide for their peer group. They appear to cope successfully and overcome the effects of risk exposure, and it is proposed that it is the protective factors associated with resilience acting preventively that enable them to do this (CDHAC, 2005).

Therefore, the identification of the protective factors associated with resilience will facilitate primary prevention and early interventions for suicide and suicidal behaviours. Informing the focus required, to promote building young adults' capacity for individual resilience towards the complex psychosocial stressors that they may encounter throughout life - a priority for both suicide prevention and wellbeing promotion (CDHAC, 2005).

Three Conceptualisations of Resilience

Fundamentally, the construct of resilience focuses upon what constitutes health and well-being, rather than illness or psychopathology (Reeve, 2005; Ungar, 2008), and to facilitate an understanding of this construct in respect to stress and suicide, in the review of the literature that follows prior resilience research that has been conducted with youth and other cohorts has been reviewed. Essentially, previous research of individual resilience has been undertaken to explore and identify the "health-enhancing capacities" (Ungar, 2008, p. 220) of both the individual and their social world, inclusive of family, community, and cultural resources (e.g., Kumpfer, 1999; Lalonde, 2006; Miller, 1996; Palmer, 1997; Rutter, 1985; Ungar et al., 2007).

Specifically, the current literature encompassing resilience focuses upon three overlapping conceptualisations (Ungar, 2008). The first portrayal of resilience may refer to an individual's positive functioning indicative of recovery after a traumatic event or experience such as a terrorist attack, grieving the recent death of a spouse, or a life-threatening injury or illness (e.g., Beardslee, 1989; Bonanno &'Mancini, 2008; Hegney et al., 2006; Rossi, Bisconti, & Bergeman, 2007; Shakoor & Fister, 2000). A second description of resilience may consist of a set of characteristics, both 'dispositional' (such as, sociability or intelligence), and 'situational' (encompassing family, peer, or community support systems) that enable an individual to have a better than expected developmental outcome (Ungar, 2008). Studies of children raised in high risk or disadvantaged circumstances, such as parental psychopathology or poverty, emphasise this form of resilience (e.g., Beardslee, 1989; Carbonell, Reinherz, & Giaconia, 1998; Gilgun, 1996; Palmer, 1997; Ungar, Brown, Liebenberg, Cheung, & Levine, 2008; Werner, 1989). While a third portrayal of resilience, may refer to an individual's successful adaptation or competence, when confronted with significant stressors in daily life (e.g., Gorman et al., 2007; ICCWA, 2006; Steinhardt & Dolbier, 2008). Specifically, it is this third portrayal of everyday resilience, which is the focus of the present study; as the risk-factors associated with suicide for young adults are both broad and numerous, potentially ranging from exposure to extremes of significant loss and adversity, to perceptions of feeling overwhelmed and unable to cope in response to perceived significant daily stressors (CDHAC, 2005).

Fundamentally, reviewing the research of these three portrayals of resilience, several common factors were broadly identified that enhance an individual's capacity to deal with significant challenges and life stressors. These factors encompassed individual,

social, and contextual aspects, and were indicative of positive reciprocal relationships between individuals and their environments (Rutter, 1985). Specifically, the individual factors of resilience included the personal attitudes, competencies and behaviours that facilitated maintaining well-being when facing stress. For instance, a sense of personal control over the environment, and a 'challenge' rather than threat orientation when facing adversity is an important individual factor of resilience (ICCWA, 2006; Steinhardt & Dolbier, 2008). Several studies (e.g., Beardslee, 1989; Gorman, et al., 2007; Ungar, Brown, Liebenberg, Cheung, & Levine, 2008) have reported that participants' ability and perceptions of being able to affect change upon their surroundings increased their personal beliefs of self-reliance, while also increasing confidence in their personal capabilities to adapt flexibly to changes in situational demands, and maintain perseverance of coping efforts throughout times of significant adversity.

While an individual's competency in interpersonal social skills, inclusive of the ability to recognise and effectively communicate emotionally and empathise with others, is another example of an individual factor of resilience (e.g., Beardslee, 1989; Rickwood, Deane, Wilson, & Ciarrochi, 2005; Werner, 1989). This factor is interrelated with the development and availability of social supports, and is integral to resilience in times of adversity and significant stress. For instance, Gorman and colleagues (2007) reported that rural men who experienced extreme emotional difficulties (for some, inclusive of thoughts of suicide), found that being able to recognise depressive cognitions and communicate emotionally with others, was therapeutic and essential to their coping efforts to persevere through tough times. It was also reported that feelings of empathy and responsibility for family members, through perceptions 'of being needed' strengthened these rural men's resilience, and increased their perceptions of self-esteem during difficult times.

An extremely important aspect of resilience is the protective factor of 'social support' (ICCWA, 2006; Tusaie & Dyer, 2004). Previous research has highlighted that an individual's perceptions of positive social support of trusted family and friends, provide feelings of belonging, being loved and cared for, compassion, and emotional comfort in times of significant adversity and emotional distress (e.g., Beardslee, 1989; Gorman et al., 2007; Ungar et al., 2007). Specifically, a sense of connectedness and attachment to family and friends provides opportunities for reciprocal pro-social interactions, which promote feelings of well-being and decreases feelings of isolation (ICCWA, 2006; Steinhardt & Dolbier, 2008). Importantly, it is the perceived quality and

not the quantity of relationships that facilitates an individual's sense of connectedness and belonging with others (ICCWA, 2006). For instance, studies (e.g., Resnick, Harris, & Blum, 1993; Sharaf, Thompson, & Walsh, 2009), which have explored the influence of family and peer support upon high-risk behaviours for youth, including suicidal involvement (i.e., thoughts and actions) using self-report questionnaires, have reported that youth ratings of 'high satisfaction' with the support received from family and friends was correlated with a decreased risk of suicide and participation in high risk behaviours, such as alcohol and other drug abuse.

While, contextual factors of resilience relate to the availability of resources and community support services to facilitate access to social, informational and instrumental supports (ICCWA, 2006; Rickwood, Deane, Wilson, & Ciarrochi, 2005). For instance, Beardslee (1989) noted that for children of parents with an affective disorder, the availability and usage of certain community supports such as mental-health treatment and hospitalisation for parents, and the availability of local employment for themselves, aided these children in the ability to cope and not feel overwhelmed, in response to stressful life demands. While Gorman and colleagues (2007) reported that seeking help from professional mental-health supports, such as counsellors or doctors, although initially personally difficult to access due to concerns of the stigma attached to mental-health problems, was found to be beneficial and empowering for rural men. As they gained access to information about the signs and symptoms of depression and how it may be managed, and the realisation that depression was a common disorder and they were not alone.

Therefore, it appears that resilience is multi-determined, encompassing individual, social, and contextual factors, which enable an individual to effectively cope; adapt and recover; and function above the expected average, despite significant stress or adversity (Tusaie & Dyer, 2004). In addition, as noted by Rutter (1985) individual resilience is not a static property, it is a dynamic process, which essentially lies on a continuum, varying within an individual over time and situational aspects. For instance, in a sample of young adults (Wilburn & Smith, 2005) it has been reported that suicidal ideation is significantly associated with occurrences of acute and chronic situational stressors, such as academic failure or relationship breakdowns. However, only acute stressors that had occurred within 6-months of the study were associated with levels of suicidal ideation that required clinical intervention. A possible explanation to account for the finding that chronic stress was not related to clinical levels of suicidal ideation in Wilburn and

Smith's (2005) study may be offered by the research of Folkman and Moskowitz (2000), and Tugade and Fredrickson (2004). These researchers posit that in the context of chronic stress, the experience of positive emotions such as optimism, interest, excitement and eagerness, even momentarily, facilitates finding positive meaning in adverse circumstances, such as 'a lesson to be learnt' attribution, and assists an individual's capacity to cope, and consequently augments psychological resources like resilience.

Issues with Exploring Resilience Quantitatively

Reflecting upon the three aforementioned conceptualisations and examples of the potential individual, social, and contextual aspects it may involve, it is apparent that resilience is both a broad and contextually heterogeneous construct (Ungar, 2003). Resilience research that has been quantitative in manner relies upon structured questionnaires (e.g., Beasley, Thompson, & Davidson, 2003; Resnick, Harris, & Blum, 1993) and observational techniques (e.g., Rossi, Bisconti, & Bergeman, 2007; Werner, 1989) to infer the underlying factors that make up individual resilience. This research has predominately used aggregated trait-based measures. For instance, in a study of rural adolescents aged between 14 and 19 years, Tusaie-Mumford (2001) presented a model to predict psychosocial resilience, as defined by the 'absence of psychosocial symptoms'- classified as minimal substance abuse and the absence of depressive symptoms, and 'cognitive coping above the 50th percentile of the sample' - as indicated by a higher level of approach, than avoidance coping. In this regression model, the personality-trait of optimism accounted for 19.7% of the overall variance in relation to the defined construct of psychosocial resilience. While the other direct factors, which increased the variance accounted for to 31.2% of psychosocial resilience, in order of relative importance were, perceived social support of family, number of negative life events, and age - specifically younger adolescents were reported to be more psychosocially resilient.

Notably in Tusaie-Mumford's (2001) study, there is a lot of variance still unaccounted for by utilising structured questionnaires and a trait-based measure. Specifically, the age range of the participants in this study potentially make this a heterogeneous sample, as within the developmental context of adolescence, there are many changes and transitions that take place in a short span of time (Arnett, 2007). However the lack of variance accounted for, may also be an artifact of the research design, as 'coping' was ultimately utilised as part of the definition of psychosocial resilience for this study, rather than as a predictor variable. It has been noted in the literature (Beasley, Thompson, & Davidson, 2003; Folkman & Moskowitz, 2000;

Tugade & Fredrickson, 2004), that coping styles such as problem or task/approach coping rather than emotional or avoidance coping, may potentially facilitate an individual's capacity for resilience, and therefore may be somewhat more efficient as a predictor variable in regression models of individual resilience, rather than as a definitional variable.

For instance, in a study of mature-age university students, Beasley and colleagues (2003) measured individual resilience with two specific measures, namely 'cognitive-hardiness' and 'coping style', in response to perceived life stress on several outcome measures of psychological health. Essentially, cognitive-hardiness is a personality variable, which is comprised by the three personality characteristics of, a) 'commitment' to inter-personal relationships versus personal alienation or isolation; b) a 'challenge' orientation to change, rather than the avoidance of threat; and, c) a 'control' belief of own circumstances, rather than feeling powerless or hopeless. In this study, coping-style measures consisted of, a) 'task-coping', such as logical analysis or seeking help; b) 'emotion-coping', for example, becoming emotionally distressed; c) 'avoidance-coping', such as cognitive avoidance; and, d) 'social diversion-coping', such as distraction.

Among the models Beasley and colleagues (2003) presented, a direct-effects model for predicting 'general mental health and psychopathology', which was calculated via scores on measures of 'psychological distress', was presented for both males and females. The male model accounted for 49% of the total variance in general mental health and psychopathology; while for females 44% of the total variance in general mental health and psychopathology, was accounted for. In order of relative importance, the male model consisted of; negative life events, social distraction-coping, and cognitive hardiness. Whereas, the female model included; negative life events, emotional coping, and cognitive hardiness. Specifically, it was reported for these participants', that increases in the number of negative life events, and increases in use of social distraction, or emotion coping, were associated with increases of psychological distress scores. While, higher scores on scales of cognitive hardiness were related to decreases in psychological distress scores. Thus, by utilising cognitive hardiness, which is a constellation of three trait-based measures, and coping-style as a predictor variable in their study, Beasley and colleagues (2003), were able to account for a larger amount of variance in their models for exploring resilience in relation to general mental health and psychopathology. Whilst further illustrating the distinct pattern of coping strategies utilised by males and females within this sample of mature-age university students.

Thus, as illustrated (i.e., Beasley, Thompson, & Davidson, 2003; Tusaie-Mumford, 2001), often the amount of variance accounted for in quantitative resilience research is highly dependant upon a specific researcher's definition of what characteristics in a particular sample denote resilient individuals, as well as the choice of variables and whether they will be utilised as criterion or predictor variables. Further, sample populations that may be diverse, such as adolescents aged between 14-19 years (e.g., Tusaie-Mumford, 2001) or participants with varied ethnic backgrounds (e.g., Palmer, 1997), are less likely to be captured by quantitative measures of predefined resilience constructs, which may not 'capture' inter-individual differences between the contexts of the populations studied, or adequately tap into contextual or cultural aspects of resilience, as evidenced by low correlations (Ungar, 2003; Ungar & Teram, 2005).

Qualitative Studies of Resilience

Fundamentally, qualitative resilience research facilitates a detailed understanding of the individual and contextual factors and processes that may buffer against the negative effects of adverse life situations or circumstances (e.g., Gorman et al., 2007; Hegney et al., 2006). Unlike quantitative enquiry, homogeneity within a certain at-risk population is not assumed (Ungar & Teram, 2005). It is the uniqueness or variability in a sample achieved by way of gathering data rich in description, which assists in the elucidation of lived experience, with themes and concepts that are salient to the participants' life-world (Ungar, 2003).

For example, in a recent study by Hegney and colleagues (2006), undertaken to facilitate development of a psychological wellness 'resilience tool-kit' for rural people; researchers qualitatively investigated the construct of individual resilience among individuals who were seen to be leaders in the community of a rural Queensland town. The town had recently experienced several environmental stressors, such as drought and bushfires. These researchers found that for these participants, 'personal protective and risk factors' were identified in relation to defining individual resilience, whilst also the impact of 'environmental stressors' and their effect(s) relating to 'shaping' individual resilience in a rural environment, were expressed. Therefore, by targeting individuals within a specific population Hegney and colleagues (2006), obtained perceptions of how rural people define individual resilience, and collected detailed descriptions of the individual and environmental factors that challenged this construct, which may not have been identified if a quantitative approach using structured questionnaires had been utilised to average measures across specifically pre-defined constructs.

The importance of both 'cultural' and 'contextual' aspects of resilience, and how these factors may influence and shape individual resilience, has also been demonstrated through recent qualitative research (e.g., Lalonde, 2006; Ungar, Brown, Liebenberg, Cheung, & Levine, 2008). Specifically, the 'cultural aspects of resilience' refer to the accepted norms inclusive of values, beliefs, customs, and social interactions associated with coping. While 'contextual aspects of resilience' refers to the community, inclusive of the structures and opportunities, in which culture is manifested (Ungar et al., 2007). Qualitative inquiry has highlighted how cultural and contextual aspects of resilience can be protective or detrimental in facilitating individual resilience in times of adversity (e.g., Lalonde, 2006; Ungar et al., 2007).

For instance, Abbott-Chapman (2001) reported that Tasmanian rural adolescent school-leavers who participated in a resilience study over a period of 12 months, were buffered against limited education and low unemployment opportunities, by a sense of connectedness and belonging that they shared with their immediate and extended family, by way of economic, social, and emotional support. Interviews undertaken with school-leavers, parents and older siblings, indicated that it was seen as commonplace and acceptable within their rural communities, to offer extended emotional and instrumental assistance in times of limited opportunities. Whereas, in a qualitative study identifying and comparing health priorities between Australian urban and rural adolescents living in New South Wales (NSW) (Quine et al., 2003), focus groups of rural adolescents voiced serious concerns that limited opportunities in employment and education, coupled with limited recreational opportunities, were linked to depression, which may lead to suicide within their peer group. In this study, Quine and colleagues (2003) also noted that rural adolescent males expressed a greater difficulty in communicating to peers or health professionals, at times of emotional distress, or thoughts of suicide. The researchers concluded that this may be related to the 'tough, macho-male' social role in rural Australia.

Contrasting these two studies of Australian rural adolescents, it is apparent that in the first study (Abbott-Chapman, 2001) the cultural and contextual aspects of resilience were protective and potentially facilitative of the individual resilience of the Tasmanian rural adolescents. For these rural youth, instrumental, social and emotional needs were obtained in culturally accepted ways within their communities. While, in the second study of NSW rural adolescents (Quine et al., 2003), it appears their contextual aspects of resilience did not foster individual resilience, as evidenced through their expressed

cognitive-association of limited opportunities, depression and suicide. Further, it seems that cultural aspects of resilience, with implicit male social roles encouraging self-reliance and not seeking help, were detrimental to these rural NSW adolescent males' individual resilience, at times of suicidal thoughts or emotional distress (Niner et al., 2009; Patterson & Pegg, 1999). Therefore, to understand what constitutes successful coping for young adults, it is also important to consider both the cultural and contextual aspects of resilience, and how these aspects may influence young adults' perceptions and experiences of individual resilience (Ungar, Brown, Liebenberg, Cheung, & Levine, 2008).

Towards Community-based Strategies of Resilience

In the late 1990's, several researchers (e.g., Kumpfer, 1999; Palmer, 1997; Polk, 1997) proposed tentative resilience models, in response to a shift in public health (and funding) priorities from focusing on risk-factors, to encouraging a broader promotion of health and illness prevention, for individuals within society (Kumpfer, 1999). These models were based on quantitative and qualitative resilience literature, and posited that individual resilience is characterised as a dynamic transactional process, which mediates via factors that take place between an individual, their proximal environment and/or outcome. While recently, through extensive resilience research in both westernised and non-westernised youth, Ungar and colleagues (2008; and Ungar et al., 2007) have furthered this view of resilience, as theorising that an individual's capacity for resilience is an ongoing process associated with experiences that enhance mental-health and sustain well-being. Within their proposed framework for individual resilience, the importance of both the capacity of the individual to 'navigate' towards the "resources that sustain well-being" (Ungar, Brown, Liebenberg, Cheung, & Levine, 2008, p. 2), as well as the capacity of an individual's ecology (comprised of relational, contextual, community, and cultural aspects) to 'provide' the resources that facilitate well-being (Ungar et al., 2008), are emphasised. Thus to create and promote effective broader community-based resilience interventions for youth, it is imperative to identify and consider both the individual aspects of resilience and the influences of an individual's ecology, and the potential interplay between them.

For instance, Smith and colleagues (2007) noted that there appears to be an increasing dominant representation of young people in western society as being seen and regarded as 'problematic'. These researchers posit that the frequent popular media portrayal of young people primarily implicated in reports of anti-social behaviour

perpetuates a public discourse that encourages a fear and distrust of youth. Potentially this broader aspect of a young adult's ecology may have a deleterious influence on the availability and perceived accessibility of needed social supports when facing adversity (Prilleltensky & Prilleltensky, 2005), negatively impacting upon individual resilience.

Notably, within the resilience literature, several researchers (Friesen & Brennan, 2005; Prilleltensky & Prilleltensky, 2005; Ungar & Teram, 2005) have advanced the standpoint that when young adults within a community are viewed 'as resources rather than problems', this will facilitate the development and promotion of resilience for youth across several contexts, by fostering inclusion and a sense of connectedness and belonging within both family and the larger community. Further, as noted by Bandura (2004) societal programs that prioritise the health and well-being of youth, such as community interventions to decrease suicide, need to be incorporated across several different levels, such as home, educational and community levels, to aid young adults in building a self-resilience personal history. This may be achieved through opportunities to build personal mastery of challenging situations and the reinforcement of self-efficacy, encouraging perceptions and appraisals of self-competency to cope in times of future adversity (Bandura, 1977). For instance, the avoidance of stressful or challenging activities impedes the development of individual resilience (Rutter, 1985), however through exposure and successful coping in relation to manageable forms of stress within different contexts, the development of a resilience self history is facilitated. This process has been referred to as 'stress inoculation'', where it has been proposed that exposure to milder or more manageable stress at an early age, enhances resilience towards adversity at later stages throughout life (Haglund, Nestadt, Cooper, Southwick, & Charney, 2007).

Promoting Resilience for Young Adults in the Context of Suicide

Within the current literature, it seems that to date, previous research that has investigated the factors needed to promote the protective construct of resilience to the problem of suicide have attempted to incorporate community-based studies and programs (e.g., CDHAC, 2005; ICCWA, 2006). In these programs, strategies such as fostering "a sense of connectedness, belonging and empathy" (CDHAC, 2005, p. 69), through the encouragement and education of the benefits of positive interactions to develop pro-social supports with family, friends and community members is promoted. Providing public information to increase the knowledge and awareness of the signs and symptoms associated with depression, that aim at promoting positive help-seeking behaviours and decreasing the stigma that ignorance and misinformation foster

(Livingworks, 2004). While promotion of community knowledge of available crisis support services, and the recommendation of 'gatekeeper' training (Livingworks, 2004), which provides suicide specific prevention and intervention skills for community individuals such as doctors, who may be in a position to observe high-risk behaviours and provide prompt intervention when necessary (CDHAC, 2005; ICCWA, 2006), have been identified and promoted at a community level.

'Community resilience' is therefore an extremely important tool in the campaign to decrease suicide. However, there is a need to identify the 'transfer or mediating factors' that promote individual resilience 'within' a person, in relation to broad community interventions (Niner et al., 2009). As ultimately it is an individual's own thoughts, feelings, and behaviours that may lead to the recognition and acceptance of suicide as an option (Livingworks, 2004).

Notably, in reviewing previously published resilience research, it appears that prior studies undertaken to identify the protective factors that 'make-up' individual resilience have primarily focused upon populations who were physically and/or psychologically vulnerable, facing significant adversity through disadvantaged circumstances (e.g., Abbott-Chapman, 2001; Beardslee, 1989; Gilgun, 1996; Palmer, 1997), or extreme situations of personal or environmental risk (e.g., Hegney et al., 2006; Rossi, Bisconti, & Bergeman, 2007; Shakoor & Fister, 2000). However, as noted by Ahern and colleagues (2008) little is known about the construct of resilience in individuals who may be considered to be mentally and/or physically healthy. Thus to aid in the exploration and identification of the mediating factors that promote resilience within the context of suicide for young adults, it is important to understand how 'healthy' young adults who are demonstrating resilience day-to-day, define this protective factor.

In summary, this review has highlighted the necessity to adopt a primary intervention approach to suicide in regard to the preventative efforts targeted at young adults. However, it shows the need for incorporating a community-wide strategy to promote well-being and resilience (CDHAC, 2005). Young adulthood is a relatively healthy period, though previous research has highlighted that young adults appear to be highly sensitive to perceptions of stress throughout their daily lives (Stawski, Sliwinski, Almeida, & Smyth, 2008), and are at risk from both individual and contextual circumstances (CDHAC, 2005). Specifically, for rural youth there appears to be an increased risk of suicide. Facing rural young adults are both the individual suicide risk-factors associated with their peer-group and their unique contextual circumstances, such

as limited availability and accessibility of mental-health services (Cantor & Neulinger, 2000), limited opportunities in employment (Quine et al., 2003), and the limited availability of affordable non-alcoholic recreational activities to promote social interaction (ICCWA, 2006; Quine et al., 2003). Coupled with the disturbing finding from recent research that young adults socially withdraw and do not seek help or assistance from formal or informal supports at times of extreme emotional distress or thoughts of suicide (Rickwood, Deane, Wilson, & Ciarrochi, 2005), underscores the importance of promoting and building the protective factor of resilience. The construct of resilience is a multi-determined dynamic process, encompassing psychological, social, contextual and cultural factors, which enables an individual to cope effectively with adverse life circumstances, albeit sometimes better than others, as individual resilience fluctuates over time and across situations (Rutter, 1985; Ungar, 2008).

There is a paucity of suicide research literature specifically related to what makes youth resilient to suicide identified by the review. In particular a lack of any rich, detailed, and expressive descriptions of how youth think community-based efforts can support the building of 'individual resilience' and how these efforts transfer to the problem of suicide in young adults. The current project hopes to fill this gap utilising an exploratory qualitative approach; and it is anticipated that this research may potentially provide a background for further research of the links or mediating factors, which may facilitate the promotion of individual resilience via the implementation of community-based broad interventions related to suicide.

The questions this research will address are:

1) How do young adults' define resilience with regard to the problem of suicide?

2) What are the community-based strategies that are needed to promote resilience for young adults?

Methodology

Research Design

This interpretative study adopted a collective case-study design (Stake, 1994), which incorporated a phenomenological perspective (Becker, 1992) to facilitate exploration of the perceptions, and subjective views of the informants' experiences of resilience. In particular, how the informants' defined resilience with regard to the problem of suicide, and their perceptions of the strategies needed to promote resilience among the peer-group of young adults was investigated. The rationale for the case-study approach was to

facilitate exploration in the case of resilience in one bounded rural/regional environment, as youth suicide rates have been noted to be higher for both males and females within this context (ICCWA, 2006). Phenomenology posits that knowledge of ourselves – others, and the world in general, is based upon our own subjective or 'lived' experience (Becker, 1992; Creswell, 2003). While the case-study approach is also based upon a constructivist paradigm, which claims truth or knowledge is dependent upon our own perspectives (Baxter & Jack, 2008).

Specifically, a collective case-study design was employed in the present study to enable an in-depth investigation of the protective factor of individual resilience related to the problem of suicide, by utilising data collection from multiple sources of information (Creswell & Maietta, 2002). Accordingly, as suggested by Burgess-Limerick and Burgess-Limerick (1998), interview data were obtained from different informants, to aid in drawing upon multiple perspectives to clarify meaning(s) and verify the repeatability of interpretations (McDonnell, Jones, & Read, 2000; Stake, 1994). Further, through the utilisation of an interpretative phenomenological interview and analytic based methodology, which underscores the importance of peoples' lived experiences as valuable sources of knowledge (Becker, 1992), the present study generated 'rich data' to encapsulate informants' subjective, lived experiences of resilience, and how in their life world this protective factor is related to suicide (Wojnar & Swanson, 2007). From a philosophical viewpoint, combining case-study and phenomenological approaches to explore 'the phenomenon of resilience related to suicide', greatly facilitated the generation of relevant data, based upon informants' lived experiences of resilience, and their subsequent related perceptions of suicide within a rural/regional context.

Informants

This study included ten informants located from rural/regional areas in the South West of WA. Seven informants who were aged between 18 and 24 years, and 3 informants over the age of 24, were included in the study. To aid in the identification and exploration of resilience factors for young adults' within the context of suicide and to minimise the possibility of psychological distress, a criterion of the study was that recruited informants had not been diagnosed presently or in the past with a 'mental health disorder'. This exclusion criteria was screened by the researcher with all informants, prior to organising an interview time.

Informants were primarily recruited through 'volunteer sampling' (Liamputtong & Ezzy, 2005). Tear-off flyers (Appendix A) and information sheets (Appendix B) which

outlined the study and provided contact details, were distributed on noticeboards at community libraries, public sport/gym areas, and the university library within the Bunbury/Busselton area. In addition, the researcher also contacted a youth group coordinator for regional South West WA, who forwarded tear-off flyers and information sheets to leaders of community youth groups. Responses for involvement in the study of the initial targeted age-range of 18-24 years, was poor. A total of seven participants, namely 4 females and 3 males had volunteered at this stage. However through the process of recruitment, several individuals who work with young adults in rural/regional WA, expressed their interest in participating in the study. This is a form of 'opportunistic sampling', which as posited by Liamputtong and Ezzy (2005) is the recruitment of participants in the process of fieldwork, by way of 'unexpected opportunities'. As these individuals were over 24 years of age, an ethics amendment was sought and granted from Edith Cowan University's (ECU) ethics committee. Subsequently, three female informants aged over 24 years (two aged 28 years, and 1 aged 35 years) who work with young adults, were also included in the present study.

In relation to the difficulties of the initial recruitment of 18 to 24 year olds in the present study a tentative explanation is offered, which confirms that of another study undertaken by Gorman and colleagues (2007) in rural Queensland. This explanation relates to the stigma of suicide and/or concerns about confidentiality, specifically for individuals within rural/regional areas, where it has been previously reported in studies there is a concern of 'high visibility' in regard to privacy (e.g., Niner et al., 2009; Rickwood, Deane, Wilson, & Ciarrochi, 2005). In the present study, to facilitate the attraction of potential volunteers, advertising flyers were placed in high traffic community areas. However, due to the sensitive nature of the present enquiry it is possible that this may have thwarted recruitment, as potentially interested individuals may have experienced feelings of perceived uncomfortableness and/or embarrassment, when initially noticing the information flyers regarding the study.

Of the sample of 18-24year old informants, 43% were unemployed at the time of interview, 43% were enrolled in tertiary education, 29% were engaged in full-time employment, and 29% were employed part-time. In addition, 57% were living independently in their own home, 29% resided in the parental home of their partner, and 14% were living with their own parents.

Interview Schedule and Materials

Individual semi-structured interviews were conducted solely by the researcher to facilitate elicitation of data that was based on the perspectives of salience to the informants' regarding resilience and suicide (Barbour, 2009). The utilisation of open-ended questions enabled the informants' to elaborate, and openly discuss their lived experiences and subjective views (Becker, 1992). For example, "What sort of things do you think are needed in your community to help build resilience for young adults?" Or, "How would you define resilience with regard to the problem of suicide within your community for young adults'?" To facilitate the elaboration of relevant data in relation to the peer-group of young adults, minimal variations in the actual wording of questions were made between the interview schedule for young adults (see Appendix C), and the interview schedule for the 'older adults' aged over 24 years (see Appendix D).

Each informant was provided with an information letter outlining the details and procedure of the study (Appendix E), and an informed consent form, which was signed and returned to the researcher (Appendix F). A support services listing outlining available counselling services, was provided to all informants at the completion of the interview (Appendix G). A tape recorder and tapes were used to record interviews, and the researcher utilised a journal for recording self-reflective thoughts and observations throughout the interviews, and the duration of the study, which also included detailing decisions made regarding aspects of data analysis (Depoy & Gitlin, 1998).

Procedure

Following approval from the ECU ethics committee to conduct the research, the researcher advertised the study as aforementioned. Interested individuals contacted the researcher via telephone or email, and a mutually convenient time and place to undertake the interview, was negotiated with each informant. Prior to being interviewed, all informants read the information letter outlining the present study and their rights, and signed an informed consent form. To facilitate the development of rapport with the informants, demographic information was sought in the form of a brief discussion, and informants were advised that to ensure their confidentiality, this information would only be used as broad descriptors of the participant breakdown within the study.

Predominantly the interviews were undertaken in a quiet room within each informant's home, while two interviews took place in a private study room in ECU Bunbury's library. Each individual interview took approximately 45-60 minutes to complete. A tape-recorder was used to record the interviews, to enable later verbatim

transcription, which was devoid of all names and identifying information to ensure privacy. At the conclusion of the interview, the researcher debriefed each of the informants by allowing time to answer queries or discuss any concerns they may have had, whilst also supplying a support services listing to each informant. In addition, at the conclusion of each interview, the researcher made brief notes into a journal with regard to any issues or concerns that may have developed within the interview process, these included making notes of responses that generated interesting and relevant information (Liamputtong & Ezzy, 2005).

Data Analysis

Following the completion of the interview process, the researcher transcribed the audiotapes verbatim, to ensure accuracy of the informants' responses. The transcripts of the interviews were then read through several times allowing the researcher to become immersed in the data, thus increasing her familiarity with the raw data (Liamputtong & Ezzy, 2005). Essentially, an interpretive phenomenological approach emphasises the understanding of the phenomenon within context (Wojnar & Swanson, 2007). To achieve this, salient themes and meanings, which reflected each informant's experience, were sought within the data to facilitate describing the phenomenon from the study informants' perspective (Becker, 1992). Using the informants' language as much as possible, recurrent themes and significant concepts were recorded, and significant statements noted. This was completed for each informant and adapted into a descriptive summary or portrayal of the phenomenon. These descriptive informant summaries were then utilised to identify common themes and issues via cross-case analysis, using all descriptive informant summaries, thus arriving at an analysis of the complete data which portrays the unique themes reflecting informants' experiences and perspectives of individual resilience related to the problem of suicide within a rural/regional setting (Becker, 1992). The realisation that saturation had been achieved in both sampling and developing coding categories was apparent when data from the interviews was repeating, and no additional insights or fresh understandings emerged from the informants (Depoy & Gitlin, 1998; Liamputtong & Ezzy, 2005).

Authentication of the data were achieved in three ways, using triangulation, peer review, and the presentation of discrepant information (Creswell, 2003). Firstly, to facilitate a complex portrayal of the phenomenon, methods triangulation was utilised (Liamputtong & Ezzy, 2005; Wojnar & Swanson, 2007). This involved the researcher carrying-out an extensive review and analysis of the literature, conducting semi-

structured in-depth interviews, and during each of these interviews undertaking discreet observation of informants to facilitate rapport and ensure content of the data that was relevant to the phenomenon under study (Liamputtong & Ezzy, 2005; Wojnar & Swanson, 2007). Secondly, to further corroborate the findings within the context of the relevant literature, a peer reviewed and checked the identified themes and sub-themes (Barbour, 2009). While thirdly, discrepant information, such as the identification of any differences or contrasts between the younger and older adults' perspectives related to the themes or sub-themes was presented (Creswell, 2003; Wojnar & Swanson, 2007).

In addition, as the present study is exploratory in nature, and to enable inferences to be made from the interviews, the researcher reviewed the related literature a second time once the themes had emerged from the data, to facilitate building a valid argument for their selection.

Findings and Interpretations

Five themes emerged from the data; these were support, awareness of internal processes, stepping stones, acceptance, and suicide education. Table 1 illustrates the five major themes and related sub-themes identified from the analysis of the informants' responses, and although these are presented independently below, in reality they often overlapped and interconnected.

Table 1.

Promoting Resilience Towards Suicide for Young Adults Themes and Sub-themes

Main Themes	Sub-themes
Support	Informal support
	Formal support
	Resource awareness and accessibility
Awareness of Internal Processes	
Stepping Stones	Perseverance
Acceptance	Support of older members of the community
Suicide Education	Survivor talks and interviews

Support

Experiences and perceptions of support were contained within three sub-themes, which reflected the informants' perceptions that awareness, availability, and accessibility of both formal and informal supports were instrumental to coping in times of emotional adversity, and for promoting social well-being. It emerged from the data that both formal and informal supports were viewed as strategies to facilitate access to informational, instrumental, social, and emotional sources of support, that could facilitate the strengthening of young adults' coping capacity throughout times of adversity. This finding supports the work of Gorman and colleagues (2007), who also found that support from family and friends and seeking help from professionals was beneficial to personal coping and perceptions of resilience in times of perceived extreme emotional difficulty.

Informal support

In particular, informants' placed great emphasis upon the support received from their family and friends. Aspects of trust, familiarity and being cared for were highly valued in these relationships: *"when you're upset you want someone who is there for you, someone you can trust"*. Interestingly, for the majority of the young adults' a preference was noted towards parents over friends within times of personal-emotional distress. Several of the young adults' suggested that it was parents that could be best relied upon to be available and appropriately responsive, in times of personal adversity. For instance:

> *"Support from parents is a really big issue, probably not so much support from your friends unless they're really close, cos' of all the peer- pressure. Like there's always peer pressure to do things from your friends no matter what, it becomes like a bit of an issue if you can't please them. So friends aren't always there, but family is. Should always be able to talk to your family to help you, whether or not they can help you themselves, they can help you find help. Even though like your parents, they'll probably be upset if it's something bad, or disappointed. But they're not going to sit there and judge you, they help you move along and get through it, and then tell you something afterwards, like 'what you do that for?'"*.

For the young adults' it was the immediacy and extent of the support that parents may provide, which was found to be beneficial and lead to perceptions of feeling supported:

"...just the knowledge that my parents were there, I had good communication with them as well, so I guess they guided me a lot. Because it's a small community, so you know everyone was aware when something happens. So they sit you down and talk to you about it as well, and see how you feel about it. So although I wasn't exactly very close to those that like committed suicide, it still affects you because it's a small community. But yeh just talking with my parents...".

" ...money and family support would be one of the key factors, like giving parents the option-possibility, ah giving them the option of what they can do regards to offering their support, whether it be financially, ah be emotionally".

Surprisingly though, this is the only sub-theme where the older adults' perceptions and experiences differed to those of the younger adults' in this study. The older adults' posited that at times of personal challenges or distress, young adults would more likely turn to their friends than parents for support if needed, for example:

"...resilience from everything, I think absolutely peer groups play a huge part, as we do rely on our peer groups more than our parents as a young person".

However, the finding that these rural young adults' prefer to turn to their parents in times of distress and adversity concurs with the findings of Abbott-Chapman (2001), who identified that young rural people turn to their families who provide a buffer during adverse times, providing both instrumental and emotional supports.

Also, in relation to friend support, the young adults' valued older established friendships with a shared personal history over newer friendships. From the data it emerged that friends offered reciprocal opportunities for social connectedness and emotional support (ICCWA, 2006), which was integral to daily life and perceptions of well-being. For example:

" I'd just talk to my friends especially the ones that had been there for a while... that way they can help you through it because they look at your past, you don't have to explain it to them. They will push you up sort of thing and when you have your good days and you talk to them about your good days, when you're having a bad day and you call them or contact them, they can go 'well remember your good day you did this and felt good', and that's when you pick yourself up again...".

The importance of the 'quality' of informal social networks that people develop has been noted within the literature as a protective factor contributing to individual resilience (ICCWA, 2006; Steinhardt & Dolbier, 2008). Notably, the findings from the present study further accentuate this, underscoring the benefits and value of established quality informal supports for young adults within a rural/regional context. Specifically, it appears that positive, caring relationships with friends and family offer opportunities for both social connectedness, and assistive coping supports during stressful times, ultimately decreasing the prospect of a young adult feeling isolated from resources. This is a key finding associated with social withdrawal and the help negation effect (Livingworks, 2004; Rickwood, Deane, Wilson, & Ciarrochi, 2005). For instance, not having a support network made up of family and friends was seen as a negative factor, and as one young adult suggested it may lead to personal vulnerability and thoughts of suicide:

> *"...if you have no friends or no family, you wouldn't want to do anything to help yourself...cos' if you live with that loneliness everyday, and you go home to nothing, then those* [suicide] *thoughts probably would crop up".*

Within the study, to aid in the establishment of quality supports, the availability of opportunities to decrease isolation and increase connectedness and a sense of belonging with other people within the local community, such as social, sporting and support groups was expressed. For several informants' this was related to individual feelings of self-esteem and well-being, *"something that'll boost them up"*. A common finding was a call to make recreational activities in the rural/regional setting more affordable for youth to access, and promote social activities that do not cost money:

> *"One of my friends when she had a job, she was heaps a happier person, now she works 2-hours a week and she's starting to feel crap about herself. She hasn't got much money and can't go out with friends and stuff, and friends are important, so she's starting to feel down. Doing stuff that doesn't cost money, people these days are just not interested in that. Like I'll ask so many people, do you want to go to the beach? And they're like 'uhh beach', like it's really boring".*

The high cost of social contact for youth in Australian rural areas has been previously highlighted in the literature (Patterson & Pegg, 1999). In a study conducted by Quine and colleagues (2003), it was similarly found that limited

affordable recreational prospects for rural NSW youth were detrimental for their emotional health and wellbeing.

Formal support

All informants' acknowledged several different types of professional supports as important strategies for promoting individual resilience; in order of preference - these included, face-to-face counselling, support groups, and telephone help-lines. For the young adults' it appeared that the need to talk and connect with professionals within the same physical context was paramount to assuage feelings of isolation, while promoting feelings of social connectedness, as highlighted in the following examples:

> *"I'm seeing a psychologist...I don't know with all this help-line stuff, I, people don't really want to talk to a... random stranger".*

> *"Seeing a counsellor, cos' they can put you into groups, to help you have an understanding that there are people out there that have a feeling of the same thing. That way if you go into a group you can clearly see you're not alone".*

Notably, previous research conducted by Ungar and colleagues (2007), has identified that the capacity of an individual's ecology to 'provide' the resources and opportunities that assist well-being, is an essential component facilitating individual resilience and associated coping efforts. However in the present study, a problem for some of the young adults' was expressed as a lack of accessible face-to-face professional supports within their local rural communities:

> *"I think that people actually need that personal contact...in rural areas, the counselling you need...I don't think it's readily available in country towns".*

The older adults' supported this view, suggesting there should be more available services within their local rural communities that may facilitate a comfortable and safe milieu to promote connecting socially and emotionally for young adults. For example:

> *"In the South-west I think it tends to be services, like what's available for young people to talk, um like drop-in centres or group supports would be good".*

In the literature it has been proposed that professional help seeking is a highly adaptive and protective behaviour, which may reduce risk factors related to suicide (ICCWA, 2006; Rickwood, Deane, Wilson, & Ciarrochi, 2005). For those young adults' who had experiences of professional support in the study, it was viewed as both beneficial and integral to reducing their distress throughout extremely emotionally challenging times. Though as Gorman and colleagues (2007) found for rural men, the initial step of making contact with a professional support is the most difficult aspect. This was also a perception confirmed by some of the informants':

> "[I] *just wanted to curl up in to a ball and disappear. I did go to counselling, at first I was very against it - couldn't get me to counselling, mum use to have to drag me there, but in the end it was the best thing I pretty much ever did. They help you think differently, and put that jigsaw puzzle back together that's been broken sort of thing".*

> "*It just needs to be known they're not going to judge you when you go to counselling... and it needs to be said it's 'OK' to talk to someone. It is very scary, 'cos you do think, oh my god, talk to someone! They're gunna lock me up or they'll put me in a straight jacket".*

Interestingly, in contrast to Gorman and colleagues (2007), who reported that rural men who faced the initial contact with formal supports alone and via their own self-motivation; in the present study over 70% of the young adults' acknowledged that the initial step to approaching professional supports for their own emotional problems would need to be bridged by the accompaniment of a trusted friend or family member. For instance:

> "*...maybe they* [friends/family] *told them like look 'there's this organisation available maybe I could come with you, if you don't feel comfortable going by yourself?' Maybe, that would initiate a better response, a taking up of things".*

Again, this emphasises the importance of both the quality of supports and established networks as an essential requirement to aid facilitating individual resilience for these rural young adults. Powerfully, it was also expressed by the male informants' that to enable them to take up professional help, they would need someone to approach them first who recognises that they need assistance. This was associated with perceptions of 'an un-comfortableness'

that surrounds seeking professional help, and the 'uncertainty' of what to expect. For instance:

> *"I wouldn't go find help myself, just because I find it uncomfortable, I wouldn't know what, you know, it's sorta like...The most effective way to get that help to those people who need it, would be sorta, with peer-support sorta thing, so watching, watching, and you notice someone needs a hand... I think it needs to be the external source breaching that gap and making the first, taking the first step in contact".*

Notably, this finding is supported by both the research undertaken by Quine and colleagues (2003), and the research conducted by Rickwood and colleagues (2005). Firstly, Quine and colleagues (2003) similarly reported that rural males expressed a greater difficulty compared to females in relation to outwardly communicating to others at times of extreme emotional distress, concluding that this was related to the stereotype of the 'tough, macho-male' social role in rural Australia. While secondly, research conducted by Rickwood and colleagues (2005) found that males who actually do seek professional psychological help, were initially strongly influenced by established and trusted relationships, such as intimate partners, parents or other family members, and friends.

Resource awareness and accessibility

Generally, to aid promoting individual resilience through pro-active help-seeking behaviour, an increased awareness of what formal resources are presently available and how to access them was expressed by the majority of informants'. For instance, perspectives from young adults':

> *"I myself have talked to a lot of other young people um they don't actually know that there's support out there. There's not really that much, I guess promotion or general awareness of organisations or agencies that can help you".*

> *"Unless you know what you're looking for, and you know how to look for it, no one would have a clue. I could ask all my friends and they wouldn't have any idea. You get it in schools and everything, but at that stage you don't think it will ever happen to you...but at the end of the day, these issues happen later on in life...".*

Prior research (e.g., Rickwood, Deane, Wilson, & Ciarrochi, 2005) has highlighted that the stigma of professional help-seeking for emotional problems associated with perceptions of high visibility and limited

confidentiality within rural/regional areas is a barrier to the appropriate mental-health seeking behaviours of Australian youth. In the present study several of the informants' qualified this, suggesting that to aid accessing formal supports for young adults both advertising and the actual physical locality of professional resources require aspects of privacy and confidentiality to be met. For instance:

> "In rural areas we have mental health guys, a mental health building – who's going to walk in? Needs to be broadcasted in a way that someone who is looking from the outside couldn't say he's looking at this because of this and this. So example everyone watches TV, I'm not watching it for this, it just happened to be on as an ad, but if it was a pin-up board or a big mental health sign everyone knows, and you know, it needs to be that anonymous from the outside, whether they talk to the person on the inside about it, everyone else needs to be thinking there's nothing actually there".

In addition, concerns of the associated costs involved with accessing professional supports, was also expressed by the informants' as a potential barrier to formal help-seeking. Notably, for several young adults' this was also associated with potential issues of confidentiality, which may contribute to friction with informal supports:

> "People my age, the idea of counselling is expensive and they either don't have much money, or if they're still living with their parents like quite a lot of my friends are, some might not want them to know, well their parents would be paying for it".

Awareness of Internal Processes

A common theme that emerged from the data for all informants' was the ability to recognise internal processes especially regarding suicidal thoughts, and the identification and acknowledgement of the personal need for help, and willingness to seek out and/or accept assistance offered, as suggested in the following examples:

> "It depends on the person, I mean do they think they're thinking those [suicidal] thoughts? Like it could be very small, a fleeting thought that could get them there".

> "There's just not that much help out there for guys, like that's acknowledgeable and men have a different interior. Women seem to come across as stronger and tougher, and the men just can't, are too scared to get help. It hurts their pride".

As previously reported, the male informants' expressed a greater difficulty to seek-out help for personal-emotional problems than the female informants. However, the importance of individual emotional competence (Rickwood, Deane, Wilson, & Ciarrochi, 2005) via the self-ability to personally identify, effectively express and communicate emotions to others was emphasised by all informants' in the study. Importantly, this was an integral factor of personal resilience within the context of suicide in this setting, which for these informants' appeared to be a personal strength and ability, that may decrease the possibility of the 'help-negation effect' (Carlton & Deane, 2000). For instance, the following perceptions from young adult males':

> *"I think the best way to get through this* [suicidal thoughts] *is counselling, whether it's with a counsellor or with a mate, just chatting through. Cos' by chatting through, working it through in your head, and I think you can talk as much as you like, but until it's gone through your head and you've worked it out and you've processed it, it's still in the background. So it's really important to be able to communicate how you're feeling".*

> *"For any guy who's gone through troubles, um seeking help, it's more a matter of whether they realise they need help or they've been affected by their own pride. You know, they don't want to be seen as weak, so um, emotionally and socially you'd have to have someone you can actually talk to, help you out... to see different options than suicide".*

Specifically, these findings posit the importance of the process of self-awareness and the emotional capability to recognise and share emotionally distressing thoughts related to suicide in a comfortable and supportive atmosphere, to aid unburdening the self and decreasing emotional distress to levels where clearer thinking is possible. Importantly, for some of the young adults it was the actual process of '*chatting through*' that aided cognitively processing suicidal thoughts, potentially combating cognitive rigidity from predominating, which has been associated with suicide attempts in youth (e.g., Lalonde, 2006). For instance:

> *"I've had a couple of thoughts like that, it's like a black hole when you're going through it, and for that instant it's all about me, and I didn't care about anyone else. But, you want to try and get rid of it, work past it* [narrowed thinking and distress], *like I just needed to tell someone what I'm thinking...um so I could just 'talk them out'* [suicidal thoughts] *with someone who wasn't judgmental and would*

sit there and listen and just be calm. Sorta like a sounding board, not advice".

Stepping Stones

For the young adults' in this study personal resilience was seen as a continuous self-learning process (Ungar et al., 2007), that required ongoing self-directed efforts to persevere in the face of challenging or distressing times. The importance of experiencing challenging situations themselves and learning from them was expressed in terms of building *"stepping stones"* likened to a shortcut, to assist in handling future adversity. For example:

> *"Work out what the problem is, and you've gone through all the issues, trying to see it from every different angle... you have those procedures that you followed before – a point of reference, it's more comfortable. You have something to look back on, a stepping stone. Setting up like a method. I think you need to come across those yourself, so you can say this works, this works, and this works".*

Several young adults' also described that resilience could be strengthened by an individual facing their fears or anxieties through a process of incremental steps in a supportive atmosphere:

> *"Any experience would make you stronger, so you know if they were scared of doing something, like say they're afraid of um bungee jumping, they should try it with a friend or someone they trust, just to see how it is, and if it's too much they can back out, but once they do it, they probably realise it's not such a big deal. Um that's pretty radical, but you know if they're scared of doing something, they should just try it and see".*

The older adults' echoed the need for young adults to learn from personal experience:

> *"Hey they're young adults, and that's what that means, if they don't try things and make their own mistakes sometimes, they're not going to learn from it".*

These findings of personal experience and a non-avoidance orientation of challenging situations, support the works of both Bandura (1977) and Rutter (1985); which posit that through exposure and successful coping of difficult or challenging situations, an individual's self efficacy is reinforced, which enhances perceptions and appraisals of self-competency to cope in times of future challenges or adversity.

Perseverance

A consistent perspective among the informants' was the importance of self-agency and perseverance within challenging situations, as an older adult expressed *"...there are no quick fixes, problems and issues require perseverance to pull through"*. This entailed an individual's own ability to identify available options, choose an option, and integrate it into coping via a sustained effort:

> *"...need to see different options, then the option that's just closest to you, like not to drink and not to do drugs if you're pissed off or your craps pretty bad. Cos' with a young person the closest option when you're upset, depressed, anything like that is, you know alcohol, drugs or violence. They're like the easier things to do, but to actually be the bigger man and just actually deal with it [issue] and move on with your life is one of the harder things to do. Um because I get angry very, very easily [and] I don't want to hold on to that... I'm seeing a psychologist to help me now"*.

This finding concurs with other resilience studies (e.g., Beardslee, 1989; Gorman et al., 2007; Ungar et al., 2007) that have also identified that an individual's experiences of being able to exert power and control to obtain and sustain health benefits, is integral to psychological health and well-being throughout times of personal challenges or adversity.

Within this study, several factors emerged from the data that the young adults' utilised to aid in maintaining perseverance when experiencing challenging or stressful situations. These included a future orientation and a belief that things will improve that aided focusing and sustaining coping efforts, supporting the finding of Gorman and colleagues (2007), who found that 'hope related to the future' was a personal strength:

> *"...I've suffered from you know, feeling crappy through high school. But I focused on the future and like, this is just high-school and it's not a forever sort of thing"*.

Other factors were related to momentary experiences of positive affect such as humour, or researching things that were seen as interesting, these facilitated some informants' to see beyond the setbacks or frustrations they experienced within their daily realities and persevere with a sense of purpose or meaning:

> *"Like right now I feel crap, cos' I don't have a job, I just keep looking for jobs, and um sometimes when I'm down, I like think about full vile,*

and then I'll be like 'oh I'm over this!' And then I'll just start
researching things on frogs, it's an obsession, and then when I'm
talking about a frog, I get so excited and happy because of something
new and I feel better about myself, and um I kinda realise, like I
know... I'm trying to do something with my life by looking [for
work]...".

These findings of transitory experiences of positive feelings facilitating an

individual's personal determination to persevere are supported by the work of

Tugade and Fredrickson (2004). They also identified that individual resilience

may be augmented in perceived stressful situations, through personal

experiences of positive emotions such as excitement and interest, and

positive-meaning finding, which aids in strengthening an individual's coping

ability.

Acceptance

A key component of community-based approaches to promote the

protective construct of resilience to the problem of suicide is the fostering of

"a sense of connectedness, belonging and empathy" (CDHAC, 2005, p. 69)

among members within a community. However, as noted by Smith and

colleagues (2007) there is an increasing dominant representation of youth in

western society as 'problematic', with frequent negative popular-media

portrayals of young people implicated in primarily anti-social behaviours,

perpetuating a public discourse of youth to be feared and distrusted. As one

young adult expressed:

> *"I think for young adults, there's kind of a stigma, we're kinda seen as*
> *hooligans, like the cause of a lota problems in society, graffiti and*
> *violence. I think it's across the board, not just* [regional town name]
> *or rural. I think that older generations tend to just look at the*
> *problems that they see, that a small minority group of youth maybe*
> *causing some problems and kinda label everyone as the same".*

This negative portrayal of youth may deleteriously influence the social and

emotional interactions between the older and younger generations that exist

within communities. Potentially, it can develop into a source of psychosocial

stress (Judd, Cooper, Fraser, & Davis, 2006) for young adults that negatively

impacts upon their perceptions of both the availability and accessibility of

potential local social-supports (Prilleltensky & Prilleltensky, 2005), and

feelings of community belonging. Notably, in the present study a common

theme that emerged from the data was related to the need for more respect and understanding directed towards young adults. As an older adult suggested:

> *"There is a need to address inter-generational issues, especially in rural areas, there is like a lack of understanding with the young person and where they're coming from, and a very quick labelling of you're bad, or you're this or you're that".*

Rather than feelings of belonging and support, several young adults' verbalised perceptions of a general unwarranted exclusion and discrimination within their communities. As expressed in these examples:

> *"...like I'll be on the bus and people won't sit next to me because I'm a teenager, and it's rude, and you know, you get funny looks from older people and it just makes you feel that you're a bad person for being what you are".*

> *"I feel ridiculed and looked down upon by older people... having kids early and because I look younger than I am, it's really difficult! Some people think like I'm a bludger off the government!".*

This finding adds support to previous research (e.g., ICCWA, 2006), which has found that young adults are one of the most frequently identified groups excluded within rural/regional communities.

Support of older members of the community

Critically, in the present study, several of the young adults' perceptions of potential discrimination or lack of understanding from older adults appeared to have a detrimental effect upon their anticipated positive help-seeking behaviours (Prilleltensky & Prilleltensky, 2005). Thus, while approaching older members of the community for support, such as educators or sporting group coaches whom they view as more experienced was desired, this was thwart by anxiety of how they may be seen or treated. For example:

> *"Older people can help, because they've actually had more experience, when you actually need help, you tend to go to them more, because they understand what you're going through. But older people need to just show that they're not gunna treat you like crap. They're going to actually listen to what you say, because if you tell someone something and they're like 'oh you're just being pathetic', it just doesn't help!'".*

Suicide Education

In the literature, it has been previously reported that suicide is an important personal concern for Australian young adults (Mission Australia, n.d.). However, another critical finding of the present study that has not been discussed in the suicide literature - is that these youth wanted to talk publicly about the taboo topic of suicide, including aspects of awareness and education, and public talks with those bereaved by suicide. Specifically, concerns have been raised in the literature that the public communication of suicide may potentially be harmful to young people, such as reporting the methods used or romanticising individuals who complete suicides (Baume, Cantor, & Rolfe, 1997; Patterson & Pegg, 1999). However in the present study, several of the young adults' who had personal experiences with suicide through the bereavement of friends or same age peers, explicitly expressed the need for an increased awareness and acceptance within their communities to openly talk about the issue of suicide. For instance:

> *"You never hear about suicide, because everyone just shuts the door on it. Pretty much like in the 50's and you fell pregnant and no one knew about it sort of thing. Whereas I think now, the way society is everyone just needs to get over it and these are the issues that are happening, and we need to address them".*

While, the majority of the young adults' also emphasised that suicide education which may empower them with the knowledge and skills *"to realise and get help... before they get to that point"* would promote resilience in regard to suicide for their peer group. In particular, they stressed the importance of finding out practical information related to the signs and symptoms associated with suicide and where and how to seek help, so that they may be prepared and potentially empowered for both themselves and their friends. For example:

> *"Lifeline is conducting around the South West suicide alertness, it's a one day workshop and it just talks about general suicide alertness, what the signs are and stuff, and um like awareness of where and what resources for help are available. So I think that's something anyone can do really...it's just a good thing to promote awareness. It's good that someone is delving into it, besides it's something that's not really talked about, kinda like a 'taboo' topic, that society kinda tries to shun. Which it needs to just have that focus on it, so if people need help they can actually come and talk to people".*

Here an older informant also highlighted the benefits that young adults gained from attending a similar community suicide talk:

> *"It was really interesting, the young people really seemed to get something out of the suicide awareness session... they wanted to talk about suicide and talk about how they can be involved in the process of helping each other... to be proactive with their own health, they wanted the information and where they can access help...".*

As noted in the suicide intervention literature (Livingworks, 2004), to reduce the stigma and taboo that surrounds the sensitive issue of suicide, aspects of avoidance and secrecy need to be decreased, which entails increasing the extent of correct public knowledge about suicide to facilitate the development of shared collective beliefs. Essentially, this is potentially an important community strategy, as it may conceivably change culture and encourage help-seeking behaviour, as individuals may feel enabled to recognise signs of suicide in self or others, and offer/or seek appropriate professional help.

Survivor talks and interviews

The term 'suicide survivor' refers to an individual who has been bereaved by a family member or a friend who has died by suicide (Livingworks, 2004). Emotionally and financially the costs associated with suicide are substantial; for those affected it is a traumatic life event, and survivors often struggle with the impact of someone's suicide for the rest of their lives (CDHAC, 2005; Livingworks, 2004). In the present study, several informants' specifically appealed for public talks or televised interviews with suicide survivors to share their experience of loss and how it has affected their lives: *"it needs to be known how much harm it does to other people, it hurts family and friends"*. It was suggested that through the process of empathy, a translation effect may occur in which young adults who view these accounts, would perceive and potentially understand the emotional pain that others have experienced, and not want to cause that extent of emotional distress for their own loved ones. As these examples suggest:

> *"...more parents or siblings who have lost somebody to suicide that would be more publicised, that maybe they had these interviews on TV, or talks... Because I mean empathy is important, for a very good reason".*

> *"...there needs to be more talks or lectures with someone who has*

lived through the experience. Like this is what happens to family and friends, how everyone is affected, like a reality check. And hopefully they go 'I don't want my family to ever go through something like that', and hopefully they get some help...".

The young adults' emphasised several strategies that may encourage both help-seeking behaviour and potentially reduce the culture of stigmatisation that surrounds suicide. However, we must be mindful in relation to the concerns of the possible harm that may be caused by publicly communicating suicide (Baume, Cantor, & Rolfe, 1997). Particular care would need to be taken in how such strategies would be presented. For instance, suicide awareness talks, suicide education, and publicised interviews would need to be sensitively managed, all efforts would need to be made to use language and content that does not sensationalise, normalise, glamorise or romanticise the act of suicide or those who have completed suicides (CDHAC, 2005), to decrease the perception of suicide as a valid option. Help-seeking behaviour should be promoted for both mental-health disorders such as depression and the presence of suicidal thoughts (Livingworks, 2004). The catalyst being the awareness and acknowledgement of both formal and informal resources, in the event of future use or need (CDHAC, 2005; Livingworks, 2004).

Conclusions

This study, undertaken within a rural/regional context, aimed to explore informants' experiences and perceptions of resilience to identify what strategies they think are needed to promote resilience among young adults within their community, while also discovering how young adults' define resilience to the problem of suicide. Despite the relatively low number of young adults who took part in this study, those who did, shared their perceptions and experiences in depth, which contributed to a valued understanding of rural/regional young adults' perceptions of resilience within the context of suicide. While, perceptions from the older adults' predominately confirmed and aided verification of the relevant themes, further assisting the understanding of resilience towards suicide for young adults within their local communities. Thus facilitating the overall purpose of this research, which was to identify the possible links or mediating factors,

which may promote individual resilience 'within' a person, via the implementation of broad community-based interventions related to suicide.

Results of this study suggest that for young adults in a rural/regional setting, resilience towards suicide is comprised of individual, relational, cultural, and contextual aspects. Specifically, factors surrounding support, awareness of internal processes, stepping stones, acceptance, and suicide education, were the major areas addressed by the informants.

Findings from this study suggest that these young adults' define resilience to the problem of suicide, via the synthesis of several factors. Importantly, during times of extreme emotional distress and/or suicidal cognitions, established informal quality supports made up of family and friends were perceived as integral to promote social connectedness and assistive coping supports (ICCWA, 2006), inclusive of providing an instrumental link to facilitate access of professional mental-health resources. While, the ability to self-recognise internal processes related to suicidal thoughts, including the identification and acknowledgment of the personal need for help; and the emotional competence to effectively communicate distressing cognitions to others to enable 'chatting through' suicidal thoughts to facilitate clearer thinking, was emphasised. In addition, these young adults also expressed the importance of experiencing adversity and persevering through challenging situations themselves (Rutter, 1985). This enabled them to build a resilience self-history, identifying and becoming familiar with a range of potentially useful coping processes or 'stepping stones', which reinforced their self-efficacy (Bandura, 1977) and enhanced perceptions and appraisals of self-competency to effectively cope in times of future adversity or stressfully challenging situations.

Potentially, facilitating the focus required to encourage a primary prevention approach towards suicide for young adults (CDHAC, 2005), the results of this study identified several community-based strategies suggested by the informants' that may facilitate the links or mediating factors required to promote individual resilience for young adults. These included, an increased acceptance and decrease of discrimination and exclusion of young adults from older members of rural/regional communities (ICCWA, 2006), to potentially facilitate feelings of belonging, and promote positive help-seeking

behaviours. The critical finding that several young adults' expressed a desire to publicly and openly talk about suicide within their communities. Specifically, aspects of awareness and education, inclusive of public talks with suicide survivors, were suggested by several informants' - to aid empowering themselves and their peers to recognise suicide signs and symptoms, and where and how to access assistance in event of future use or need. While, an increased availability of affordable resources to promote social connectedness and decrease social isolation, and an increase of face-to-face professional mental-health resources that meet aspects of confidentiality and decreased visibility, were other community strategies that informants' perceived to be important, to facilitate promoting resilience for young adults within rural/regional areas.

Essentially, the findings from this study support Ungar and colleague's (2007) perspective of resilience, which emphasises the importance of understanding resilience in respect to both an individual's capacity to overcome stress and adversity, as well as the capacity of an individual's ecology, comprised of relational, cultural and contextual aspects, to provide the resources that facilitate well-being. For the rural/regional young adults in this study, it appeared that experiences and perceptions of their everyday ecologies and unique life circumstances were both supportive and at times detrimental, impacting on their potential for individual resilience, especially when considered in the context of suicide.

Notwithstanding the limitations, this study contributes to an understanding of individual resilience within the context of suicide for rural/regional young adults. Utilising a qualitative research methodology, it has demonstrated that some young adults and older adults who work with youth, can provide useful insights into individual resilience related to the problem of suicide within a rural/regional context. This research has contributed a comprehensive framework of the links or mediating factors that may potentially aid promoting resilience towards suicide for rural/regional young adults. Potentially, this information may assist future research that aims to investigate the construct of individual resilience to address the problem of suicide in young adults.

Whilst this study yielded valuable information, the findings are necessarily tentative and speculative, due to the paucity of any comparable studies that have explored the protective construct of individual resilience specifically within the context of suicide for young adults (Barbour, 2009). Thus to aid transferability, the findings of the present study provide rich, detailed and expressive descriptions of how these young adults' define resilience in the context of suicide, and the community-based strategies that informants' suggested to promote resilience towards suicide for young adults (Ungar, 2003).

As previously noted, the initial recruitment of young adults was poor. Flyers advertising the study were predominately put in high-traffic areas to attract attention. However, this may have thwarted recruitment instead. For instance, from the findings, it was confirmed that perceptions of high visibility, stigma and potential embarrassment in rural/regional settings are potential barriers to young adults' help-seeking behaviours (e.g., Rickwood, Deane, Wilson, & Ciarrochi, 2005); potentially these same factors may have also minimised informant recruitment in this peer-group. Thus, to facilitate the recruitment of young adults in future studies exploring resilience and the sensitive issue of suicide; utilising advertising mediums that are potentially less visible and perceived as more confidential, such as newspapers, popular magazines, or internet advertising, may promote recruitment.

In addition, another limitation of the present study, was the under representation of male informants, which potentially biased the present study towards a female perspective of resilience within the context of suicide. Future studies should aim to address this limitation, for example using a less visible advertising medium to aid recruiting a larger sample of young adults may address the small number of male informants. While, an interesting focus for future research, may encompass exploring the 'transfer or mediating' factors within other young adult populations in different geographical contexts, such as metropolitan areas.

In conclusion, the findings from the present study contribute to the theoretical knowledge base of resilience and how this protective construct may potentially protect against suicide for young adults in a rural/regional context via the implementation of community-based broad interventions. It is

anticipated that this research may potentially provide a background for future additional research of the links or mediating factors, which may facilitate the building of individual resilience via a primary prevention approach using community-based strategies related to suicide.

References

Abbott-Chapman, J. (2001). Rural Resilience. *Youth Studies Australia, 20,* 26-31.

Ahern, N. R., Ark, P., & Byers, J. (2008). Resilience and coping strategies in adolescents. *Paediatric Nursing, 20,* 32 –36.

Arnett, J. J. (2007). *Adolescence and emerging adulthood, a cultural approach* (3rd ed.). Upper Saddle River, NJ: Prentice Hall.

Australian Bureau of Statistics (2007a). *Suicides, Australia, 2005,* cat no. 3309.0, ABS, Canberra.

Australian Bureau of Statistics (2007b). *2006 Census QuickStats: Western Australia,* ABS, Canberra.

Australian Bureau of Statistics (2008a). *Western Australian Statistical Indicators, June 2008,* cat no. 1367.5, ABS, Canberra.

Australian Bureau of Statistics (2008b). *Australian Social Trends, 2008,* cat no. 4102.0, ABS, Canberra.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioural change. *Psychological Review,* 2, 191-215.

Bandura, A. (2004). Health promotion by social cognitive means. *Health Education & Behavior,* 31, 143-164.

Barbour, R. (2009). *Introducing qualitative research: A student guide to the craft of doing qualitative research.* Cornwall, Great Britain: Sage.

Baume, P., Cantor, C., & Rolfe, A. (1997). Cybersuicide: The role of interactive suicide notes on the internet. *Crisis, 18,* 73-79.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The Qualitative Report, 13,* 544-559.

Beardslee, W. (1989). The role of self-understanding in resilient individuals: The development of a perspective. *American Journal of Orthopsychiatry, 59,* 266- 278.

Beasley, M., Thompson, T., & Davidson, J. (2003). Resilience in response to life stress: The effects of coping style and cognitive hardiness. *Personality and Individual Differences, 34,* 77-95.

Becker, C. (1992). *Living and relating: An introduction to phenomenology.* Newbury Park, CA: Sage.

Bonanno, G., & Mancini, A. (2008). The human capacity to thrive in the face of potential trauma. *Pediatrics, 121,* 369-375.

Botha, K., Guilfoyle, A., & Botha, D. (2009). Beyond normal grief: A critical reflection on immediate post-death experiences of survivors of suicide. *Australian e-journal for the Advancement of Mental Health, 8,* 1-11.

Burgess-Limerick, T., & Burgess-Limerick, R. (1998). Conversational interviews and multiple-case research in psychology. *Australian Journal of Psychology, 50,* 63-70.

Burns, J., & Patton, G. (2000). Preventative interventions for youth suicide: A risk factor-based approach. *Australian and New Zealand Journal of Psychiatry, 34,* 388-407.

Cantor, C., & Neulinger, K. (2000). The epidemiology of suicide and attempted suicide among young australians. *Australian and New Zealand Journal of Psychiatry, 34,* 370-387.

Carbonell, D., Reinherz, H., & Giaconia, R. (1998). Risk and resilience in late adolescence. *Child and Adolescent Social Work Journal, 15,* 251-272.

Carlton, P., & Deane, F. (2000). Impact of attitudes and suicidal ideation on adolescents' intentions to seek professional psychological help. *Journal of Adolescence, 23,* 35-45.

Carter, G., Issakidis, C., & Clover, K. (2003). Correlates of youth suicide attempters in Australian community and clinical sample. *Australian and New Zealand Journal of Psychiatry, 37,* 286-293.

Commonwealth Department of Health & Aged Care (2005). *Community Life: A framework for effective community-based suicide prevention* (pp. 1-132). Retrieved February 15, 2009, from http://www.community–life.org.au

Creswell, J. W. (2003). *Research design: Qualitative, quantitative, and mixed methods approaches* (2nd ed.). Thousand Oaks, CA: Sage.

Creswell, J. W., & Maietta, R. C. (2002). Qualitative research. In D. C. Miller & N. J. Salkind (Eds.), *Handbook of research design and social measurement* (6th ed.). Thousand Oaks, CA: Sage.

Depoy. E., & Gitlin, L. N. (1998). *Introduction to research: Understanding and applying multiple strategies* (2nd ed.). St Louis, MO: Mosby.

Folkman, S., & Moskowitz, J. (2000). Positive affect and the other side of

coping. *American Psychologist, 55*, 647-654.

Friesen, B., & Brennan, E. (2005). Strengthening families and communities: System building for resilience. In M. Ungar (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 295- 311). Thousand Oaks, CA: Sage.

Gerber, R. (2004). Aussie kids: still sun-bronzed, outdoors and carefree? In M. Robertson, & M. Williams (Eds.), *Young people, leisure and place. Cross cultural perspectives* (pp. 159-164). New York: Nova Science.

Gilgun, J. F. (1996). Human development and adversity in ecological perspective, part 2: Three patterns. *Families in Society, 77*, 459-477.

Gorman, D., Buikstra, E., Hegney, D., Pearce, S., Rogers-Clark, C., Weir, J., & McCullagh, B. (2007). Rural men and mental health: Their experiences and how they managed. *International Journal of Mental Health Nursing, 16*, 298-306.

Gould, M., & Kramer, R. (2001). Youth suicide prevention. *Suicide and Life-Threatening Behavior, 31*, 6-31.

Haglund, M., Nestadt, P., Cooper, N., Southwick, S., & Charney, D. (2007). Psychobiological mechanisms of resilience: Relevance to prevention of stress-related psychopathology. *Development and Psychopathology, 19*, 889-920.

Harris, K., McLean, J., & Sheffield, J. (2009). Solving suicide problems online: Who turns to the internet for help? *Australian e-journal for the Advancement of Mental Health, 8,* 1-9.

Hegney, D. G., Buikstra, E., Baker, P., Rogers-Clark, C., Pearce, S., Ross, H., King, C., & Watson-Luke, A. (2006). Individual resilience in rural people: A Queensland study, Australia. *Rural and Remote Health, 7*, 1-13.

Injury Control Council of Western Australia. (2006). *National suicide prevention strategy (NSPS) "Understanding and building resilience in the southwest" final report.* Retrieved February 18, 2009, from http://www.iccwa.org.au /wpcontent/uploads/2008/06ubr_final-report-abriged-for-websitepdf

Judd, F., Cooper, A., Fraser, C., & Davis, J. (2006). Rural suicide - people or place effects? *Australian and New Zealand Journal of Psychiatry, 40*,

208-216.

Kumpfer, K. L. (1999). Factors and processes contributing to resilience, the resilience framework. In M. D. Glantz, & J. L. Johnson (Eds.), *Resilience and development: positive life adaptations* (pp.179-224). NY: Kluwer Academic/Plenum.

Lalonde, C. (2006). Identity formation and cultural resilience in aboriginal communities. In R. J. Flynn, P. M. Dudding, & J. G. Barber (Eds.), *Promoting resilience in child welfare* (pp. 53-71). Ontario, Canada: University of Ottawa Press.

Liamputtong, P., & Ezzy, D. (2005). *Qualitative research methods* (2nd ed.). Oxford: Oxford University Press.

Lipschitz, A. (1995). Suicide prevention in young adults (age 18-30). *Suicide and Life-Threatening Behavior, 25*, 155-161.

Livingworks (2004). *Suicide intervention handbook* (10th ed.). Victoria, Australia: LivingWorks/Lifeline.

McDonnell, A., Jones, M., & Read, S. (2000). Practical considerations of the case study research: The relationship between methodology and process. *Journal of Advanced Nursing, 32*, 383-390.

Miller, M. (1996). Relevance of resilience to individuals with learning disabilities. *International Journal of Disability, Development, 43*, 255-269.

Mission Australia (n.d.) *National survey of young Australians 2007*. Retrieved February 18, 2009, from http://www.missionaustralia.com.au/ youthsurvey

Mroczek, D. K., & Almeida, D. M. (2004). The effect of daily stress, personality, and age on daily negative effect. *Journal of Personality, 72*, 355- 378.

Niner, S., Pirkis, J., Krysinska, K., Robinson, J., Dudley, M., Schinder, E., DeLeo, D., & Warr, D. (2009). Research priorities in suicide prevention: A qualitative study of stakeholders' views. *Australian e-journal for the Advancement of Mental Health, 8*, 1-9.

Palmer, N. (1997). Resilience in adult children of alcoholics: A nonpathological approach to social work practice. *Health & Social Work, 22*, 201-209.

Patterson, I., & Pegg, S. (1999). Nothing to do, the relationship between 'leisure boredom' and alcohol and drug addiction: Is there a link to youth suicide in rural Australia? *Youth Studies Australia, 18,* 24-28.

Pirkis, J., Burgess, P., & Dunt, D. (2000). Suicidal ideation and suicide attempts among Australian adults. *Crisis, 21,* 16-25.

Polk, L. (1997). Toward a middle-range theory of resilience. *Advances in Nursing Science, 19,* 1-13.

Porth, C. M. (2002). *Pathophysiology: Concepts of altered health states* (6th ed.). NY: Lippincott Williams & Wilkins.

Prilleltensky, I., & Prilleltensky, O. (2005). Beyond resilience: Blending wellness and liberation in the helping professions. In M. Ungar (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 89- 103). Thousand Oaks, CA: Sage.

Quine, S., Bernard, D., Booth, M., Kang, M., Usherwood, T., Alperstein, G., & Bennet, D. (2003). Health and access issues among Australian adolescents: A rural-urban comparison. *Rural and Remote Health, 3,* 1-11.

Reeve, J. (2005). *Understanding motivation and emotion* (4th ed.). Hoboken, NJ: Wiley.

Resnick, M., Harris, L., & Blum, R. (1993). *The impact of caring and connectedness on adolescent health and well-being.* Retrieved April 30, 2009, from Minnesota University, Children, Youth and Family Consortium Web site: http://www.cyfc.umn.edu/adolescents/ resources/caring.html

Rickwood, D., Deane, F., Wilson, C., & Ciarrochi, J. (2005). Young peoples' help-seeking for mental health problems. *Australian e-Journal for the Advancement of Mental Health, 4,* 1-34.

Robertson, M., & Chapman, J. (2004). Place and identity: Evidence from Tasmanian schools. In M. Robertson, & M. Williams (Eds.), *Young people, leisure and place. Cross cultural perspectives* (pp. 165-178). New York: Nova Science.

Rossi, N., Bisconti, T., & Bergeman, C. (2007). The role of dispositional resilience in regaining life satisfaction after the loss of a spouse. *Death Studies, 31,* 863-883.

Rutter, M. (1985). Resilience in the face of adversity, protective factors and resistance to psychiatric disorder. *British Journal of Psychiatry, 147*, 598-611.

Rutter, P., & Behrendt, A. (2004). Adolescent suicide risk: Four psychosocial factors. *Adolescence, 39*, 295-302.

Shakoor, M., & Fister, D. (2000). Finding hope in Bosnia: Fostering resilience through group process intervention. *The Journal for Specialists in Group Work, 25*, 269 – 287.

Sharaf, A., Thompson, E., & Walsh, E. (2009). Protective effects of self-esteem and family support on suicide risk behaviours among at-risk adolescents. *Journal of Child and Adolescent Psychiatric Nursing, 22*, 160 – 168.

Smith, C., Rogers, W., & Tucker, S. (2007). Risk. In M. Robb (Ed.), *Youth in context: Frameworks, settings and encounters* (pp. 219-250). London: Sage.

Stake, R. (1994). Case studies. In N. K. Denzin & Y. S. Lincoln (Eds.), *Handbook of qualitative research* (pp. 236-247). Thousand Oaks, CA: Sage.

Stawski, R., Sliwinski, M., Almeida, D., & Smyth, J. (2008). Reported exposure and emotional reactivity to daily stressors: The roles of adult age and global perceived stress. *Psychology and Aging, 23*, 52-61.

Steinhardt, M., & Dolbier, C. (2008). Evaluation of a resilience intervention to enhance coping strategies and protective factors and decrease symptomatology. *Journal of American College Health, 56*, 445- 453.

Stone, M. (1992). Suicide in borderline and other adolescents. *Adolescent Psychiatry, 18*, 289-305.

Taylor, R., Page, A., Morrell, S., Carter, G., & Harrison, J. (2004). Socio-economic differentials in mental disorders and suicide attempts in Australia. *British Journal of Psychiatry, 185*, 486-493.

Tomborou, J., Patton, G., Sawyer, S., Olsson, C., Webb-Pullman, J., Catalano, R., & Godfrey, C. (2000). *Evidence-based interventions for promoting adolescent health.* Melbourne: Centre for Adolescent Health.

Tugade, M., & Fredrickson, B. (2004). Resilient individuals use positive emotions to bounce back from negative emotional experiences. *Journal of Personality and Social Psychology, 86*, 320-333.

Tusaie, K., & Dyer, J. (2004). Resilience: A historical review of the construct. *Holistic Nursing Practice, 18*, 3-10.

Tusaie-Mumford, K. (2001). Psychosocial resilience in rural adolescents: Optimism, perceived social support and gender differences. *Dissertation Abstracts International, 63,* 183. (UMI No. 3038290)

Ungar, M. (2003). Qualitative contributions to resilience research. *Qualitative Social Work, 2,* 85-102.

Ungar, M. (2008). Resilience across cultures. *British Journal of Social Work, 38,* 218-235.

Ungar, M., Brown, M., Liebenberg, L., Cheung, M., & Levine, K. (2008). Distinguishing differences in pathways to resilience among Canadian youth. *Canadian Journal of Community, 27,* 1-13.

Ungar, M., Brown, M., Liebenberg, L., Othman, R., Kwong, W., Armstrong, M., & Gilgun, J. (2007). Unique pathways to resilience across cultures. *Adolescence, 42,* 287-310.

Ungar, M., & Teram, E. (2005). Qualitative Resilience research: Contributions and risks. In M. Ungar (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 149- 163). Thousand Oaks, CA: Sage.

Vijayakumar, L., Pirkis, J., & Whiteford, H. (2005). Suicide in developing countries (3) prevention efforts. *Crisis, 26,* 120-124.

Werner, E. (1989). High risk children in young adulthood: A longitudinal study from birth to 32 years. *American Journal of Orthopsychiatry, 59,* 72-81.

Wilburn, V. R., & Smith, D. E. (2005). Stress, self-esteem, and suicidal ideation in late adolescents. *Adolescence, 40,* 33 -45.

Wojnar, D., & Swanson, K. (2007). Phenomenology: An exploration. *Journal of Holistic Nursing, 25,* 172-180.

Appendix A
Tear-off flyers

A STUDY OF YOUNG ADULTS' EXPERIENCES AND THOUGHTS OF HOW COMMUNITY-BASED INTERVENTIONS CAN PROMOTE THEIR RESILIENCE TO SUICIDE

My name is Tracy Evans, and I am an Honours in Psychology student at Edith Cowan University. As part of my degree, I am required to undertake a research project. The Faculty of Computing, Health and Science Human Research Ethics Committee has approved this research. I am interested in talking to individuals aged between 18 and 24 years of age who have not been previously diagnosed with a mental health disorder, and exploring their experiences, perceptions, and thoughts towards 'resilience' and how this protective factor may be utilised in relation to the problem of suicide.

Participation in this project would involve a single interview of approximately 45minutes duration. For some people this may be a potentially emotional issue, however we just want to hear your thoughts related to the construct of resilience and how it may be used as a protective factor.

Your participation is entirely voluntary, and you are free to withdraw from the study at any stage, without any adverse consequences. All information will be treated as strictly confidential, with interviews tape-recorded and transcribed verbatim. No names or identifying information will be used to ensure privacy. At the end of this study, a report of the results will be available upon request. This report may also be published, but in no way will you, or any other participant, be identifiable.

If you are interested in participating in this research study, or if you have any questions about it, please feel free to contact me, Tracy Evans on 0422283057 or by email to taevans@student.ecu.edu.au, or my supervisor at the school of psychology, Dr Andrew Guilfoyle on (08) 6304 5192. If you would prefer to speak to someone independent of this research, please contact Dr Justine Dandy on (08) 6304 5105.

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Resilience and Suicide Research
taevans@student.ecu.edu.au
0422283057

Appendix B
Information sheets

A STUDY OF YOUNG ADULTS' EXPERIENCES AND THOUGHTS OF HOW COMMUNITY-BASED INTERVENTIONS CAN PROMOTE THEIR RESILIENCE TO SUICIDE

My name is Tracy Evans, and I am an Honours in Psychology student at Edith Cowan University. As part of my degree, I am required to undertake a research project. The Faculty of Computing, Health and Science Human Research Ethics Committee has approved this research. I am interested in talking to individuals aged between 18 and 24 years of age who have not been previously diagnosed with a mental health disorder, and exploring their experiences, perceptions, and thoughts towards resilience and how this protective factor may be utilised in relation to the problem of suicide.

Participation in this project would involve a single interview of approximately 45minutes duration. For some people this may be a potentially emotional issue, however we just want to hear your thoughts related to the construct of resilience and how it may be used as a protective factor.

Your participation is entirely voluntary, and you are free to withdraw from the study at any stage, without any adverse consequences. All information will be treated as strictly confidential, with interviews tape-recorded and transcribed verbatim. No names or identifying information will be used to ensure privacy. At the end of this study, a report of the results will be available upon request. This report may also be published, but in no way will you, or any other participant, be identifiable.

If you are interested in participating in this research study, or if you have any questions about it, please feel free to contact me, Tracy Evans on 0422283057 or by email to taevans@student.ecu.edu.au, or my supervisor at the school of psychology, Dr Andrew Guilfoyle on (08) 6304 5192. If you would prefer to speak to someone independent of this research, please contact Dr Justine Dandy on (08) 6304 5105.

Appendix C
Interview schedule for young adults

Before we begin, I would like to thank you for your interest and participation in this research, and for your time. Although, I am very interested to hear your thoughts about the issues raised, you have a right to refuse to answer any of the questions.

Firstly, I would like to give you a short definition of resilience from the Oxford student dictionary (2003), where resilience has been described as "recovering quickly from trouble, or difficulties…"

As a peer-group within the community, young-adults face a lot of challenges and associated pressures…

1) What sort of things do you think are needed in your community to help build resilience for young-adults?
   - Can you tell me more?

2) What do you think are external factors that help to make young-adults' feel more resilient, and overcome the challenges that they face?
   - Can you tell me more?

There are concerns within rural/regional areas regarding suicide, and I would like to hear your thoughts about this problem in relation to your peer group.

3) As a young-adult, how would you define resilience with regard to the problem of suicide within your community?
   - What makes you think this?

4) Tell me about a time in your life when you felt you were very resilient?
   - Do you think this is the same for other young-adults in your community?

Knight, A. (2003). *Oxford: The Australian integrated school file dictionary and thesaurus*. Melbourne: Oxford University Press.

Appendix D
Interview schedule for adults over 24years old

Before we begin, I would like to thank you for your interest and participation in this research, and for your time. Although, I am very interested to hear your thoughts about the issues raised, you have a right to refuse to answer any of the questions.

Firstly, I would like to give you a short definition of resilience from the Oxford student dictionary (2003), where resilience has been described as "recovering quickly from trouble, or difficulties..."

I have spoken with several young adults in the community and have heard their views on this topic, now I would like to hear your views about resilience in relation to young adults. For instance, it has been noticed as a peer-group within the community, young-adults face a lot of challenges and associated pressures...

    5) What sort of things do you think are needed in your community to help build resilience for young-adults?
-   Can you tell me more?

    6) What do you think are external factors that help to make young-adults' feel more resilient, and overcome the challenges that they face?
-   Can you tell me more?

There are concerns within rural/regional areas regarding suicide, and I would like to hear your thoughts about this problem in relation to young adults..

    7) How would you define resilience with regard to the problem of suicide within your community for young adults'?
-   What makes you think this?

    8) Tell me about a time in your life when you felt you were very resilient?
-   Do you think this is similar for young-adults in your community?

Knight, A. (2003). *Oxford: The Australian integrated school file dictionary and thesaurus*. Melbourne: Oxford University Press.

Appendix E
Information letter

Tracy Evans
C/- Edith Cowan University
School of Psychology
100 Joondalup Drive
Joondalup WA 6027

EDITH COWAN UNIVERSITY
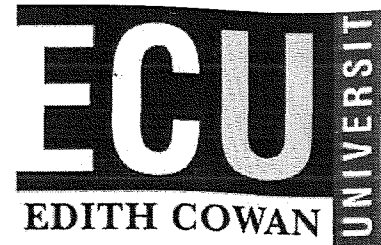
Dear Participant,
My name is Tracy Evans, and I am an Honours in Psychology student at Edith
Cowan University. As part of my degree, I am required to undertake a
research project. The research project that I am conducting aims to explore
young adults' lived experiences and perceptions of resilience, and how this
protective factor may be utilised in relation to the problem of suicide. The
Faculty of Computing, Health and Science Human Research Ethics
Committee has approved this research.

If you agree to take part in this research, you will be asked questions about
how you define 'resilience' (i.e., recovering quickly from trouble or illness),
your experiences of resilience, and what you think we can do in your
community to help young people become more resilient. The questions I ask
you and your answers will be tape-recorded, and after the interview
transcribed word-for-word. All information will be treated as strictly
confidential; for instance, no names or identifying information will be used to
ensure your privacy. It is estimated that the interview will take approximately
45 minutes. At the end of my research the audiotaped files will be destroyed.

You might feel this is an emotional issue for you, and if at anytime you
become distressed with any aspect of this study and want to talk to someone
further, assistance is available to you through a number of counselling support
contacts, as attached. Taking part in this research is entirely voluntary. You
are completely free to stop your involvement or withdraw from the study at
any stage without any unpleasant consequences. At the end of this study, a
report of the results will be made available upon request. This report may also
be published, but in no way will you, or any other person who took part in this
research, be identifiable.

Please keep this letter for your own records, and if you have any questions
about this project or would like further information, please feel free to contact
myself, Tracy Evans on ████████ or by email to
taevans@student.ecu.edu.au, or my supervisor at the school of psychology, Dr
Andrew Guilfoyle on (08) 6304 5192. If you would prefer to speak to
someone independent of this research, please contact Dr Justine Dandy on
(08) 6304 5105. If you consent to participating in this research, please sign the
attached consent form, and return it to me.
Yours sincerely

Tracy Evans
(Researcher)

Appendix F
Consent form

EDITH COWAN
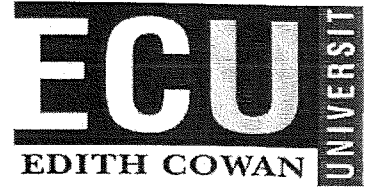
Project Title: Young Adults' Experiences and Perceptions of how Community-

Based Interventions can Promote their Resilience to Suicide.

I _____(name), on_____ (date), state
that I have read and understood the information letter provided with this
consent form, and any questions I have asked have been answered to my
satisfaction. I am aware that if I have any additional questions about the study,
I am able to contact the researcher Tracy Evans on ████████, or her
supervisor Dr Andrew Guilfoyle on (08) 6304 5192 at the school of
psychology, Edith Cowan University.

I understand that some individuals when discussing personal experiences and
perceptions may experience some distress. I further understand that
participation in this study is voluntary, and that I may withdraw my
participation from the research project at any stage without adverse
consequences. I agree that the research gathered during this project can be
used to complete a student report provided that all of my information will be
treated as confidential, with interview tapes and transcripts kept in locked
storage, and computerised documents adequately stored.
I agree to the interview being audio recorded and that the tapes will be
destroyed at the completion of the research.

I hereby consent to participate in this research project.

_____(participant signature).

_____(researcher signature).

Appendix G
Counselling services listing

Support Services Listing

After discussing your experiences of resilience and your thoughts of how this protective factor can be utilised in relation towards the problem of suicide, you may have brought up some unresolved issues. If you feel that you would like to discuss these issues with someone, a list of available support services has been compiled.

Telephone Support

Lifeline   13 11 14
24-hour confidential counselling, crisis and emergency resources line, cost of a local call.

Crisis Care   1800 199 008
24-hour emergency line.

South West 24 Help Line   1800 555 336
24-hour, seven days a week, counselling and support.

Samaritans Youth Line   1800 198 313
Suicide emergency service and confidential counselling line.

Suicide Call Back service   1300 659 467
Free telephone support program, for people at risk, their carers and the bereaved. Manned 7 days, 10.00am to 8.30pm (EST).

Teen Challenge Careline   1300 889 288
Suicide prevention for youth.

Men's Line Australia   1300 789 978
Professional information & support for men, specialising in relationship and family problems.

Psychological Support Services

All Families Mediation & Counselling   9721 1367
Confidential counselling and mediation service, located in Bunbury.

Health Information Service Link

Carelink   1800 052 222
Provides information and links for information services in your community.