Protocol for the evaluation of a non-clinical, community based facilitated support group for people who have previously attempted suicide

Full names and affiliations and email of all authors

Myfanwy Maple, School of Health, University of New England, mmaple2@une.edu.au

Sarah Wayland, School of Health, University of New England; Faculty of Health Sciences, University of Sydney, sarah.wayland@sydney.edu.au

Tania Pearce, School of Health, University of New England, tpearc20@une.edu.au

Navjot Bhullar, School of Psychology, University of New England, navjot.bhullar@une.edu.au

Corresponding author

Myfanwy Maple, School of Health, University of New England

P: 612 6773 3661, E: mmaple2@une.edu.au

Background: A research protocol is presented for the evaluation of the Eclipse group, an 8-week closed group for people who have previously attempted suicide, which aims to reduce future suicide and increase resilience and support identification and help seeking. The psychoeducational content directly addresses dealing with suicidal thoughts, suicide safety planning, increasing resilience and identifying and utilising social and professional supports.

Methods: A mixed methods research protocol is presented to evaluate the effectiveness of such a group being trialled in Australia for adults who have previously attempted suicide. The primary outcome measure is suicide ideation, with secondary outcome measures being psychological distress, resilience, support identification and help seeking. Quantitative data are collected at four time points using standardized self-report measures. At the third and fourth data collection points qualitative data are also collected.

We will use repeated measures analysis of variance (ANOVA) to examine the effectiveness of the program in terms of changes in the self-reported measures from pre- to immediate post-test, then follow-up at 1- and 6-months. The qualitative data will be thematically analysed using a narrative framework to explore the meanings participants attribute to participation in the group, their psychosocial distress and relationship with suicide and how they engage with support when needed.

Discussion: The evidence for non-clinical support groups is both scant and of generally poor quality. Thus a robust research protocol to evaluate the effectiveness of such a group for those who have previously attempted suicide is offered to improve and extend the evidence base. The Eclipse group offers a non-clinical, community-based program for people with a history of attempted suicide.

Trial Registration: This research protocol was retrospectively registered with the Australian New Zealand Clinical Trials Registry (ANZCTR) (ACTRN:12619000542190) on 05/04/2019, https://www.anzctr.org.au/Trial/Registration/TrialReview.aspx?id=377318&isReview=true

Keywords

Suicide, suicide attempt, support group, non-clinical

Background

In the context of unprecedented funding and activity in suicide prevention activities in Australia, suicide still remains a leading cause of death. The Australian Bureau of Statistics (ABS) reported 3,046 recorded as suicide, with a preliminary death rate of 12.1 per 100,000.(1) Yet, predicting suicide remains only slightly better than chance.(2) While difficult to accurately calculate the prevalence of suicide attempt and suicidal ideation some reports indicate that there are 20 to 30 suicide attempts for each suicide death(3) and that ideation and attempt may be increasing.(2, 4) Prior history of suicide attempt is a strong predictor of future death, which has been demonstrated in Australia and internationally.(5) The risk of suicide is highest within close proximity to discharge from hospital, and recent interest in the provision of evidence-based aftercare services are aimed at reducing this short-term risk.(6) Yet, many report these services to be inadequate to their needs.(7) In the longer term, there are few, non-clinical supports for people with prior suicide attempts who may continue to live with persistent suicidal ideation and repeated attempts.(8).

There is little empirical evidence demonstrating the effectiveness of support groups in reducing the risk of suicidal behaviour in suicide attempt survivors. To date, only one quantitative study examining the effectiveness of support groups on reduction of suicide ideation in suicide attempt survivors has been published. An open trial by Hom, Davis and Joiner(8) reported the

preliminary findings of the impact of the Survivors of Suicide Attempt (SOSA) support group, run by Didi Hirsch Mental Health Services in the United States.(54) In 2014, this group was accepted into the Suicide Prevention Resource Centre (SPRC) list of evaluated suicide prevention programs.(55) The program is an 8-week psychoeducation program, run jointly by professional and peer facilitators dyads. The evaluation(8) found participation by those with a history of suicide attempts (n=92) in a closed group over an 8-week period, demonstrated significant improvements in suicidal symptoms (hopelessness, suicidal ideation, suicidal desire, and suicidal intent) and resilience. However, the authors reported only modest effects in reducing of suicidal symptoms. The authors noted that continued "engagement of suicide attempt survivors into these treatment modalities may be beneficial, to markedly impact suicide rates, exploration of alternate suicide prevention approaches among attempt survivors".(8 p.290) The authors concluded that the SOSA intervention was cost effective and accessible for individuals by jointly addressing the attempting behaviours whilst also enhancing "social connection and resilience while also overcoming stigma-related barriers".(8 p. 303). The outcomes from this paper indicate significant limitations in drawing conclusions based on the design of the study, including noting the need for randomised control trials to test against treatement and usual and additional time point assessment post group.

The following research protocol was designed to evaluate the Eclipse group, which is an Australian version of the Didi Hirsch SOSA group (9), the focus of the Hom et al(8) evaluation. Given the gaps in the evidence for support groups and their effectiveness in reducing suicidal behaviour, the present research protocol is designed to extend the evidence for this model of support for people who have previously attempted suicide. The protocol details a mixed method evaluation to examine an 8-week closed, non-clinical community support group for people who have previously attempted suicide co-facilitated by a peer and professional group facilitator. The

stated aims of the group are to reduce future suicide ideation and behaviours and psychological distress and increase resilience and social and professional support.

For the purposes of this protocol, a support group is defined as having the following attributes proposed by Katz & Bender (11): (a) small, face-to-face group interaction, (b) emphasis on personal participation, (c) voluntary attendance, (d) acknowledged purpose for coming together such as to solve a problem or to help individuals cope with handicaps or illnesses, and (e) provision of emotional support.

The curriculum for the group intervention was developed by the Didi Hirsch Centre (9) with some adaptations for the Australian context. The group aims to provide a safe, non-judgemental space for group members to share their experience of suicide, and to explore the impact this has had on their lives, while simultaneously working on a safety plan and psychoeducational components to assist in deterring from future attempts, and accessing help prior to any future attempt. The group is facilitated by Lifeline Australia centre staff at each trial site by a trained staff member and peer facilitator. The research is undertaken by the authors of the present paper and is funded by the Lifeline Research Foundation.

The aims of the evaluation are to:

1. Determine whether participation in the Eclipse group reduces suicidal ideation and psychological distress in people who have previously attempted suicide?
2. Determine whether participation in the Eclipse group increases resilience and help seeking (social and professional) in people who have previously attempted suicide?

Methods

Study Design

This study is a mixed methods evaluation of an 8-week attempted suicide support group program. The evaluation was co-created and piloted at one site (Site 1) with the facilitators (professional and peer), the director of the funding body, the US-based program trainer from Didi Hirsch and members of the research team (authors MM, TP). Co-creation is an approach to increasing the application of new knowledge into practice. This is achieved through by the embedding four collaborative research processes (co-ideation, co-design, co-production and co-evaluation) into the delivery of a program.(12) In this evaluation, all stakeholders (non-research staff and research staff) participated in each of these four collaborative processes with group facilitators responsible for the ongoing collection of data prior to commencement (T0), during the delivery of the group at pre-test (T1), weekly satisfaction ratings at the completion of each session and immediately post-test (T2). Follow-up data is collected at 1-month (T3) and 6-month (T4) post group which will be collected by researchers (TP, SW). See Table 2.

Ethical approval

Ethics approval for the evaluation of the program was granted by the University of New England Human Research Ethics Committee (HE16-195). Further ethics approval was granted by the same committee to analyse the co-creation process evaluation which will be reported elsewhere.

Recruitment and Study Participants

The group was initially piloted from February 2017 through November 2017 at Site 1 to ensure the group content and the evaluation design were robust for trialling with a broader sample in multiple sites. The outcomes of the pilot included replacing the existing suicide safety planning tool which was paper based with an Australian mobile application for suicide safety planning (*BeyondNow*) (13) and the inclusion of SIDAS(14) following difficulties with the internal

suicide assessment used in the pilot location and to ensure a validated tool was being used for the primary outcome measure. The SRCS(15) was also added.

The trial of the Eclipse group evaluation will occur across Australia through an existing network of Lifeline Centres which is expected to be completed by the end of 2020. Each of the sites implementing the Eclipse program are required to notify their interest in running an Eclipse group in their centre to Lifeline Research Foundation and then receive training to ensure the program is run with fidelity across sites. Each site is responsible for accessing adequate funding. Recruitment of participants is managed locally. This is primarily done to suit local conditions, but generally is via newspaper and newsletter advertising, direct contact with prior clients who meet the inclusion criteria, and information provided to local clinical mental health services. Some sites may run multiple groups over the evaluation period, with an expected recruitment of 65 participants during April 2018 and December 2020. The sample size is based on a conservative number, that is achievable within the resources available to determine whether the expected outcomes are realised before expansion of the group to other locations.

Eligibility criteria for the group are:

i) Age over 18 years at commencement of group

ii) A history of suicide attempt/s

iii) Sound understanding of the English language

iv) Ability to attend the physical setting where the group is being run, and

v) Not actively suicidal

Prior to participation in the support group, potential participants undergo an intake and screening interview with a trained facilitator who assesses the participant's suitability against the eligibility criteria. It is during the intake interview where participants are assessed on their current suicidality. If a potential participant is in immediate suicide risk, they are referred to

clinical services and not eligible for the support group at that time. When a participant is accepted to participate in the group, the facilitator then informs them of the research evaluation, provides them with the information about the research, and the consent information. They are clearly informed that they can opt into or out of the research, and that this will not influence their participation in the support group. Only those participants who have agreed to participate in the program will have their de-identified information made available to the research team.

Power analysis

Assuming a small to medium effect size (f = .175), alpha = .05, power = .80, number of measurements = 4 and medium correlation (r = .30) among repeated measures, an a-priori power analysis using G*Power (16) for repeated-measures analysis of variance (ANOVA) suggested a minimum of 64 participants. We aim to collect full data from 65 participants which would be sufficient to detect a significant effect in the present study.

Intervention

The program is delivered in accordance with the intervention prescribed by the USA model developed by the Didi Hirsch Centre(9) (with the aforementioned adaptations for Australian conditions).

The group content is structured around a weekly topic (WT) addressing the emotional and practical needs of participants, starting with setting group rapport and safety (WT1 introductions, WT2 talking about suicide), moving on to an emphasis on tools and resources to stay safe from future suicidal ideation and attempts (WT3 giving and receiving support, WT4 what triggers suicidal thoughts, WT5 how can I cope with suicidal thoughts), and finishing with closing the group (WT6 resources, WT7 hope, WT8 where do we go from here). Between group sessions, the peer facilitator checks in with participants via phone.

Data Collection

The data collection is embedded within the implementation of the intervention aligned with co-creation collaborative practices. The facilitators simultaneously administer the collection of quantitative data and the delivery of the program during the 8-week scheduled group delivery. A researcher monitors the data collection process and proactively maintains communication with the facilitators to ensure data are collected at each appropriate time point, and to discuss any issues related to data quality or participant attrition.

Measurements are taken at baseline prior to commencing the group content in Week 1 (T1), immediately after the final group in Week 8; immediate post-intervention (T2), at 1-month (T3) and at 6-month follow-up (T4). Further, a weekly 'participant satisfaction' data are collected after each session to assess overall satisfaction with the weekly topic content, as displayed in Table 2 below. In addition to quantitative data collection, the second author (SW) will also conduct a focus group, who will be introduced to the participants by the group facilitator to assist with rapport building at T3 (1-month post group), and in-depth interview at 6-month follow up. Interview questions for T3 focus group and T4 in-depth interview are found below.

T0 **Pre group**	**T1** **Week 1**	**Weeks 2-7**	**T2** **Week 8**	**T3** **1 month**	**T4** **6 months**
Information for participants Consent Demographics (age, gender, mental health diagnoses, postcode, prior attempt/s)	INQ-15 PHQ-9 RAS SIDAS SRCS ISSS	ISSS	INQ-15 PHQ-9 RAS SIDAS SRCS ISSS	INQ-15 PHQ-9 RAS SIDAS SRCS Focus group	INQ-15 PHQ-9 RAS SIDAS SRCS In-depth interview

Table 2: Data collection timepoints

Note. INQ-15 = Interpersonal Needs Questionnaire-15; PHQ-9 = Patient Health Questionnare-9; RAS = Resilience Appraisals Scale; SIDAS = Suicide Ideation Attibutes Scale; SRCS = Suicide-Related Coping Scale; ISSS = Internal Session Satisfaction Scale

Measures

Interpersonal Needs Questionnaire (INQ-15)

Suicide Ideation Attributes Scale (SIDAS)

The SIDAS(14) is a 5-item measure of severity of suicide ideation. The SIDAS comprises five items, each assessing a specific attribute of suicidal thoughts (i.e., frequency, controllability, closeness to attempt, level of distress associated with the thoughts and impact on daily functioning) over the past month. Items are rated on an 11-point Likert scale ranging from 0 (*never/not close at all/not at all*) to 10 (*always/full control/made an attempt/extremely*). Items are summed to create a composite SIDAS score. Previous research (14) has found excellent internal consistency (Cronbach's $\alpha = .91$).

Suicide-Related Coping Scale (SRCS)

The SRCS (15) is a 17-item self-report measure to assess knowledge of and confidence in using of internal coping strategies and external resources to manage suicidal thoughts and urges to decrease risk and avert suicidal crises. Items are rated on 5-point Likert scale ranging from 0 (*strongly disagree*) to 4 (*strongly agree*), with higher scores indicating better coping. Items are summed to create composite scores for the SRCS total and two subscales (Internal Coping and External Coping). Previous research (15) has found good internal consistency for SCRS total score ($\alpha = .89$); Internal Coping ($\alpha = .82$), and External Coping ($\alpha = .73$).

The INQ-15(17) is a 15-item measure that assesses beliefs about the extent to which individual feel connected to others (i.e., thwarted belongingness) and the extent to which they feel like a burden on other people in their lives (i.e., perceived burdensomeness). Items are rated on 7-point Likert scale ranging from 1 (*not at all true for me*) to 7 (*very true for me*). Items are averaged to create composite scores for the two subscales. Previous research(17) has demonstrated very good internal consistency for the belongingness subscale (Cronbach's $\alpha = .85$) and perceived burdensomeness subscale (Cronbach's $\alpha = .89$).

Patient Health Questionnaire (PHQ-9)

The PHQ-9(18) is a 9-item self-report measure that assesses the severity of depression. Using a 4-point Likert scale ranging from 0 (*not at all*) to 3 (*nearly every day*), respondents are asked to rate the frequency of depression symptoms in the last 2 weeks. Items are summed to create a composite score, with higher scores reflecting greater symptom severity. Previous research(18) has demonstrated very good internal consistency for the PHQ-9 ($\alpha = .89$).

Resilience Appraisals Scale (RAS)

The RAS(19) is a 12-item self-report measure designed to assess respondents' appraisal of their ability to cope with emotions, solve problems and seek social support. Items are rated on a 5-point Likert scale ranging from 1 (*strongly disagree*) to 5 (*strongly agree*), with higher scores indicating greater resilience. Items are summed to create composite scores for the three subscales and the overall score. Previous research(19) has found excellent internal consistency for social support, emotional coping and situation coping subscales with Cronbach's α's of .93, .92 and .92, respectively, and for overall scale (Cronbach's $\alpha = .88$).

At the completion of each group session (Weeks 1-8), an Internal Session Satisfaction Scale (ISSS) is also administered. The session satisfaction survey was developed internally by Lifeline to assess the client satisfaction with interaction with lifeline services. In the present study, it is used at the end of each weekly group to assess participants' satisfaction with their experience of participating in the weekly group. The survey consists of 4 items with a 10-point Likert scale asking participants to rate their satisfaction from 1 (*low or very bad*) to 10 (*high or very good*). The four items are: (1) To what extent did you feel heard and understood?; (2) To what degree did we work on the issues you wanted to work on?; (3) How well did the facilitators approach, the way they worked, make sense and fit for you?; and (4) Given your answers to these specific areas, how would you rate how things were in today's session overall? This scale has not yet been validated.

Key demographic variables (e.g., age, sex, mental health diagnosis and postcode) are collected prior to start of Week 1 (T0).

Qualitative guides

Focus group (T3): The focus group is undertaken 1-month post completion of the group and all participants who have consented to be involved in the research are invited to attend by the group facilitators, informing them that a researcher (SW) will guide the focus group. The location is the same as the place in which the group was run, so it is familiar to the participants. Participants complete the standardised measures and then the group is opened for focused discussion. The questions utilised to stimulate discussion are related to the participants' experience of participating in the Eclipse group, whether or not they have experienced suicidal thoughts in the period since or required outpatient or inpatient mental health care, how they have/have not used the tools they were taught in the group and whether they have changed their lifestyle since the program.

In-depth interview (T4): The in-depth interview is conducted at 6-month post the completion of the group, by the same researcher who conducted the focus group (SW) to continue rapport built at the focus group. Following completion of the standardised measures, the interview takes place. The interview script covers the following topics: Changes to mental health, changes to suicidal thinking including frequency, intrusiveness, and managing thoughts, types and frequency of accessing mental health services and managing life with/without suicidal thinking.

Data analysis:

Quantitative data

Repeated measures analysis of variance (ANOVA) will be used to examine the effectiveness of the program in terms of changes in the self-reported measures from baseline (T1) to immediate post-test (T2), to 1-month and 6-month follow-ups (T3, T4, respectively).

Qualitative data will be analysed using the thematic analysis process set out by Braun and Clark(20). Narrative theory will be used to focus the analysis on the ways in which individuals make meaning of their participation in the group(21) through the narratives they tell of their experience of the group and the meaning they give to suicide in the context of their lives. Two members of the research team (MM, SW) will review the transcripts separately, independently coding the emerging themes. The two coders will then meet and discuss emerging themes, the data will then be re-examined following this to cross-check any codes that are not agreed upon. Following this the coders will discuss the codes and how they fit with emerging themes and meet to discuss similar and divergent themes, until consensus is reached. Further, case study trajectories will be detailed for each participant incorporating both quantitative and qualitative data to examine the individual experience of participating in the Eclipse program.

Outcomes:

The primary outcome measure is reduction in suicidal ideation. Secondary outcome measures are reduced psychological distress and increased resilience and support identification and help seeking. We will examine changes in outcomes measures from all the participants across all the sites to follow individual trajectories to match their self-reported quantitative data with qualitative interview data. The qualitative data will provide deep, rich information to accompany the outcome measures. Further, we will examine weekly satisfaction ratings of the 8-sessions of the Eclipse group for all participants as well as map these data across all sites to better understand dose and/or facilitator effects. This will allow understanding of participants' responses to the intervention as well as any site differences to determine program fidelity.

Discussion:

The Eclipse group offers a non-clinical support for community residing individuals who have a history of suicide attempt, with specific psychoeducational content aimed at reducing suicide ideation, at the same time as increasing resilience and support identification and help seeking. The study also provides scope to review any practical or operational issues involved in implemententing and evaluating a non-clinical support group. There is current interest in alternatives to clinical care for people with a history of suicide attempt, especially in the context of limited services being unable to meet demand. However, it is important that any such program for vulnerable people be thoroughly evaluated to ensure that the key outcome of reducing suicide is met in addition to increasing resilience and identifying and utilising social and professional supports. There are strengths and limitations inherent in the scope and design of the evaluation. The strengths include a collaborative partnership with the national organisation funding the research and the site delivery of the program. This leads to the ability to customise data collection training and availability to discuss any issues as they arise. Further, the facilitators, who have a developed relationship introduce the researchers to the group participants at T3, 1-month post group, which assists with rapport development. However, this approach also leads to weaknesses, being that the facilitators of the group are responsible for collecting data at pre- and post- group, along with the weekly satisfaction scales. Thus, their ability to collect the data in a systematic way may be challenging to those who are unfamiliar with the needs of data quality.

List of abbreviations

ABS	Australian Bureau of Statistics
ANZCTR	Australian New Zealand Clinical Trials Registry
INQ-15	Interpersonal Needs Questionnaire
ISSS	Internal Session Satisfaction Scale
PHQ-9	Patient Health Questionnaire
SIDAS	Suicide Ideation Attributes Scale
SPRC	Suicide Prevention Resource Centre
SRCS	Suicide-Related Coping Scale
WT	Weekly topic within the Eclipse Group

Declarations

Ethics approval and consent to participate

The study has approval from the University of New England Human Research Ethics Committee (HE16-195).

Consent for publication

Not applicable

Availability of data and materials

The datasets used and/or analysed during the current study will be available from the corresponding author on reasonable request following publication of the outcome data.

Competing interests

The authors state that they have no competing interests

Funding

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Author contributions

MM conceptualised the design of the study with key personnel within the service provider and oversees the management of the project, TP conducted the literature search, TP retrieved the data from the literature, MM, SW and TP are responsible for collection of quantitative data, SW is responsible for collection of qualitative data. MM and SW are responsible for qualitative data analysis. MM and NB are responsible for quantitative data analysis. All authors contributed to the drafting of this protocol and have approved it for publication.

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