Scientific Research Publishing

Open Journal of Social Sciences, 2026, 14(8), 556-569
https://www.scirp.org/journal/jss
ISSN Online: 2327-5960
ISSN Print: 2327-5952

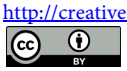
The Effects of Suicidal Ideation on Families

Kyle Van Duser[1*#], Emma Donaldson[1*], Dustin Wagner[2], Avonlea Ware[2]

[1]Pacific Analytics, Honolulu, USA
[2]Altior Healthcare, Los Angeles, USA
Email: [#]info@pacificanalytics.org

How to cite this paper: Van Duser, K., Donaldson, E., Wagner, D., & Ware, A. (2026). The Effects of Suicidal Ideation on Families. *Open Journal of Social Sciences, 14,* 556-569.
https://doi.org/10.4236/jss.2026.148032

Received: July 21, 2026
Accepted: August 18, 2026
Published: August 21, 2026



Abstract

This phenomenological qualitative study explored the lived experience of caregivers who had a child suffering from self-harm, suicidal ideation, or a suicide attempt. The study followed caregivers from their loved one's intake at a residential mental health treatment center to one-month post-discharge. Caregivers (n = 17) participated in interviews conducted at intake, discharge, and approximately one-month post-discharge. At intake, caregivers commonly described persistent fear and anxiety, financial strain, and a desire for greater peer support from others facing similar circumstances. Following discharge, caregivers reported perceived improvements in communication alongside ongoing concerns related to continuity of care. The findings highlight the importance of supporting caregivers not only during a young person's treatment but also during the transition back to the community.

Keywords

Suicidal Ideation, Caregivers, Residential Treatment, Family Systems Theory, Qualitative Research

1. Introduction

Suicide has risen to be the second leading cause of death for 15 to 24 year olds. Nearly 20% of highschoolers think about suicide and approximately 9% have made an actual attempt. The effects of suicide are far reaching. It is estimated that 115 people are exposed to a single suicide (Centers for Disease Control and Prevention, 2026; Cerel et al., 2016). As the author James Foley states "Drop a pebble in the water: just a splash, and it is gone; but there's a half a hundred ripples circling on and on and on".

[*]These authors contributed equally.
[#]Corresponding author.

Research has demonstrated that caregivers to those who engage in deliberate self-harm experience significant emotional challenges including decreased social support, poor communication within the family, and lower levels of overall well-being (Morgan et al., 2013). Further, stigma surrounding mental health makes it difficult for caregivers to receive necessary emotional support from friends and extended family (Rössler, 2016). Making matters more complicated, parental job loss or change in family's finances commonly result after children attempt self-harm or suicide. Buus et al. (2014) described parents' experiences after a son's or daughter's suicide attempt as a "double trauma", comprising the attempt itself and its subsequent psychosocial effects on family well-being. Given that most parents are not mental health professionals, they struggle with the skill set needed to navigate through the complexities of mental health (Pepperdine University, 2018). While there is existing literature exploring the initial impact of suicide attempts on caregivers and the family system, there is a gap when examining what happens over time. One of the aims of this research inquiry is to understand how the treatment process changes the family dynamic, if at all.

The purpose of this qualitative inquiry is to understand the lived experience of caregivers who have a child suffering from depression. More specifically, the effect suicidal ideation, self-harm, and suicide attempts have on caregivers. Further, this study seeks to understand the caregiver's experience from entry into a residential behavioral health facility through one month post discharge. Ultimately, the aim of the study is to help inform practice and provide a resource to future caregivers who have children struggling with suicidal ideation, self-harm, and suicide attempts.

1.1. Research Questions

This qualitative research inquiry sought to answer the following questions:

1) What is the lived experience of caregivers with children suffering from depression?

2) What was the lived experience of caregivers who sent their children to a residential treatment center?

3) What (if any) perception of change occurred after participation in treatment within the family dynamic?

1.2. Theoretical Framework

This research follows the framework of Murray Bowen's Family Systems Theory, also known as Bowen Theory (Bowen Center for the Study of the Family, 2024). As a key influence in the practice of counseling in North America, Family Systems Theory identifies a family as an interconnected emotional unit rather than a collection of individuals, where behavior is understood through relationship dynamics, roles, and patterns. Within Bowen theory, differentiation of self refers to the capacity to remain emotionally connected to others while maintaining reflective functioning and a stable sense of self during relational stress (Bowen Center for the Study of the Family, 2024). In this study, differentiation is used cautiously as

one possible interpretive lens rather than as a clinical judgment about caregivers. Fear and hypervigilance in the context of a child's acute suicide risk may be understandable, safety-oriented responses and should not be treated as evidence of pathology or deficient differentiation. In regard to the intergenerational transmission of problem behavior, this idea refers to the passing of problematic behavior (i.e., aggression, criminal tendencies, delinquency) from one generation to the next. This transmission is theorized to occur environmentally, such as through parenting, socioeconomic status, or stressors, and through genetic pathways, such as predisposition associated with genetic variation for aggressive behavior (Sentse et al., 2025).

2. Methodology

2.1. Design

This study employed a phenomenological qualitative design. The purpose of the phenomenological approach is to illuminate the specific, to identify phenomena through how they are perceived by the actors in a situation. In the human sphere this normally translates into gathering "deep" information and perceptions through inductive, qualitative methods such as interviews, discussions and participant observation, and representing it from the perspective of the research participant(s). Phenomenology is concerned with the study of experience from the perspective of the individual, "bracketing" taken-for-granted assumptions and usual ways of perceiving. Epistemologically, phenomenological approaches are based in a paradigm of personal knowledge and subjectivity, and emphasis the importance of personal perspective and interpretation. As such they are powerful for understanding subjective experience, gaining insights into people's motivations and actions, and cutting through the clutter of taken-for-granted assumptions and conventional wisdom. With this study, we are seeking to understand the lived experiences of parents with children suffering from depression. More specifically, the research inquiry sought to understand the effect suicidal ideation, self-harm, and suicide attempts had on caregivers.

2.2. Context of Research Site and Treatment Philosophy

The research transpired through a residential treatment center across their northern California and southern California facilities. The research site has over 200 active employees and provides teens, young adults and their families with meticulously thought-through, Joint Commission-accredited mental health treatment in safe, luxurious, residential settings. The research site serves individuals between the ages of 12 - 26 who experience moderate to severe mental health issues. The research site utilizes in-depth processes for assessment, treatment, and aftercare to best meet the unprecedented mental health concerns confronting today's youth. Utilizing a curated blend of traditional, evidence-based, and progressive therapeutic practices, the research site works closely with clients and their families to treat issues that include but are not limited to anxiety, depression, grief and loss, mood

disorders and trauma. The research site treats the socio-emotional underpinnings of behaviors rather than simply focusing on behaviors themselves. As such, the research site does not use point systems, phase systems or other punitive techniques. Rather, the research site approach focuses on the whole individual, and the unique needs of each client and family served. The research site prioritizes lasting efficacy as a cornerstone of its treatment philosophy, which empowers its young clients to build and hone the skills they need to lead meaningful, productive lives, long after they complete the treatment program.

2.3. Participants

A phenomenological framework requires a relatively homogenous group of participants (Creswell, 2007). The phenomenon being examined in this inquiry is the experience of parenting children suffering from depression. Purposeful sampling was utilized. Purpose sampling strategy involves the researcher selecting the participants purposively since they can understand the phenomenon; thus, the researcher can decide whether participants share significant and meaningful experience concerning the phenomenon under the investigation. In addition, criterion-based selection is commonly used as a sampling method. In this study, the common criteria were participation at the research site.

Upon admission to research site, caregivers were asked if they wanted to participate in a study examining the affect their loved one's struggle with mental health was having on them. Caregivers who opted to participate completed an informed consent document which outlined the purpose of the study and procedures. Caregivers were then provided with a scheduling link for the initial intake interview. In total, 17 caregivers participated in the study which represented 11 families. The initial design of the study sought to schedule an interview at intake, at discharge, and one-month post. However, due to scheduling issues, some interviews with participants N = 3, only transpired at intake and one month post discharge from the research site. In those instances, the discharge questions and one month post discharge questions were asked during the same meeting.

2.3.1. Participant Characteristics and Interview Completion

The 17 caregivers represented 11 families and included mothers and fathers. No other caregiver relationship was observed. The young people were aged 16 to 23 years old and were admitted with depression accompanied by suicidal ideation, self-harm, and/or a history of suicide attempts. All 17 caregivers completed an intake interview, however only 14 caregivers, 9 mothers and 5 fathers, completed separate discharge and one-month post-discharge interviews. The remaining three caregivers, 3 mothers, completed an intake interview and a combined interview one month after discharge, during which both the discharge and one-month questions were asked.

2.3.2. Analytic Unit

The family was the primary analytic unit (n = 11), rather than each caregiver being

treated as a fully independent case. When more than one caregiver from the same family participated, their interviews were retained as distinct perspectives during initial coding and then compared within a family-level case summary. Overlapping descriptions were treated as shared evidence about one family experience when themes were compared across families, while differences between caregivers were retained as divergent perspectives. Themes were therefore developed across the 11 family cases rather than by treating all 17 caregiver accounts as independent observations.

2.4. Data Collection

In this phenomenological study, the major data gathering method involved in-depth interviews with participants. The purpose of a phenomenological interview is to describe the meaning of a phenomenon that several individuals share (Marshall & Rossman, 2006). Frequently, in phenomenological studies, multiple interviews are conducted with each of the research participants (Creswell, 2007). Creswell (2007) suggested that three serial in-depth phenomenological interviews with each of the research participants should be appropriate to collect phenomenological data. As developed by Seidman, previous experience with the phenomenon of interest is assessed in the first interview while the following interview is based on the current experience. The third interview combines the information obtained from the previous two interviews to describe the individual essential experience with the phenomenon. Moustakas (1994) suggested that phenomenological interviews could start with a social conversation in order to create a relaxing and trusting atmosphere. Three interviews were scheduled with participants based on Seidmans framework for phenomenological design.

Interview Procedures

Kyle VanDuser, the study's lead researcher and an investigator with Pacific Analytics, conducted the interviews through HIPAA-compliant video conference software. As this study occurred during the tail-end of the pandemic, video conferencing was preferred by families. Interviews lasted approximately 45 minutes to 1 hour. With participant permission, interviews were recorded and transcribed verbatim through the video conferencing software. The transcripts were checked against the recordings. The three semi-structured interview guides were related but not identical. A common set of questions examined caregiver experiences and family relationships across time points; intake questions focused on experiences before admission, discharge questions focused on caregivers' perceived changes during residential treatment, and one-month questions focused on experiences after return home and whether perceived changes had continued, changed, or diminished. The same lead interviewer conducted the serial interviews whenever scheduling permitted.

2.5. Data Coding and Analysis

The study employed *in Vivo* coding, which uses words or short phrases from par-

ticipants' own language as codes (Saldaña, 2013), to preserve caregivers' phrasing and meanings. Kyle VanDuser conducted the initial coding, Emma Donaldson reviewed the coding, and the transcripts were double coded. Codes were compared within each family case, grouped into descriptive categories, and developed into candidate themes by examining recurrence across families, the meanings assigned by caregivers, and relevance to the research questions. Candidate themes were checked against the full interview transcripts and revised to ensure that each theme was internally coherent and distinct from the others. Disagreements and alternative interpretations were addressed through discussion, return to the relevant transcript passages, and retention of divergent caregiver accounts rather than forcing consensus. The final themes reflected patterns across family cases while preserving exceptions and contrasting perspectives.

2.6. Ensuring Credibility

Ensuring credibility is arguably one of the most important aspects of any research inquiry. Credibility helps build trustworthiness in the findings, which in turn, allows practitioners to utilize findings in professional practice (Merriam, 1998). This study drew upon member checking, peer examination, triangulation, iterative interviewing, as qualitative techniques to ensure the credibility in the findings (Lincoln et al., 2011). Peer examination involves sharing the study's design, process, and findings with fellow colleagues (Anney, 2014). The findings from the study were shared with the Therapists, Psychiatrists, staff, and leadership team within research site for peer review. Triangulation is the process whereby the researcher "uses different sources of data or research instruments, such as interviews, focus group discussion or participant observation, or that utilizes different informants to enhance the quality of the data from different source" (Anney, 2014). Client files, which included background and history of clients, therapists' notes, and standardized mental health assessments were referenced for triangulation.

Relationship with the Treatment Provider and Use of Records for Triangulation

Pacific Analytics was paid by the treatment provider to conduct the longitudinal outcomes study. The lead interviewer and primary research team were affiliated with Pacific Analytics, while two coauthors held leadership roles with the treatment provider and facilitated study implementation and participant coordination. To manage this relationship, provider-affiliated staff could offer factual or contextual feedback during peer examination but did not conduct primary coding or determine the final themes. The final publication decisions remained in a collaborative effort with the independent research team and treatment provider. Client files, therapist notes, and standardized mental health assessments were consulted only to verify chronology and contextualize interview accounts; they were not independently coded and did not contribute to code or theme development. Participants' written consent specifically authorized access to and use of these records

for triangulation.

2.7. Ethics Approval and Consent to Participate

The lead researcher consulted with Advarra, a private human subjects Institutional Review Board (IRB), to determine if the study needed formal oversight. All human-related procedures were performed in accordance with the Declaration of Helsinki and IRB ethics regulations. Using the Department of Health and Human Services (DHHS) regulations at 45 CFR 46, Advarra IRB determined that the research project did not meet the DHHS definition of human subjects research under 45 CFR 46 and, therefore, did not require IRB oversight. Specifically, data presented in the findings are for an undisclosed recovery program's institutional improvement, anonymized, and aggregated in a way that safeguards any personally identifiable information. While IRB oversight was not deemed a requirement, written consent was ascertained throughout the data collection process.

3. Results

The data coding and analysis yielded major themes across families. Findings are presented for intake and for the post-discharge period. Intake themes were a continuous state of fear and uncertainty, financial challenges, and a need for peer group support. Post-discharge themes were caregiver-perceived changes in communication and issues with continuity of care. Discharge and one-month observations are identified separately where the time point was documented. Because three caregivers received both sets of questions in one follow-up interview and the analysis did not treat the time points as fully separate datasets, the post-discharge findings should not be interpreted as evidence that treatment caused change or that perceived changes were sustained for all families. An explanation of each theme and support using *in vivo* quotes from research participants is provided in the ensuing paragraphs.

3.1. Intake Themes

3.1.1. Continuous State of Fear and Uncertainty

Caregivers expressed a continuous state of fear prior to their loved one entering residential treatment. In many ways, caregivers put their life on hold to help prevent their loved one from engaging in self harm or attempting to complete suicide. One father noted "*the lowest point for me is. Worry about whether my child is gonna be alive the next day that terrifies me… we carry that everyday… it's not sustainable*". Another caregiver stated, "*It is exhausting and terrible to think that this is going to be our daily existence*". Another caregiver stated "*It's a constant worry and it's so hard to just see her like that. It's depressing. It's heartbreaking.*" Another caregiver communicated how the stress had been ongoing. She stated: "*I lived in a state of just like high alert crisis and grief. For months and months and months, I mean, I think my whole, nervous system was affected by it, you know?*" Another caregiver stated: "*it's just super depressing. Because she pretty much*

wants to kill herself 24 hours a day and the only reason she hasn't is because we removed all of the things that she could use. So it's like I'm constantly on edge like every time that my phone rings or you know, I'm like Oh my God, what happened now?". Another caregiver stated "*Like I don't want to be alone like I used to love my alone time but now it's like I'm scared for my phone to ring… I'm just really anxious*".

3.1.2. Financial Challenges

The decision to have a loved one participate in a residential treatment center is a major financial cost for most families. The cost for 35 days of treatment at the research site is $65,000. For the families that can afford treatment, they see it as an investment, as stated by one parent, "*It's gonna be expensive, but money well spent.*" However, due to the cost, most families cannot afford residential treatment unless it is covered by insurance. Caregivers struggle with the anxiety of not knowing whether they will be able to keep their loved one in the program for the full recommended amount of time because of insurance coverage. One mother stated, "*…part of me feels like we did leave too early. But you know, insurance. They said that she completed the standard of care, right? But they* [*treatment center*] *did want the extension,*" the client referenced in the quote remained depressed with suicidal ideation after discharging from the program and later needed to re-admit back into residential treatment. Another parent stated that as her loved one was actively in the program, she had to wait on hearing back from her insurance company to know whether they could continue with care. "*I'm curious to know if insurance is denied and we can only pay for like* 3 *extra days. What will be done? What sort of plan will be put in place? …the thing I worry about the most is that we've only had two family therapy sessions when insurance said no more.*" Insurance gives authorizations frequently one week at a time, sometimes only days at a time. Caregivers are required to anxiously stand by while they wait to hear whether insurance will cover cost of care. This uncertainty creates additional financial hardship as clients and caregivers coming from out of state need to book flights, hotels, rental car, and take time off work to help facilitate the discharge process.

Financial challenges were not just associated with cost of treatment, but also traversed to employment issues due to care-taking responsibilities. Caregivers had to take extensive time off work or were forced to leave work entirely. One mother stated: "*I just didn't feel safe having her on her own, you know, so I haven't. I haven't worked full time since May because of this.*" In this instance, the mother had been intentionally unemployed for over six months to care for her daughter. Another caregiver stated "*we definitely have a lot less money*" in reference to needing to take his attention away from a small owned business to focus on his loved one.

3.1.3. Need for Peer Group Support

Another reoccurring theme among families was the importance of support from

other caregivers with a similar experience. Caregivers were concerned that their child's suicidal ideation and self-harm are so personal and potentially disturbing to hear that they are hesitant to disclose this to their typical support system. One father stated, "*Who do you tell and how much do you tell and how do you allow* [*client*] *to have her own story to tell*? *And is it more important that we feel support, or is it more important that* [*client*] *feel security based on knowing that mom and dad aren't, you know, just talking about her to help themselves.*"

3.2. Discharge and One-Month Post-Discharge Themes

3.2.1. Caregiver-Perceived Changes in Communication

At discharge and/or the one-month follow-up, caregivers who participated in family therapy and other clinician recommendations described perceived changes in how they communicated with their loved one. These accounts reflect caregivers' interpretations rather than a causal estimate of treatment effects. One mother reflected on her interactions with her daughter and stated:

"*I would just say we really opened up to each other and admitted some things that had been between us for a long time that neither one of us wanted to really like bring up and so obviously it creates intimacy and trust when you communicate. And I also think that like I really understand her more, and I think she understands me more and just some of the family dynamics. I think that we've backed off her a little bit. We used to be like, really on top of her with every day that she didn't go to school or didn't do her work or laid in bed. We just like given her some space and I think that makes her feel trusted and loved.*"

Caregivers also described feeling better able to respond to their child's suicidal ideation and impulses to self-harm. One mother attributed part of the perceived change in her approach to what she learned during family therapy. The mother stated:

"*She was five weeks self harm free and then she did have one minor incident of self harm recently… [my] reactions to self harm are different… how we address what was before to us very disturbing. You know her cutting. We learned a lot about how to handle that. I've learned questions not to ask sometimes by trial and error. definitely the reaction to self harm I mean… understanding it as an impulse but. UM. If she does it, I don't freak out, I just say like, OK, well let's make sure it's cleaned up and. We can talk about it later if you want to. I used to like. Try and pressure her to wear long sleeves to cover it up in certain situations, and now I'm just… I'm just trying to let her be the judge of that*"

Caregivers described perceived communication changes extending beyond conversations about self-harm and suicidal ideation to other aspects of the relationship. One father believed that reframing his responses from evaluative to more open and trust-focused made it easier for his daughter to discuss substance use. The father stated:

"*She went from this kind of withdrawn. I don't know type of response to, you know to be very responsive to maybe a little bit more probing… then she would*

open up and. You know, even I mean to for her to get the courage to tell us that she was having an alcohol problem. That wouldn't have happened before"

At the discharge time point, one mother began to cry while describing renewed hope for her future relationship with her daughter. This account represents an observation at discharge and does not, by itself, demonstrate that the perceived change was sustained one month later. The mother stated:

"*Tuesday, my phone rang and it was* [*Treatment Center*] *and I thought it was someone calling from the program and it was* [*my daughter*]*. Then she said. I love you mom. I know that I've been so mad at you, but I really appreciate you and I'm doing really well and you don't have to worry about me and everyone's really nice and I'm learning so much about myself*"

Some caregivers perceived broader changes in relationships within the family. The research site grounds its work with families on Dr. Thomas Gordon's Parent Effectiveness Training (PET) model and asks caregivers to read PET while their loved one is in residential care. Caregivers who read the book and participated in clinician-led training described perceived changes that extended beyond the relationship with the young person receiving treatment. One mother reflected:

"[*I'm*] *trying really hard to apply active listening the way that you know Thomas Gordon, I guess and PET describes it because it's different than how I used to think of active listening. I've seen the impact of that. With two of my daughters not just* [*loved one at treatment center*] *but our other daughters, when I didn't do it, and what result I got and when I did do it, what result I got. I see there being less tension, more mutual respect for one another. Better able to communicate how we feel rather than just kind of yelling and getting frustrated. And then I think something that I am hoping is to model growth in the area of accountability because I think I discovered through the PET classes that I'm really bad at.*"

3.2.2. Issues with Continuity of Care

A major theme that appeared across nearly all families was issues related to continuity of care. The caregivers in the study expressed their frustration with the insurance agencies hindering the continuity of care for their loved one. The caregivers felt it served as a negative contributing factor to their loved one's mental health. One father stated "*the lack of continuum of care which is not* [*Research Site's*] *fault. It's Kaiser's fault and has been really frustrating and challenging. It took us over* 2 *weeks to get anything*." Another caregiver expressed difficulties when there was a lapse in care for their loved one. Specifically, it took time for the caregiver to work with the insurance agency and secure a new psychiatrist and therapist after discharging from residential care. The caregiver stated: "*There were some challenging moments in there … for us as a family. And I think that's because it was a challenging time for* [*Client*], *and a little bit scary when we didn't have a new psychiatrist in place and a new therapist*". Another caregiver stated "*I really would have loved for* [*Client*] *to have been able to keep her therapist for a month… just as a transition*".

One caregiver requested there be a mandatory transitional program. The caregiver stated "*I think it should kind of be mandatory. Maybe like… this is the aftercare program and you stay in touch with. Your therapist once a week. Or you know* [*treatment center representative*] *twice a week in group… even if it's just for one or two weeks, so that when they transition home*". The research site does offer a continuation of care program via virtual counseling. However, this option is not viable for all clients given the cost is currently out of network for insurance companies and there are legal limitations for providing therapeutic services across state lines.

4. Discussion

Bowen theory may offer one tentative lens for interpreting the relational themes in these findings. Caregivers' fear and hypervigilance occurred in the context of acute suicide risk and may represent understandable efforts to maintain safety; these responses should not be pathologized or treated as direct evidence of an inability to differentiate self. From a family-systems perspective, the accounts may suggest that sustained crisis affected the emotional functioning of the family as a whole. Caregivers attributed perceived improvements in communication and family relationships to changes in the young person, family therapy, and participation in the residential program. However, the qualitative design cannot establish that treatment caused these changes. Caregivers described early hope and communication shifts at discharge, while the combined analysis of discharge and one-month data limits conclusions about whether those changes were sustained one month after discharge.

Well known American Psychologist and a founder of the humanistic approach, Carl Rogers, highlights how the client-therapist relationship is one of the most important aspects of therapy. Therapists must first begin to build a relationship with the client to help facilitate the process of psychological growth (Rogers et al., 1989). Individuals suffering from depression, and subsequent suicidal ideation, self-harm and suicide attempts are often required to bounce from one treatment stage to the next, frequently without continuity of clinicians to support them. After a suicide attempt for example, an individual will go from the emergency room to the psychiatric hospital. Stays in a psychiatric hospital last for a relatively short period of time; ranging from a few hours to several weeks. Depending on severity, individuals will then be discharged to a residential facility or Partial Hospitalization Program (PHP). While some hospitals do have a built in PHP program, many have to refer out. If residential is the recommendation, patients will go to a residential treatment center for anywhere from one to three months, sometimes longer. After residential, the trajectory branches further. At each stage, the individual suffering from depression must build new relationships with clinicians.

As evident from the findings, there are frequent lapses in care for loved ones struggling with their mental health. Not only are there lapses in care, but there are challenges with insurance covering the necessary costs for treatment. When costs

can't be picked up by insurance, the out-of-pocket costs can make receiving care near impossible. Even when families receive full insurance authorization or have readily available funds to cover the cost of care, there is still the issue of finding available space to match the level of care needed. In some rural parts of the country, appropriate treatment options are not readily available. From the caregiver's perspective, frequent breaks in care hinder the perceived progress of their loved one suffering from depression.

While the findings are limited in scope and generalizability due to the small sample, they raise attention to the current model of mental health treatment for individuals who experience suicidal ideation, active self-harm, and suicide attempts. The model of abrupt transition between the stages of treatment hinders the therapeutic progress made by individuals. As noted in the findings, it takes time to build the therapeutic relationship for psychological growth. Caregivers and clients alike request the ability to have continued access to their therapists. At each stage of care, clinicians have full caseloads of incoming and current clients. Clinicians are not able to continue seeing discharging clients. The current mental health model for treatment does not support the possibility of ongoing relationships between clients and clinicians.

Limitations

This qualitative inquiry has notable limitations. The study is bound by the research site. There is variability amongst residential treatment centers in their ability to help both clients and caregivers, treatment approach, and case load management. As such, the lived experiences of families going through treatment program are bound by the research site. Further, the study had a sample size of 17 and cannot be generalized to the millions of caregivers who have a loved one suffering from depression, and subsequent suicidal ideation, self-harm, and suicide attempts. Additionally, discharge and one-month interviews were not analyzed as fully separate datasets, and three caregivers received both sets of questions during one interview. The study therefore cannot determine whether perceived communication changes observed at discharge were sustained one month later for all families.

5. Conclusion

This qualitative study drew upon a phenomenological design to understand the lived experience of caregivers who have a child suffering from suicidal ideation, self-harm, and suicide attempts. Interviews served as the primary means of data collection. Interviews transpired at intake, discharge, and one month post discharge. In total, 17 caregivers participated in the study. Findings were separated between intake and post-discharge themes. Major themes that caregivers reported at intake included being in a constant state of fear and anxiety, financial challenges, and a need for peer group support. Post-discharge themes included caregiver-perceived changes in communication and issues with continuity of care. These findings reflect caregivers' perceptions; they do not establish that treatment

caused the reported changes or that perceived changes were sustained one month after discharge for every family.

Implications for Behavioral Health

This study does not call for an entire change to the mental health care model. Rather, it directly raises attention to the model itself and poses challenging questions. One question, is the current mental health model of hard transitions between treatment stages effective? How do we assess the effectiveness of the current model? Should the stages of treatment be a public service paid for through tax dollars, or, should it be privately run? As long as we continue to have deaths by suicide there will be a constant need to assess the effectiveness of the mental health treatment model.

Acknowledgements

We would like to acknowledge Paradigm Treatment for the support of this study, and the families that participated.

Ethics Statement

This study was reviewed by Advarra Institutional Review Board (IRB), which determined that the project does not meet the definition of human subjects research under 45 CFR 46 and therefore does not require IRB oversight. In accordance with this determination, the requirement for IRB review and approval was waived. All procedures were conducted in accordance with applicable ethical guidelines and regulations, including the Declaration of Helsinki.

Funding Statement

Pacific Analytics was paid by the treatment provider to conduct the longitudinal outcomes study. The provider supported study implementation and participant coordination. The independent research team retained responsibility for analysis and manuscript preparation.

Author Contributions

Kyle Van Duser designed the study, performed the interviews, and wrote up the findings; Emma Donaldson continued writing the findings and prepared the manuscript for publication; Dustin Wagner and Avonlea Ware oversaw the study implementation and coordinated with participants.

Data Availability

The anonymized data are available from the authors upon reasonable request.

Conflicts of Interest

Pacific Analytics, the firm with which Kyle VanDuser and Emma Donaldson were affiliated, received payment from the treatment provider to conduct the longitu-

dinal outcomes study. Dustin Wagner and Avonlea Ware held leadership roles with the treatment provider during the study. The authors report that the independent research team collaborated with the treatment provider for publication decisions.

References

Anney, V. N. (2014). Ensuring the Quality of the Findings of Qualitative Research: Looking at Trustworthiness Criteria. *Journal of Emerging Trends in Educational Research and Policy Studies, 5,* 272-281.

Bowen Center for the Study of the Family (2024). *Differentiation of Self.* https://www.thebowencenter.org/differentiation-of-self

Buus, N., Caspersen, J., Hansen, R., Stenager, E., & Fleischer, E. (2014). Experiences of Parents Whose Sons or Daughters Have (Had) Attempted Suicide. *Journal of Advanced Nursing, 70,* 823-832. https://doi.org/10.1111/jan.12243

Centers for Disease Control and Prevention (2026). *Suicide and Self-Inflicted Injury.* National Center for Health Statistics. https://www.cdc.gov/nchs/fastats/suicide.htm

Cerel, J., Maple, M., van de Venne, J., Moore, M., Flaherty, C., & Brown, M. (2016). Exposure to Suicide in the Community: Prevalence and Correlates in One U.S. State. *Public Health Reports®, 131,* 100-107. https://doi.org/10.1177/003335491613100116

Creswell, J. W. (2007). *Qualitative Inquiry and Research Design* (2nd ed.). SAGE Publications.

Lincoln, Y. S., Lynham, S. A., & Guba, E. G. (2011). Paradigmatic Controversies, Contradictions, and Emerging Confluences, Revisited. In N. K. Denzin, & Y. S. Lincoln (Eds.), *The SAGE Handbook of Qualitative Research* (4th ed., pp. 97-128). SAGE Publications.

Marshall, C., & Rossman, G. B. (2006). *Designing Qualitative Research* (4th ed.). SAGE Publications.

Merriam, S. B. (1998). *Qualitative Research and Case Study Applications in Education* (2nd ed.). Jossey-Bass.

Morgan, S., Rickard, E., Noone, M., Boylan, C., Carthy, A., Crowley, S. et al. (2013). Parents of Young People with Self-Harm or Suicidal Behaviour Who Seek Help—A Psychosocial Profile. *Child and Adolescent Psychiatry and Mental Health, 7,* Article No. 13. https://doi.org/10.1186/1753-2000-7-13

Moustakas, C. (1994). *Phenomenological Research Methods.* SAGE Publications, Inc. https://doi.org/10.4135/9781412995658

Pepperdine University (2018). *Navigating Family Life after a Suicide Attempt.* https://onlinegrad.pepperdine.edu/blog/family-life-teen-suicide-attempt/

Rogers, C. R., Kirschenbaum, H., & Henderson, V. L. (1989). *The Carl Rogers Reader.* Houghton Mifflin.

Rössler, W. (2016). The Stigma of Mental Disorders: A Millennia-Long History of Social Exclusion and Prejudices. *The EMBO Reports, 17,* 1250-1253. https://doi.org/10.15252/embr.201643041

Saldaña, J. (2013). *The Coding Manual for Qualitative Researchers* (2nd ed.). SAGE Publications.

Sentse, M., de Roo, M., & Kretschmer, T. (2025). Intergenerational Transmission of Problem Behavior: Genetic and Environmental Pathways. *Development and Psychopathology*, 1-10.