EARLY FAMILY ENVIRONMENT AND EMERGING ADULTS' SUICIDAL BEHAVIOURS: A CASE OF TWO SELECTED UNIVERSITIES IN NAIROBI COUNTY, KENYA.

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A DISSERTATION SUBMITTED TO GRADUATE SCHOOL IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR THE AWARD OF THE DEGREE OF DOCTOR OF PHILOSOPHY IN MARRIAGE AND FAMILY THERAPY

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Declaration

I declare that this dissertation is my original work and has not been presented for a degree to any other program in another university.

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Dedication

I dedicate this dissertation to my husband and friend, Rev. Stephen Mwangi Thuo, for cheering me on to pursue my dreams and fulfil God's purpose for my life.

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Abstract

This dissertation examined early family environments and related implications for emerging adults' suicidal behaviours. The principles of attachment theory, life course development and the Satir model guided the study. The study explored the prevalence and early family environments associated with suicidal behaviours among emerging adults aged 18–29 in selected universities. The psychological stressors compelling emerging adults to suicidal behaviours and the role of spirituality were useful constructs of this study. This study adopted a convergent mixed-methods design. Data was collected from two selected universities in Nairobi County. The study population comprised 431 undergraduate students and six university counsellors. Simple random, stratified and snowballing sampling techniques were applied in the sample selection. A pre-test was done on a sample of 30 undergraduate students at a selected university that was excluded from the study. Data was collected after obtaining relevant permits, informed consent and the confidentiality of participants was guarded. The data was concurrently collected using quantitative and qualitative methods. The data was concurrently analyzed. The quantitative data was analyzed using Statistical Package for Social Sciences (SPSS) version 27. The qualitative data was analyzed using NVIVO version 11. The relationship between the variables was established through Multivariate Statistical Analysis (MANOVA). The results were triangulated and presented using tables and figures. The results showed emerging adults were engaging in suicidal thinking (17%) and attempts (7.8%). Studying at a private university, living in hostels and living alone were risk factors for suicidal behaviours. Additionally, female students engaged in suicidal behaviours: thought dying was better than living ($t=13.0$, $p.004$); purchased items to end their lives ($t=4.2$, $p.043$); came close to taking away their lives ($t=8.8$, $p.002$) and engaged in cutting ($t=5.4$, $p.036$) as a form of self-harm. Family relations, chronic and mental illness, maltreatment and parental divorce before the age of 12 were risks for suicidal behaviours. Feelings of hopelessness, depression, anxiety and financial difficulties were the psychological stressors associated with suicidal behaviours in emerging adulthood. Religion was both a protective and a risk factor for suicidal behaviours. These findings will greatly inform marriage and family therapists' practises as they seek to prevent, mitigate and intervene for suicidal behaviours in emerging adulthood. Other stakeholders who will benefit from this study include parents, university administrators, counsellors and chaplains, religious organizations and mental health providers.

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Abbreviations and Acronyms

AAMFT	American Association of Marriage and Family Therapy
AIDS	Acquired Immune Deficiency Syndrome
COVID-19	Coronavirus
CUE	Commission of High Education
FES	Family Environment Scale
HIV	Human Immunodeficiency Virus
KU	Kenyatta University
MFT	Marriage and Family Therapy
NCISH	National Confidential Inquiry into Suicide and Homicide
NSSI-AT	Non-Suicidal Self-Injury Assessment Tool
PAC	Pan Africa Christian University
University	
PMFT	Doctor of Philosophy in Marriage and Family Therapy
SAFS-T	Suicide Assessment Five Steps Evaluation- Triage
SLESQ	Stressful Life Events Screening Questionnaires
SPSS	Statistical Package of Social Sciences
TFAR ORG	Trust for American Organization and Well Being Trust
UK	United Kingdom
UNICEF	United Nations Children's Fund
USA	United States of America
USIU-A	United States International University- Africa
WHO	World Health Organization

Operational Definition of Terms

The research operationalized the following terms as follows:

Early Family Environment

The childhood family atmosphere characterized by physical, emotional, relational, social, and spiritual settings that enable the family to function (Repetti et al., 2002; Omar et al., 2010). The study adopted the same terms.

Emerging Adults

Young adults aged between 18 - 29 pursuing undergraduate studies in the university (Arnett, 2000; Arnett et al., 2011; Arnett, 2018). The profile of emerging adults was described by changing family and sociocultural structures, increased technological use, and individuation from parental guidance. (Arnett et al., 2011; Ng & Jasmin, 2015; Frey, 2018). Emerging adults, according to this study, are young people aged 18-25 years-old.

Suicidal behaviours

Suicidal behaviours refer to self-directed violent thoughts and actions with and without intentions of dying, including; suicidal thinking, suicide plans and suicide attempts (Klnosky et al., 2016). Unintentional suicidal behaviours were self-directed violence intended to relieve emotional or mental pain without the intention of dying. Self-harming behaviours include cutting, piercing, and burning (Klnosky et al., 2016; O'Lounghlin et al., 2020). Both intentional and unintentional self-directed violence were referred to as suicidal behaviours.

Psychological Stressors

Psychological stressors refer to the events and experiences in an emerging adult's social and physical environment linked to psychological distress. They interfered with their ability to

function and cope effectively (Hirsch et al., 2019; LAbate, 2012; Monroe & Slavich, 2016). In the study, this term referred to events, experiences and responses compelling suicidal behaviours.

Chapter One

Introduction and Background of the Study

This chapter is an overview of the study that examined early family environments and emerging adults' suicidal behaviours in selected universities. It discusses the background of the study, the problem statement, the study objectives, and the significance of the study. Furthermore, the chapter describes the study's assumptions, scope, limitations and delimitations, and the chapter summary.

Introduction

Suicide is violence towards self with intentions of dying (Doan et al., 2012; Stone et al., 2017). Suicide is a culmination of serious behaviour patterns known as suicidal behaviours. Suicidal behaviours range from suicidal thoughts, plans, and attempts resulting in serious injuries or death (Klnosky et al., 2016). Self-harm is a suicidal behaviour that inflicts self-injury with no intents of dying. Self-harm involves cutting, piercing, picking fingers, pulling hair, breaking bones or burning to quickly release strong negative emotions (Klnosky et al., 2016; Mental Health Commission of Canada, 2018). Studies showed that self-harm was a strong predictor for later suicide (Kokkevi et al., 2012; O'Lounghlin et al., 2020). These suicidal behaviours have been a major public health concern accounting for serious injuries, death, negative psychological and social problems among emerging adults (Stone et al., 2017). Kenya was no exception (Nyamori, 2015; Wakesah, 2019; Wanyoike, 2015). Frequent reports of suicide deaths and injuries continue to be reported in Kenyan universities, both public and private.

Most research on suicidal behaviours was skewed towards children and adolescents (Geenl et al., 2014; Skinner & Mcfaull, 2012; Khasakhala et al., 2013; Ross et al., 2017; Sui, 2019). While suicide behaviours in childhood and adolescence are alarming, suicidal behaviours

are on the risen among emerging adults in universities. A study by Trust for American Well-being Trust (2019) reviewed studies from 2011 to 2016 that showed a 20% increase in suicide death among emerging adults. Consequently, suicide is the second cause of death and serious injuries among emerging adults aged 18 -29 years in university (Ayubi & Raju, 2020; Stone et al., 2017; World Health Organization [WHO] 2014; WHO 2016). Suicide is an outcome of progressive suicidal behaviours such as suicidal thinking, planning, attempting and self-harming. These suicidal behaviours were on the rise among emerging adults in the university (O'connor et al., 2018; Russell et al., 2019; Sivertsen et al., 2019). It was estimated that 1 in 10 emerging adult students struggled with suicidal thoughts, and one in nine have attempted suicide (Lageborn et al., 2017; Mortier et al., 2017). A suicidal attempt is the last step towards suicide; it is proceeded by suicidal thinking and planning. Studies observe that 48.8% of suicide attempters have prior suicidal thoughts and plans (Scocco et al., 2008). In addition, one in six emerging adults is engaging in self-harm. The tragedy was that emerging adults engaging in self-harm will attempt suicide two years after the first episode of self-harm (O'connor et al., 2018). Therefore, the need to examine the risks and protective factors for emerging adults in the universities. Suicidal behaviours: suicidal thinking, planning, attempts, and self-harm were the dependent variables in this study.

Emerging adulthood is a transitional period when adolescents are moving on to adulthood between the ages of 18 to 29 years (Arnett, 2000; Arnett, 2018; Frey, 2018; Ng & Jasmin, 2015). This is a transitional period where one is moving from being a child to being an adolescent, characterized by self-search, feeling "in-between", unsteady, self-focused and open to possibilities (Tanner & Arnett, 2016; Arnett, 2018). Emerging adults today belong to two generations; the millennials and Generation Z, whose upbringing has been characterized by

increased family and social changes like divorce or separation, women empowerment and career advancement, as well as an expanding and fast technological revolution (Debczak, 2019; Frey, 2018; Ng & Jasmin, 2015). Besides, emerging adults were raised in middle-class families living in culturally diverse communities. They are pursuing college or university education, are self-sufficient, relative values, optimistic and hold high expectations of themselves (Arnett et al., 2011; Ng & Jasmin, 2015).

Background of the Study

Emerging adults are faced with multiple transitions, such as; leaving home, decreasing parental guidance and supervision, adjusting to university life, managing opportunities and increasing access to many risky activities, and balancing the decisions related to career development and committing to starting a family (Carter & McGoldrick, 2005; Sivertsen et al., 2019). Transitional tasks are achieved when the emerging adult forms personal values, finds a career path, manages social pressure and academic demands (Salakangas et al., 2020). These competencies are achievable if emerging adults are equipped with life skills such as; expressiveness, self-regulation, problem-solving skills, conflict management, life purpose, and adaptability (Salakangas et al., 2020; Omar et al., 2010) taught in childhood through overt and covert family interactions.

The early family environment has been instrumental in preparing emerging adults to transition smoothly with the least harm into adulthood. They are the physical, emotional, relational, and social atmospheres in the family experienced during childhood and adolescence (Omar et al., 2010). A family is the natural environment responsible for grooming and nurturing healthy children and adolescents to become well-adjusted emerging adults (Al-Qudah, 2016). In her theory, Virginia Satir 1991, saw parent-child attachment, family atmosphere and experiences

as supportive in the formation of a person's worldview, self-expectations, other expectations, interpersonal and coping skills (Satir et al., 1991). Early family environments characterized by secure attachment, authoritative parenting, congruent communication patterns, positive modelling and increasing independence; are associated with healthy development throughout the lifespan (Al-Qudah, 2016; Omar et al., 2010).

On the contrary, exposure to adverse childhood experiences such as neglect, maltreatment, family conflict, divorce, physical, emotional and sexual abuse was associated with mental disorders and suicidal behaviours in emerging adulthood (Hartanto et al., 2020; Merrick et al., 2017; Pournaghash-Tehrani et al., 2018). The way early family experiences were managed shaped emerging adults' outlook on life, expectations, beliefs and responses to various situations encountered in university (Valdez et al., 2013). Thus, the early family environments must be examined to understand the specific features associated with emerging adults' suicidal behaviours. Therefore, the early family environment was the independent variable in this study. It constituted three features, namely: family relations, support for personal growth and childhood life stressors, that were examined to find out which ones were linked with emerging adults' suicidal behaviours.

Developing personal spirituality is a critical transitional task emerging adults are expected to achieve (McGoldrick et al., 2014). The process of forming spiritual identity begins at home as with identifying with the family spiritual identity that helps to socialize emerging adults toward a personal spiritual discovery or a lack of spiritual discovery (Bengtson et al., 2013). As a preventative factor, family spirituality provides constructive answers to existential questions generated by the prevailing experiences of the emerging adult (Koenig, 2012). These existential questions are related to the emerging adult's identity, the meaning of life, values of living, and

availability of social support during distress (Taliaferoo et al., 2010). Adherence to spirituality was associated with better mental health and a protective factor against suicidal behaviours among emerging adults (Lawrence et al., 2016; Nkansah-Amankra, 2013). Moreover, spirituality has been known to help people cope with life stress, recover from depression, abuse substance use, find social support and meaning for life (Cook, 2018). Research by Koenig (2012) reviewed the impact of spirituality on mental health and revealed a positive and significant relationship. Koenig concluded that spirituality might help emerging adults cope with adversity, support positive emotions, and generate hope, optimism, meaning, purpose, and positive self-esteem. Other studies that viewed spirituality as a protective factor noted that spirituality might help emerging adults against hopelessness, depression and suicidal behaviours (Cook, 2014; Talib & Abdullahi, 2017). On the contrary, other studies revealed spirituality as a risk factor for emerging adults' suicidal thinking, negative self-esteem, and depression (Koenig, 2012; Lawrence et al., 2016; Taliaferoo et al., 2010). Other studies on spirituality and suicidal behaviours among emerging adults presented spirituality as both a preventative and a risk factor for mental health problems and suicidal behaviours (Koenig, 2012; Lawrence et al., 2016). The role of spirituality on emerging adults' suicidal behaviours was a question for further inquiry.

Suicide is a global problem, with an estimated 800,000 people dying by suicide annually around the world (WHO, 2016). It has been a serious public health concern and one of the top five causes of death in emerging adulthood in many countries in the world (Palmer, 2011; Lewieckie & Miller, 2013; WHO, 2014; Mortier et al., 2018). For every suicide, numerous suicidal behaviours go unreported (Alabi et al., 2014). Nevertheless, suicidal behaviours might indicate a known or unknown mental illness; mental health is the fifth goal in the Millennium Development Goals needing international and political attention (WHO, 2008; Hambrey, 2017).

In addition, suicide prevention is the third goal in the health-related objectives in the sustainable development goals (Droogers et al., 2020). Although suicide prevention has been an international and political agenda (Pollock et al., 2020; Arensman et al., 2020), it requires the smallest unit of society, the family, to engage in meeting this goal (Hooven Et al., 2012; Edwards et al., 2021). Therefore, exploring the influence of early family environments on emerging adults' suicidal behaviour will provide evidence-based insights into how the family can significantly contribute to achieving these development goals. Suicide is the top two leading causes of death among emerging adults in Europe, America, Australia/Oceania and Asia (Asarnow & Ougrin, 2019). This means several suicidal behaviours such as; suicidal thinking, planning, and attempts were ongoing among this population. A study in the United States among university students on four college campuses showed a 13% lifetime prevalence of suicidal thoughts (Mortier et al., 2017).

A study in four universities in USA, Midwest, Northwest, and Canada revealed that thoughts of suicide among university students were higher in male students at (13%) than (10%) in female students (Mackenzie et al., 2011). Mortier and colleagues concluded that one in four university students in the United States and Canada reported depression symptoms, and one in 10 struggled with suicidal thinking. Another prevalence study in the United States of America revealed a prevalence of non-suicidal self-injury at 5,9%, while 2.7% engaged in non-suicidal self-injury five times or more (Klonsky, 2011). Still, Whitlock et al. (2013) study in eight Northwest and Midwest public and private Universities in the United States of America showed that self-harm was a "gateway" to suicidal thinking. They argued that engaging in self-harm more than twenty times was a risk of suicidal thinking.

Studies on suicide risk among university students in Europe revealed a twofold risk of suicide among undergraduate students compared to university graduates (Lageborn et al., 2017).

A study branded ongoing students' death by suicide between the first of January 1993 and the thirty-first of December 2011 revealed that 2.07% to 2.72% of male and 1.77% to 2.61% of female students had died by suicide (Lageborn et al., 2017). Lageborn et al. observed that more male students died by suicide than female students, a sign that they were engaged more in suicidal thinking, planning, and attempts. In another study by O'connor et al. (2018), among young adults ages 18 - 34 years in Scotland, a lifetime prevalence of suicide attempt and non-suicidal self-harm (NSSH) was 11.3% and 16.2%, respectively. O'connor et al. concluded that one in nine young adults attempted suicide, and one in six were engaged in non-suicidal self-harm. Besides, those engaged in non-suicidal self-harm were at risk of attempting suicide two years after the first non-suicidal self-harm episode (O'connor et al., 2018).

A study in China investigating the correlation between family environment and suicidal ideation among university students showed a 9.2% prevalence of suicidal ideation in this population (Zhai et al., 2015). Similar research in Turkey among university students reported that 15.1% of students experience lifetime suicidal thoughts. In addition, 28.2% of the students experience depressive symptoms and 33.1% battle with anxiety (Oyekcin et al., 2017). Another study on self-harm in two Turkey Universities reported a lifetime prevalence of 15.4% in self-harming behaviour among students (Toprak et al., 2011). A review of suicide in Middle Eastern Countries on suicide among Muslim females revealed that suicidal behaviours are common among 15 - 27 years old with a prevalence of 8.6% (Rezaeian, 2010). Iranian research among university students showed that 3.6% of female and 7.0 % of male students engaged in suicidal behaviours. Moreover, there was a 13% increase in suicidal behaviours during the summer (Motamedi et al., 2016).

Suicidal behaviour is a public health concern in Africa (Mars et al., 2014). A literature review of 53 countries in the continent of Africa found that only 16/53 countries had suicide rates data and 7/53 countries' suicidal attempt data (Mars et al., 2014). Africa studies on suicidal behaviours in the continent focused on children and adolescents. At the same time, the majority of mental health practitioners relied on studies from Europe, North America and Australia to understand the risk and protective factors of suicidal behaviours (Mars et al., 2014; Rukundo et al., 2018; Quarshie et al., 2020).

Two systemic review studies on suicidal behaviours in Sub-Saharan Africa from 1950 - 2018 revealed increased suicidal behaviours among young people aged 10 – 25 (Rukundo et al., 2018; Quarshie et al., 2020). The prevalence rates for suicidal behaviours in Sub-Saharan Africa were 10.3% median lifetime, 16.9% median six-months and 3.2% median one-month prevalence (Quarshie et al., 2020). Quarshie et al. argued that countries in the Western Sub-Saharan African region had the highest rates of suicidal behaviour in a 12-month median of 24.3%. In addition, Quarshie et al. (2020) noted that none of the studies they reviewed reported protective factors against self-harm. Further studies in Sub-Saharan Africa have revealed that victims of bullying are at risk of engaging in suicidal ideation, and having supportive relationships can mitigate this risk (Eze et al., 2021).

A study involving five countries in Sub-Saharan Africa ranked countries based on their prevalence rates of suicide behaviours among adolescents (Palmier, 2011). Palmier revealed that Zambia had the highest suicidal behaviour rate of 31.9%, followed by Kenya at 27.9%, then Botswana at 23.1%, Uganda at 19.6% and the lowest rates were recorded in Tanzania at 11.2%. Although Palmier’s study involved adolescents, similar studies in Africa among university students showed increased suicidal behaviours alongside mental disorders (Bentajes et al., 2019;

Korb & Plattner, 2014; Wanyoike, 2015; Abdu et al., 2020; Owusu-Ansah et al., 2020). A study in South Africa of 1,402 first-year students in two universities revealed that 38.5% of students had a lifetime of common mental disorders (Bantjes et al., 2019). The common mental disorders were: major depressive disorders accounting for 24.7%, and generalized anxiety disorders, at 20.8% (Bantjes et al., 2019). Through a prospective study, Cluver et al. (2015) examined suicidal ideation, planning and attempts against adverse childhood experiences (ACEs) among children and adolescents in South Africa. Cluver et al. revealed that the risk of suicidal behaviours increases with children with more than five ACEs. The comparative prevalence for children and adolescents with no ACEs and those with five and above were: suicidal ideation from 4.2% with no ACEs to 15.6%; suicidal planning from 2.4% to 12.5% and suicidal attempt from 1.9% to 6.3% (Cluver et al., 2015). A Botswanan study of university students showed that 47.5% of students experienced suicidal ideation, and 28.7% attempted suicide (Korb & Plattner, 2014). Both depression and anxiety disorders were positively associated with suicidal behaviours among university students (Korb & Plattner, 2014; Bantjes et al., 2019). In Ghana, Owusu-Ansah et al. (2020) examined the prevalence, risks and preventative factors for suicidal behaviours among university students. Their study revealed that 24.3% of university students experienced death wishes, 15.2% struggled with suicidal ideation, 6.8% planned suicide, and 6.3% attempted suicide (Owusu-Ansah et al., 2020).

A similar study on suicidal behaviours in Ethiopia among university students revealed a worrying lifetime trend where 58.3% suffered suicidal ideation, 37.3% planned suicide, and 4.4% attempted suicide (Abdu et al., 2020). Furthermore, female students were at a higher risk of suicidal ideation, especially those with poor social support, a family history of suicide, who use alcohol, who live in rural areas and who engage less in religious practices (Abdu et al., 2020).

Although these studies illustrated an increase in suicidal behaviours among emerging adults, studies in Africa examined more the influence the early family environment plays for them to arise. Additionally, there was a need for a study using a mixed methods approach in order to obtain lived experiences from students and an expert consensus from the university counsellors.

In Kenya, it is estimated that 1408 people die of suicide annually (Wakesah & Kigongo, 2019). Young people aged 15 – 29 are more likely to die by suicide (Wakesah & Kigongo, 2019). A study among adolescents aged 16-18 showed that adolescents with two or more psychiatric disorders were more likely to engage in suicidal behaviours than adolescents with one or no psychiatric disorder (Khasakhala et al., 2013). Granted that Khasakhala et al. study focused on adolescents, it was unclear if these behaviours were carried into emerging adulthood as the individuals continued on the psychiatric treatment. A study by Wanyoike (2015) in six Kenyan Universities examined 'causes, implications, and interventions for suicide among undergraduate university students' it observed five common causes of suicide in the population. These causes were depression at 39%, hopelessness at 30%, Anger at 15%, loneliness at 10% and conflict at 6% (Wanyoike, 2015). Wanyoike's study surveyed the immediate factors in the undergraduate's life that led them to suicide. It alluded to the thought that early family environment, too, had some contribution, although none was recorded.

Diaspora reports revealed an increase in suicidal death among Kenyans abroad (Wanjohi, 2019; Ramadhan, 2020). One such report showed that Kenyan Students studying in the United States of America had a surge in suicidal deaths from 2014 to 2019 (Wanjohi, 2019). According to Wanjohi, an estimated three out of five deaths by suicide in the USA resulted from either domestic violence or suicide. He added that having a family while going to college and having a career were risk factors for suicide among Kenyans living in the diaspora. Although these

emerging adults were far from home, the diaspora and local reports showed similar narratives where students are unable to deal with emerging adults' transitional challenges (Ramadhan, 2020; Wanjohi, 2019; Owiti, 2019; Nyamori, 2015; "Campus Suicides"). Therefore, further studies in the Kenyan context were vital in understanding what feature in the early family environment was predisposing emerging adults locally and in the diaspora to suicidal behaviour.

In addition, local discourses on online, print, and visual media cited increased suicide among university students (Wakesah & Kigongo, 2019; Nyamori, 2015; Owiti, 2019; Wanjohi, 2019; "Campus Suicides"). One print media reported four suicides, three of which involved 4th-year male undergraduate students from three universities in Kenya (Nyamori, 2015). There were similar reports on Standard Digital on 26th October 2018, "Campus Suicides: Over 20 Students have ended their lives, mostly due to love", where three out of the six students whose year of study was known, three were fourth-year students, two were second-year students, and one was a fifth-year student. Another media interview highlighted several reasons university students engaged in suicidal behaviours, such as intimate relationship problems, academic pressures such as missing marks, university demands and personal financial difficulties (Wanjohi, 2019; Owiti, 2019; Nyamori, 2015; "Campus Suicides"). In addition, family problems such as the loss of parents, triangulation in parents' marital conflicts, and family financial stress drove students to suicidal behaviours (Owiti, 2019; "Campus Suicides"). While these were informal inquiries, they resounded the need to examine the conceptual relationship between early family environment and emerging adults'suicidal behaviours among university students in Kenya.

There was a need to understand the psychological distressors emerging adults were facing during this transitional period compelling them to suicidal behaviours (Drapeau et al., 2012; Monroe & Salvich, 2016; Lengvenyte et al., 2019). These stressors were viewed as mediating

factors that were directly linked to suicidal behaviours among emerging adults in the university. Mental illness symptoms (Mortier et al., 2017; Tucker et al., 2015; Wanyoike, 2015), university stressors (Abi-Joaude et al., 2020; Lageborn et al., 2017; Mortier et al., 2017) and poor problem-solving skills (Hannon et al., 2013; Oconnor et al., 2018; Katz et al., 2013; Sher et al., 2018; O'connor & Nock, 2014; Barzilay & Apetr, 2014) to the psychological stressors have been directly linked to suicidal behaviours in this population. Similarly, this period helps them establish personal religious and spiritual identity, develop values, beliefs and make life an essential feature for positive adjustment (Barry & Abo-Zena, 2014). This happened because spirituality provides tools for coping, social support, hope and self-worth, equipping emerging adults to face their transitional challenges (Lawrence et al., 2016; Koenig, 2012). However, spirituality has been seen as a risk factor for suicidal behaviours, low self-worth and depressive symptoms in emerging adults (Koenig, 2012; Taliaferoo et al., 2010). Thus, it was paramount to explore what makes spirituality a protective or a risk factor for suicidal behaviours among emerging adults (Barry & Abo-Zena, 2014; Nelson & Padilla-Walker, 2013). This was crucial for enlightening stakeholders on the preventive and intervention measures to support emerging adults' suicidal behaviour during their university years.

Most early family environments and suicidal behaviours studies focused on children and adolescents (Geenl et al., 2014; Skinner & Mcfaull, 2012; Khasakhala et al., 2013; Ross et al., 2017; Sui, 2019). This study sought to fill this gap by providing data on suicidal behaviours among emerging adults. Despite the availability of these studies and reports on suicidal behaviours among emerging adults, suicidal deaths are on the rise (Lageborn et al., 2017; Asarnow & Ougrin, 2019; Lewieckie & Miller, 2013; Moritier et al., 2018); with several undocumented suicidal thoughts, plans, attempts and self-harm (Townsend, 2014). Going by this

trend, many emerging adults in universities are at risk of death by suicide if a solution is not forthcoming. There is a need to expand the scope of inquiry to examine the familial risk, and protective factors are needed (Zhai et al., 2015). The early family factor has not been empirically factored into the Kenya situation. This was the gap this study set out to fill by examining the effects of early family environment on emerging adults' suicidal behaviours. In addition, reviewed studies on early family environments and suicidal behaviours among emerging adults were conducted in America, Europe and Australia (Mars et al., 2014; Rukundo et al., 2018; Quarshie et al., 2020). The generalizability of these studies is in question due to the contextual differences. This study sought to fill this gap.

Statement of the Problem

Globally, suicidal behaviours among emerging adults have been a tremendous public health concern (Russell et al., 2019; Bernardi et al., 2016; Townsend, 2014). In the USA, approximately 1,100 university students die by suicide each year (Wilcox et al., 2010). Another study in USA and Canada revealed that one in four students have depression symptoms and one in ten students struggle with suicidal thoughts (Mackenzie et al., 2011). In Europe, one in nine university students attempted suicide, and one in six students self-harmed (O'connor et al., 2018). A recommendation based on a Chinese study by Zhia et al. (2015) was the need to extend this study to explore family-related risks and protective factors of suicidal behaviours.

In Africa, studies on suicide in Ghana, Bostwana, Ethiopia and South Africa revealed that university students were engaged in suicidal behaviours (Abdu et al., 2020; Owusu-Ansah et al., 2020; Korb & Plattner, 2014). These studies revealed an increase in suicidal behaviours, thus calling for more studies to understand the role of the early family in emerging adults' suicidal behaviours (Abdu et al., 2020). Although these studies reveal the state of suicidal behaviours

among emerging adults in the African continent is much bigger that the current studies. More studies are needed to compare regional risk and protective factors because of contextual similarities.

In Kenya, a study by Nyangwencha and Ojuade (2022) revealed that suicidal behaviours among university students in Kenya recorded 29.7% in suicidal thinking, 48.5% in suicidal planning and 13.8% in suicidal attempts. This was confirmed by previous media that reported an increase in suicidal death among university students (Wanjohi, 2019; Owiti, 2019; Nyamori, 2015; "Campus Suicides"). These media reports mentioned cases of suicidal behaviours in the two institutions (Owiti, 2019; Nyamori, 2015; "Campus Suicides"), pointing to the need to explore suicidal behaviours in these universities.

Suicidal behaviours in the site locations continue to be experienced. Although the statistics are not officially documented, suicidal thinking, planning, attempts, and self-harm are ways emerging adults have responded to stressful events. In one semester, USIU-A lost four students (two males and two females) to suicide. At Kenyatta University, rarely does an academic year end without reported incidences of suicidal deaths. This excludes the many failed suicidal attempts, suicidal planning, suicidal thinking and self-harming behaviours.

The Purpose of the Study

This study aimed to investigate the influence of early family environment on emerging adults' suicidal behaviours among university students in Kenya. The study will contribute to an increase in the knowledge of the prevalence, underlying psychological distresses, the role of spirituality and systemic interventions for suicidal behaviours among emerging adults.

Research Objectives

The main objective of this study was to explore the role of early family environment suicidal behaviours among emerging adult students in selected universities in Kenya.

Specific Objectives

The specific objectives of this study were to:

1. Examine the prevalence of suicidal behaviours among emerging adults in selected universities in Nairobi County, Kenya.
2. Investigate the features of early family environment linked to suicidal behaviours emerging in adult students in selected Kenyan universities in Nairobi County, Kenya.
3. Determine the psychological stressors compelling emerging adults to suicidal behaviours among university students in selected universities in Nairobi County, Kenya.
4. Explore the role of spirituality on emerging adults' suicidal behaviours among university students in selected universities in Nairobi County, Kenya.

Research Questions

By focusing on the above objectives, the study answered the following questions: first, what are the prevalence rates of suicidal behaviours among emerging adults in the universities in Nairobi County, Kenya? Second, which features in the early family environment influence emerging adults towards suicidal behaviours in selected universities in Nairobi County, Kenya? Third, what are the psychological stressors compelling emerging adults to suicidal behaviours in selected universities in Nairobi County, Kenya? Four, how does spirituality determine the engagement in suicidal behaviours among emerging adults in selected universities in Nairobi County, Kenya?

Assumptions of the Study

This study was founded on the assumption that: first, the prevalence of suicidal behaviours among emerging adults in the university was on the increase in Kenya. This was confirmed in the study in which emerging adults were engaged 17.1% in suicidal thinking, 7.8% in suicidal attempt, 5.9% in suicidal plans and 5.5% in self-harm. In addition, more female students engaged in suicidal behaviours than male students, while private university students engaged more in suicidal behaviours than those in public universities. Second, the early family environments influenced emerging adults' suicidal behaviours among university students in Kenya. This was confirmed to be true, with family relations being most influential in suicidal behaviour, followed by stressful life events before age 12.

Third, the underlying psychological stressors led emerging adults in the universities to engage in suicidal behaviours. This was confirmed in the study that current family structure and parenting style were psychological stressors compelling emerging adults to suicidal behaviours. Other psychological stressors associated with suicidal behaviours among emerging adults are hopelessness, feeling depressed and feeling anxious. Emerging adults' responses to psychological stressors like avoiding, blaming others for their distress and believing others can solve one's problem are associated with suicidal behaviours.

Four, spirituality played a role in determining emerging adults' suicidal behaviours. This was confirmed to be true in this study, where the presence of some spiritual aspects was a protective factor, and the absence of some spiritual aspects was a risk factor against suicidal behaviours. Aspects of spirituality that were protective factors for emerging adults' suicidal behaviours were: a) viewing self as a spiritual being, b) viewing self as a lovable person, c) being hopeful of a bright future and d) believing one is essential in the universe. Whereas feeling

unloved, unaccepted, invalidated and feeling life was meaningless were risk factors for suicidal behaviours among emerging adults.

Justification of the Study

The alarming rates of suicide behaviours among emerging adults globally and locally required an empirical evaluation in emerging adulthood to help explain the causes, risks and protective factors. This study was urgent in an attempt to engage inter-disciplinary participation in the prevention and intervention of emerging adults' suicidal behaviours in Kenya. Most of the knowledge involving the early family environment and suicidal behaviours among emerging adults was based on studies carried out in the U.S.A., Europe and Asia (Zhai et al., 2015; Quarshie et al., 2020). Even though early family environments are culturally determined by socio-cultural reasons like race, ethnicity, gender, education, social class, and political, religious and spiritual values (McGoldrick et al., 2014; Zhai et al., 2015). Hence the need to examine the influence of early family environment on emerging adults' suicidal behaviours in the Kenyan socio-cultural context. The results will be helpful with interventions at national, community and family levels application. This study was critical because it has shed light on the prevalence of suicidal behaviours, the early family environment linked to suicidal behaviours, and underlying psychological stressors as leading to suicidal behaviours in emerging adults. In addition, this study has revealed the spiritual determinants for engaging and not engaging in suicidal behaviours among emerging adults in Kenya.

Significance of the Study

This study has provided empirical evidence and knowledge and created awareness of the role of early family environment in suicidal behaviours among emerging adults in Kenya. These findings will benefit parents and guardians, marriage and family therapists and religious leaders

with vital knowledge to help them address parenting and family relationship risks for younger children and emerging adulthood. The family has been central in preparing children to be healthy and responsible citizens. It will ensure that children grow up biologically, mentally, psychologically and socially healthy through nurturing family relationships and environment (Valdez et al., 2013). This find offers other stakeholders like the government, child department services, tertiary institutions, religious institutions, and the general public the bases to establish structures that support healthy families in the quest to develop mentally healthy adults.

In addition, the study offers clinical knowledge for marriage and family therapists, psychologists, psychotherapists, and counsellors. It will help them to prevent and assess suicidal behaviours and self-harm systemically. Furthermore, the knowledge generated from this study provides additional bases for considering a biopsychosocial approach in treatment with families and emerging adults presenting suicidal behaviours. This study informs the treatment models to apply in supporting individuals and families within a clinical setting. This research adds to the existing literature and provides bases for future research in this population.

Scope of the Study

This study was carried out among emerging adults aged 18 to 26 years-old in two selected universities in Nairobi County. As revealed in numerous studies, emerging adults are at risk of suicide by death. Emerging adults are the backbone of a society's family, work force, religious institution and nation (Bachman et al., 2013). A risk to their lives and a risk to the health and stability of a nation and generations to come. The rationale for conducting the study in the universities was that most emerging adults are pursuing education in the universities (Arnett, 2018). Consequently, Lageborn et al. (2017) pointed out that ongoing university education was a risk factor for emerging adults compared to their peers not pursuing education. The participants

involved undergraduate students from the United States International University- Africa (USIU-A) and Kenyatta University (KU) main campus. The number of universities selected was informed by previous studies on the population, emerging adults and suicidal behaviours. Many researchers conducted such studies in one university (Korb & Platter, 2014; Howel & Miller-Graff, 2014; Filipkowsk et al., 2016; Walt, 2016, Bantjes et al., 2019; Abdu et al., 2020). Still, others conducted such a study in two universities (Topraks et al., 2011; Becker et al., 2018; Wang et al., 2019; Ogachi et al., 2019). Three studies stratified the university into public and private (Lew et al., 2019; Sivertsen et al., 2019; Whitlock et al., 2013).

According to EduRank (2023), Kenyatta University (KU) is a public university with a student population of 45,000 students. At the same time, United States International University-Africa (USIU-A) is a private university with a student population of 6,152. The two universities representing the largest universities share several characteristics; they have a large student population in their categories, are close to the city of Nairobi, are sort after, and have diversity in the students' socio-economics. In addition, six university counsellors working in the universities were interviewed. This number of university counsellors was informed by the Delphi study design. According to Keeney et al. (2011), there is disagreement on the number of field experts to be employed in a Delphi study. However, based on previous studies, at least six to twelve experts are sufficient to provide reasonable consensus on specific issues (Jordan et al., 2018; Rossi et al., 2021; Scarpazza et al., 2023). The key participants were male and female students in different years of study and taking various undergraduate degree programs.

The dependent variables covered all four suicidal behaviours; suicidal thinking, planning, attempts and self-harm. This is because suicidal behaviours rarely take place in isolation, but they are a progression of self-violence, thus the need to study them together (Klnosky et al.,

2016). The independent variables were: family relations, personal support and stressful childhood events. These were the best-fitted features to examine the quality of the early family environments which shape the psychological healthy and personal resilience of emerging adults (Bergel et al., 2011; Valdez et al., 2013; White et al., 2019; Szkody et al., 2020).

Limitations and Delimitations of the Study

The research focused on emerging adults in the university pursing the first degree, thus limiting the generalizability of the study to children, adolescents, and emerging adults in colleges and outside the university. However, the study delimited itself to capture the children and adolescent factors associated with suicidal behaviours through the early family environments. While capturing the psychological stressors among university students provides a checklist to compare with future studies on suicidal behaviours among college students or emerging adults outside institutions of learning.

This study used a self-administered survey questionnaire. Surveys capture participants' attitudes, beliefs and experiences concerning the study objectives. This method is limited because it obtained subjective responses; surveys are good at describing a problem of study in a clear and contextually relevant way. To overcome the subjectivity of the participants, the researcher delimited the study by use of a mixed methods design in the data collection, analysis and presentation to reduce the chances of subjective responses.

Another limitation of this study was that it was impossible to screen for participants with mental illness symptoms which are strongly associated with suicidal behaviours. The researcher delimited the mental illness symptoms by capturing them as mediating variables. This provided an opportunity to see their association between the dependent and independent variables while

leaving room to identify other psychologically compelling emerging adults to suicidal behaviours.

This study was limited to two selected universities in Nairobi County, Kasarani Constituency. The study delimited itself to this geographic scope because the two universities are within the Nairobi metropolis, which is cosmopolitan, attracting students from across the nation. Furthermore, the study delimited itself to focus on answering the research questions and providing an all-inclusive geographical picture of suicidal behaviours in the universities.

Chapter Summary

This chapter was an overview of the research background and reasons for the study. It discussed research questions and the knowledge gap the researcher sought to fill by conducting the study. The chapter emphasized the significance of the in light of the stakeholders' benefit from the study. Finally, this chapter spelt out the study location and participants involved.

Chapter Two

Literature Review

This chapter reviewed the research work done by other scholars on the early family environment and emerging adults' suicidal behaviours. It discussed the study's theoretical alignments, conceptual framework and operationalized the study terms. The literature will be reviewed in line with the study objectives. A summary of the chapter will be included.

Theoretical Review

A theoretical framework guides the researcher to objectively and tentatively explain the study problem for study (Adom et al., 2018). This study was anchored on three integrated family therapy theories founded on system theory. The theories are Life Course Development Theory, Attachment Theory and the Satir Model. System theory was based on the work of biologist Ludwig Von Bertalanffy (1901 -1972), who viewed an individual's life in light of the larger family. Systems theory sees a family as a group organized around a chain of command that maintains homeostasis and balance by modifying changes in their setting (Gladdings, 2015). The family unit is upheld through repetitive, stable or unstable communication patterns among members (Smith-Acuna, 2011; Dallos & Draper, 2015). The family is complexly attached and reliant on each other to meet individual and shared needs for optimum growth and development (Dallos & Draper, 2015). In addition, system theorists argued that family relations created and sustained behaviours and mental disorders among family members (Dallos & Draper, 2015). Therefore, mental and behaviour disorders were moulded as family members' related, coped with problems, and premeditated on future goals (McGoldrick et al., 2014). Meaning suicidal behaviours among emerging adults were significantly linked to early family interaction and how

families handled experiences and problems. The three systems theories in this study were fundamental as they collectively contributed to answering the study objectives.

Life Course Development Theory

Life course developmental frameworks are a combination of theories that enable family therapists and sociologists to understand the family structure and relationships over time (Boss et al., 1993). The first application of the life course development theory was by Rowntree (1899-1901), a social reformer and industrialist, in 1901 in a study on poverty in the family (Boss et al., 1993). Rowntree's family life course theory provided a framework to study families based on: a person's age, the family progress or generational time, and the life course or trajectory (White et al., 2019; Boss et al., 1993; Burton-Jeangros et al., 2015). The life course perspectives were merged in the 1980s in the quest to examine chronic diseases in family trajectories and transitions (Burton-Jeansgros et al., 2015). Other theorists like Cater and McGlorick (2005) identified six family life cycles that examined a person's development across the lifespan within the family system, their changes through expected transitions, and the influenced later life (Berge et al., 2011; McGoldrick et al., 2014; White et al., 2019, p. 138). According to the life course development framework, changes and life events pressed families to adapt roles and emotional relationships to allow for shifting responsibilities, closeness and organization (White et al., 2019).

On the contrary, lack of alteration and modification to these changes resulted in behavioural and mental disorders in a family member (McGoldrick et al., 2014). Arnett (2000; 2004) developed the emerging adult theory (Tanner & Arnett, 2016), which shed light on the first stage in Cater and McGoldrick's (2005) family life cycle development theory. The Emerging adult theory was developed by Arnett (2000). He defined emerging adulthood as a

stage of emotional and personal stressors experienced by individuals aged 18 – 25 in their 'college years' as they transitioned from adolescence to adulthood (Arnett, 2000; Tanner & Arnett, 2016; Arnett, 2018). According to this theory, the characteristics of an emerging adult are one searching for distinctiveness, suffering unsteadiness, absorbed in self-growth, a sense midway adolescence and adulthood and having an expectation of a life with multiple pathways (Arnett et al. 2011, p. 13). The demands at this stage of life required early preparation in the early family environment and continued support to help individuals gain competences and coping skills (Valdez et al., 2013). This study reviewed the concepts and implications of families with young children and adolescents and their influence on this life course developmental stage on the emerging adult stage.

Life Course Development Concepts. ***Family Structure and Norms.*** The life course development perspective views families as constantly changing in structure and connections, calling for modification in the interaction between family members (White et al., 2019). Changes through exits as in divorce, separation, death, moving into university, and entries like in birth, marriage, remarriage or being an emerging adult; call for family restructuring (McGoldrick et al., 2014; White et al., 2019; Goldenberg et al., 2017). Family members were defined within the membership structure around their sociocultural factors, responsive and interactive patterns (McGoldrick et al., 2014). Although each family member has unique physical, emotional, and mental needs, they belong to an organized structure; with socially assigned spots, rules, and roles (White et al., 2019; McGoldrick et al., 2014). All family positions are socially defined based on one's gender, marital status, association, and generational relations through roles such as father, mother, son, daughter, brother, sister, husband, wife and extended relatives (White et al., 2019; McGoldrick et al., 2014). These positions determine one's roles and norms in the family based

on the age and stage in the life course of development (White et al., 2019). Changes in the family structure during childhood, like separation, divorce and remarriage, death, and abuse, have negative physical, cognitive and social-emotional health and development outcomes in emerging adulthood and beyond (White et al., 2019; Goldenberg et al., 2017). These changes bring about new structures in addition to the existing ones, including step-parents, step-children, step-extended family, ex-spouses and ex-extend family that impact connections, interactions, and communication (Goldenberg et al., 2017). Changes in the family structure in childhood affect attachment formation, communication and the ability to meet children's needs (McGoldrick et al., 2014). Thus changes in family structure in childhood and a family's inability to manage this change positively risks developing an emerging adult unsure of self and incapable of navigating this transitional stage.

In addition, families with emerging adults need to change their norms to allow for more collaboration, freedom and responsibilities to foster the evolving adult (McGoldrick et al., 2014; Goldenberg et al., 2017). Emerging adulthood is an expected transition period in the family life cycle where the family must reorganize themselves to support their children aged 18 - 29 to enter adulthood (Arnett, 2000, 2011; 2016; 2018). This transitional stage requires the family to restructure emerging adults' roles, expectations, conduct and relations with family members; to allow for greater independence and connectedness (Valdez et al., 2013; Arnett, 2018). Adjusting family norms, increased independence, connectedness and the assigned roles and interactions challenging them towards growing up (Valdez et al., 2013). Furthermore, this stage challenged emerging adults to apply past coping skills learnt in childhood as the family managed different changes and challenges (Valdez et al., 2013). Thus, families that lost their structure, connection, cohesion and childcare roles during stressful; nurture children with impaired identity, little

coping skills and low self-regulation (Goldenberg et al., 2017; Valdez et al., 2013; Lengvenyte et al., 2019) evident by suicidal behaviour in emerging adulthood.

Family Changes and Development. Change is normal and expected in an individual's and family life (McGoldrick et al., 2014; White et al., 2019). Goldenberg et al. (2017) noted that some families experienced change differently; some families experienced change systematically, slowly, and nonstop while others experienced abrupt, troublesome and disjointed change. These changes resulted from normal life transitions or tragic events during the family developmental cycle (McGoldrick et al., 2014; Goldenberg et al., 2017; White et al., 2019). The emerging adults grew up in the early family and social changes such as an increase in divorce or separation, absent parents, culturally diverse communities and advanced technology and access to social media (Debczak, 2019; Frey, 2018, Ng & Jasmin, 2015; Sooryamoorthy & Makhoba, 2016; Anyanwu et al., 2020). Healthy families found ways of accepting and adjusting to change without compromising the family or the member's needs (McGoldrick et al., 2014; Valdez et al., 2013), especially the children. Such families adjusted to the changes by rearranging family communication patterns and roles and meeting children's needs (Valdez et al., 2013).

Regardless of the source of change, families needed to adjust and cooperate to keep the family steady and unceasing (Goldenberg et al., 2017). The inability to adapt to family changes results in a lack of mastery in individual and family development tasks, resulting in chaos, abuse, neglect, mental illness, and suicidal behaviours along the family life cycle (Goldenberg et al., 2017). Adjustment means repelling disruptions by; sustaining a secure parent-child relationship, equipping children with positive self-view, self-regulation, and nurturing resilience in the face of challenges (see, Bergel et al., 2011; Valdez et al., 2013; White et al., 2019; Szkody et al., 2020). Joining university is a significant transition for emerging adults, which tests the ability of the

individual and family to adjust to change (McGoldrick et al., 2014). Emerging adults whose families accepted challenges, dealt with challenges, sought help and remained connected were better equipped to transition to college (Bergel et al., 2011; Valdez et al., 2013; White et al., 2019; Szkody et al., 2020). They, too, sought support, used their spiritual resources and adjusted emotionally and socially to non-aggressive solve problems solutions that do not include suicidal behaviours (Valdez et al., 2013; White et al., 2019). Unfortunately, families that discontinued, disconnected and failed to address conflict develop emerging adults (White et al., 2019; Walsh, 2016). These emerging adults could not deal with the challenges of this transitional stage; therefore, they engaged in suicidal behaviours.

Family Life Cycles. Family life cycles are the shared progressive life stages expected in every family (Goldenberg et al., 2017). These cycles are predictable series of events and periods when the family experiences significant shifts in the family composition and members' autonomy (White et al., 2019; Goldenberg et al., 2017). Carter and McGlorick (2005) proposed six normal family life cycles: the single young adults leaving home; the new couple joining family through marriage; families with young children; families with adolescents, launching children and moving on; and families in later life (Berge et al., 2011). Families experience these periods and events smoothly as a unit or roughly as a divided household (McGoldrick et al., 2014). Ideally, individuals are at the centre of the periods and events that define the family life cycle. However, the entire family is expected to emotionally transition to allow for its member's developmental continuity (Carter & McGoldrick, 2005; McGoldrick et al., 2014). That means the failure of families to transition emotionally might result in behaviour and mental disorders in the family members at the centre of the period and events (McGoldrick et al., 2014). This was true, especially for emerging adults whose transitional periods are accompanied by intense

adjustments and demands at the university (Valdez et al., 2013). Families that responded appropriately to emerging adults' childhood needs were seen as secure and trustworthy to assist them with emerging adulthood challenges (Valdez et al., 2013; McGoldrick et al., 2014). Such families might reduce the risk of emerging adults' suicidal behaviours.

Emerging adulthood is considered the first family life cycle stage involving a family member leaving home to pursue education and work (Cater & McGoldrick, 2005; McGoldrick et al., 2014). The primary developmental task for the emerging adult was to be emotionally, financially and spiritually independent from the family of origin (McGoldrick et al., 2014). Although emerging adults need independence, they need family support to; differentiate from their family of origin, form intimate peer relationships, establish self-respect at work, become financially independent, belong in society and advance spirituality (Cater & McGoldrick, 2005; Goldenberg et al., 2017; McGoldrick et al., 2014). The success of the emerging adulthood transition depended on achieving the tasks in the previous family life cycles (Goldenberg et al., 2017; McGoldrick et al., 2014). These previous achievements support self-efficacy, resilience and coping skills for further challenges (Goldenberg et al., 2017). Hence, families are supposed to assist emerging adults in achieving life cycle tasks (McGoldrick et al., 2014). Families that hurriedly disconnected or were overly involved in emerging adults' lives put them at risk of not achieving their developmental tasks (Goldenberg et al., 2017; McGoldrick et al., 2014). An example, Smith-Acunas (2011) noted that family life cycle alterations were associated with eating disorders. Therefore, failure to smoothly transition children into adulthood could lead to suicidal behaviours.

Stressful Life Events. Stressful events are predictable and unpredictable life encounters that bring about psychological stress to individuals and their families (McGoldrick et al., 2014).

These events were divided into vertical and horizontal stressors (White et al., 2019; McGoldrick et al., 2016). Vertical stressors were historical events related to the family's biological, genetic, cultural, religious, psychological and relational disputes (McGoldrick et al., 2016). At the same time, the horizontal stressors were associated with events outside the family influence, such as; life cycle transitions, historical or economic or political events, and tragedies like death, trauma, accidents, chronic illness, unemployment, migration and natural disasters (Cater & McGoldrick, 2005; McGoldrick et al., 2016). Emerging adulthood is a stage of the development cycle associated with intense stress and limited coping skills to handle these stressors (McGoldrick et al., 2014). Over time, coping with prevailing stressors depends on personal, family, community and socio-cultural life events (Cater & McGoldrick, 2005; McGoldrick et al., 2014). Emerging adults with more than one vertical and horizontal childhood stressful event were at risk for depression, anxiety, and suicidal behaviours (Pournaghash-Tehrani, 2019). Therefore, emerging adults with unresolved childhood stressful events were at risk of suicidal behaviours.

Unresolved childhood stressful events were a risk for suicidal behaviours among emerging adults (Merrick et al., 2017; Pournaghash et al., 2018; Hartanto et al., 2020). This was because unresolved stressful life events in childhood linger on and were expressed in emerging adults as they try to adjust and cope with prevailing issues (Valdez et al., 2013). Several factors might determine the degree to which unresolved childhood stressful life events impact emerging adults (White et al., 2019). These factors included the age, frequency, and sequence of these events (White et al., 2019). White et al. observed that the chronological age of a family member during these stressful life events affected their cognitive abilities, coping and adjustment. For instance, the death of a parent and sexual abuse in early childhood had a more significant, longer and more negative impact on emerging adulthood if these events remained misunderstood and

unaddressed (White et al., 2019). Besides, the greater the number of adverse childhood experiences or stressful childhood life events, the greater the risk of suicidal thinking in emerging adulthood (Wang et al., 2019). This is because family stress in childhood inhibits cognitive growth, lowers self-esteem, impairs emotional regulation, causes interpersonal shortfalls and predisposes emerging adults to amplified stress levels (Brodsky, 2016; Johnston et al., 2017; Karatekin, 2018; Duprey et at., 2019; Wong et al., 2019). In addition, people born and brought up around the same time experience similar formative experiences and have a shared collective identity for the rest of life (McGoldrick et al., 2016; White et al., 2019). Since emerging adults grew up in similar social changes, their family structure, multiple stressful life events, technological advancement and communication, they share an outlook on life and problem-solving (White et al., 2019). Thus, the increase in suicidal behaviours among emerging adults when faced with overwhelming demands. They lack adequate coping and problem-solving skills to deal with prevailing stresses in emerging adults.

Family Resilience. The nature of stressful life events was that they affected all family members and emotionally destabilized the family functioning, and emerging adults were not exempt (McGoldrick et al., 2014). Healthy families used individual and family resources to deal positively with stressful life events to build resilience and cope (White et al., 2019). Walsh (2016) and Goldenberg et al. (2017) observed that family resilience was rooted in the system's ability to resist stressful events, thrive, remain stable, and function well physically and psychologically despite these events. Walsh (2016) argued that resilient families had strong interpersonal ties, were flexible, responsive, and kept few unresolved conflicts or secrets. Families that helped each other to find balance and worked on stressful life events had emerging

adults build resilience (Walsh, 2016; Goldenberg et al., 2017). In short, resilient emerging adults were firm, malleable, sought help and solved problems in non-suicidal ways (Walsh, 2016).

On the contrary, emerging adults nurtured in vulnerable families were unsteady, strict, and withdrew when faced with stress, thus resulting in suicidal behaviours (Walsh, 2016; Goldenberg et al., 2017). The early family environment is responsible for training children to be resilient when faced with expected and unexpected stressors (Walsh, 2016). Resilience lessons were learnt through family relationships and the family environment during stressful childhood events (Walsh, 2016). McGoldrick et al. (2014) noted that healthy early family environments nurtured their members to; form a positive self-view, safety, individuality, acceptance, belonging, flexibility, renewal and personal principles. Besides, families that continued to engage in supportive relationships with emerging adults nurtured resilience as they transitioned into adulthood (McGoldrick et al., 2014). Goldenberg et al. (2017) argued that families developed resilience in emerging adults when they: a) related competently and caringly, b) engaged cognitively and self-regulated, c) supported a formation of positive self-view, d) and motivated effectively regardless of the situation. Furthermore, resilient families intentionally equipped emerging adults to a) cultivate a positive belief system, b) stay flexible with life's changes, c) develop problem-solving skills, and d) be congruent communicators (Goldenberg et al., 2017). In conclusion, the family life course development framework viewed individual and family resilience as a critical preventative factor for suicidal behaviours among emerging adults.

Life Course Development and Suicidal Behaviours

The life course development framework saw an individual's psychological problems as developing and being maintained by past experiences and interactions in the family (McGoldrick et al., 2016). Therefore, suicidal behaviours among emerging adults were signs that emerging

adults were ill-equipped to resolve problems and remain functional (Goldenberg et al., 2019). Nevertheless, families were responsible for nurturing physically and psychologically healthy emerging adults through secure relationships and a stable family environment (Al-Qudah, 2016). While many factors contributed to suicidal behaviours among emerging adults, a negative early family environment was at the top of the list (Purnaghash- Tehrani et al., 2019). Thus, numerous studies on suicidal behaviour among emerging adults listed factors such as early family relations, parenting styles, unresolved conflicts, poor adjustment to developmental transitions, multiple family secrets, losses, child abuse, maltreatment and neglect as significant risk factors (see. Brodsky, 2016; Goldernberg et al., 2017; Al-Qudah, 2016; Purnaghash- (Tehrani et al., 2019; Salokangas et al., 2019). Iyer et al. (2023) confirm that families supporting adolescents' self-esteem and remaining connected were protective factors against mental health outcomes in emerging adulthood.

Additionally, positive early family environments nurtured confident and resilient emerging adults to constructively cope with future life challenges (Al-Qudah, 2016; Walsh, 2016). These families assisted emerging adults in processing disappointments, painful experiences, losses, family secrets, and conflicts constructively (Walsh, 2016). Walsh echoed hopeful early family environments to equip emerging adults to accept life changes, find the meaning of life in distress, and use helpful intergenerational resources to generate hope for a better future. These coping skills enabled emerging adults to adapt, solve problems and remain resilient, thus preventing them from suicidal behaviours (Hartanto et al., 2020). So, a positive early family environment was a protective factor against suicidal behaviours among emerging adults (Zhai et al., 2015; Nguyen et al., 2020). Emerging adults were groomed to be confident,

flexible, congruent communicators who coped and solved problems instead of engaging in self-violent activities.

Strengths and Shortfalls of Life Course Development Theory

This theory provided an understanding of the early family environment in relation to emerging adults' suicidal behaviours. It provided clear tasks the emerging adults ought to accomplish in order to adjust to emerging adulthood, such as developing a personal spiritual and morality are key tasks at this stage (Cater & McGoldrick, 2005; Goldenberg et al., 2017; McGoldrick et al., 2014). The theory showed the association between childhood stressful live events and suicidal behaviours later in life (Brodsky, 2016; Johnston et al., 2017; Karatekin, 2018; Duprey et al., 2019; Wong et al., 2019). However, this theory failed to provide literature associating suicidal behaviours among emerging adults and possible clinical interventions based on the theory.

Attachment Theory

Attachment theories are grounded on Sigmund Freud's psychoanalysis theory that John Bowlby associated adult behaviour with childhood experiences (Miniati et al., 2017). According to Miniati et al., John Bowlby's (1907-1990) developed the attachment theory arguing that human behaviour forms the attachment between parent-child through daily interactions with each other. Bowlby defined attachment as the biological-universal drive that monitors the caregiver's location and pursues proximity for safety or survival during distress and danger (Miniati et al., 2017). Bowlby's work was advanced by Mary Ainsworth (1913 -1999), who conducted various experimental studies on child-mother attachment (Marrone, 2014, p. 64). The caregiver's responses shaped the children's physical and internal security, influencing their personality development, social connection, emotional stability, adult relationships and psychopathology

(Johnson, 2008; Cassidy et al., 2014; Miniati et al., 2017). Based on Bowlby's work, a person's sense of safety, social acceptance and well-being are grounded on the quality of the relationship established in childhood with the primary attachment figures (Kruglanski & Higgins, 2007; Cassidy et al., 2014). Therefore, emotional instability among emerging adults in the university was traced back to their relationships with the primary attachment figures.

According to Bowlby (1977 & 1988), a secure base was the heart of the attachment theory (Cassidy et al., 2014). Attachment theory was a way to make meaning of the intense human emotional bonds with others (Marrone, 2014). It explains much emotional distress and personal disturbances such as; anger, emotional detachment, anxiety, depression, anxiety and suicidal behaviours (Cassidy et al., 2014; Marrone, 2014). A secure base was established when the attachment figure was available, sensitive, responsive to children's needs, nurtured confidence, and their freedom to explore the environment (Cassidy et al., 2014). Such caregivers nurtured emotionally healthy children, supported them in exploring the world and acted as a safe haven in distress (Cassidy et al., 2014). Through childhood experiences, emerging adults learnt to seek emotional support in distress from the primary attachment figures (Cassidy et al., 2014; Kruglanski et al., 2007). For instance, if the attachment figure is available, caring, and responsive, the child may develop secure cognitive scripts associated with the positive response from the attachment figure (Cassidy et al., 2014; Marrone, 2014). Thus the child may feel secure to confidently and safely return to explore the environment until the subsequent distress (Marrone, 2014). Kruglanski et al. (2007) claimed that parents were secure attachment figures if they: a) remained close in times of need and resisted separation, b) provided a safe haven for comfort, protection, support, relief, and c) were secure bases allowing children to pursue non-attachment goals in a safe environment. So, emerging adults with secure attachment figures in

childhood were better equipped to navigate life's challenges associated with emerging adulthood (Cassidy et al., 2014; Marrone, 2014), such as establishing intimate relationships, developing a career, and pursuing personal spirituality.

Attachment Theory Concepts. ***Primary Attachment Styles.*** Primary attachment styles are the basic bonding patterns between caregivers and children (Marrone, 2014). There are four primary attachment patterns observed between caregivers and children: a) secure, b) avoidant, c) ambivalent, and d) disorganized (see. Stepp et al., 2008; Davaji et al., 2010; Marrone, 2014; Miniati et al., 2017).

Insecure Attachment Styles. Three out of the four patterns of attachment are insecure, that is, avoidant, ambivalent and disorganized/fearful-avoidant attachment styles (Davaji et al., 2010; Marrone, 2014; Miniati et al., 2017). These insecure attachment patterns were associated with emotional distress and psychological problems (Davaji et al., 2010; Marrone, 2014; Miniati et al., 2017). The insecure attachment was linked to negative self-concept due to insufficient bonding and inconsistent responsiveness of the primary attachment figures (Marrone, 2014; Miniati et al., 2017). A caregiver who primarily used the avoidant attachment style tended to be dismissive, emotionally distant and unresponsive (Miniati et al., 2017). Such caregivers developed an emerging adult who became avoidant, uncomfortable with close relationships and overly independent (Stepp et al., 2008; Davaji et al., 2010).

On the other hand, ambivalent emerging adults who grew up under caregivers who sometimes were sensitive and responsive; other times, they were insensitive and neglectful (Miniati et al., 2017; Davaji et al., 2010). These caregivers establish inconsistent bonds with the children. Such an emerging adult strongly desired close relationships but feared abandonment (Davaji et al., 2010; Miniati et al., 2017). While disorganized or fearful-avoidant caregivers were

seen as extremely erratic, abusive, inconsistent and fear-breeding towards their children (Davaji et al., 2010; Miniati et al., 2017). They reared psychologically inconsistent emerging adults who are insecure with trusting others and at risk of relationship and mental health problems (Marron, 2014).

Secure Attachment Style. A securely attached caregiver nurtures a healthy, emotionally secure emerging adult (Miniati et al., 2017). Securely attached caregivers were close, helpful, approachable, and dependable to children (Stepp et al., 2008; Davaji et al., 2010; Miniati et al., 2017). Davaji et al. (2010) claimed that securely attachment caregivers allowed children to learn regulation and progress from past stressful life events. As a result, a securely attached emerging adult enjoyed close relationships with peers, sought help and depended on them in times of need without fear of abandonment (Miniati et al., 2017). On the contrary, insecurely attachment caregivers; shaped emerging adults who formed avoidant, ambivalent, and disorganized or fearful-avoidant attachment styles, predisposing them towards suicidal behaviours (Stepp et al., 2008; Davaji et al., 2010; Marrone, 2014; Miniati et al., 2017). Insecurely attached emerging adults had low self-regulation, difficulties connecting with peers, seeking help and relying on others for support in distress. Instead, they turned to suicidal behaviours to resolve the distress.

Attachment Theory and Suicidal Behaviours

Studies on attachment styles and suicidal behaviours revealed a significant relationship between attachment styles and suicidal activities among emerging adults (Cuenca, 2013; Miniati et al., 2017; Goodman et al., 2018; Green et al., 2021). For instance, insecure attachment styles were linked to emotional and mental disorders like personality disorders, depression, anxiety, eating disorders, dysfunctional relationships, hopelessness, self-harm and suicidal behaviours (Kruglanski et al., 2007; Kasomo, 2013; Mathews et al., 2016; Miniati et al., 2017; Goodman et

al., 2018; Green et al., 2021). Miniati et al. (2017) revealed that insecurely attached undergraduate students who were anxiously attached and had unresolved traumas were at a higher risk of suicidal behaviours. Furthermore, students with a history of suicidal behaviours were associated with family instability and low degrees of individuation from parents (Miniati et al., 2017). Therefore, insecurely attached caregivers and unresolved childhood traumas were breeding grounds for suicidal behaviours among emerging adulthood.

Further studies confirmed that insecure attachment styles were associated with suicidal thinking and suicide attempts (Stepp et al., 2008; Davaji et al., 2010; Goodman et al., 2018). For example, Mandal and Zalewska (2012) observed that the avoidant attachment style alongside an early family environment with; child abuse, death, suicide, domestic violence and rejection were risk factors for a suicide attempt. Nevertheless, securely attached emerging adults recorded lower levels of depression, anxiety, feelings of inadequacy, substance use, antisocial and aggressive behaviours, and risky sexual behaviours (Davaji et al., 2010). The reason was that emerging adults have an increased capacity to manage pain, maintain close relations and seek help when in need (Mathews et al., 2016). Therefore, a childhood history of secure attachment enables emerging adults to work through negative emotions that might rob them of a chance to build and maintain a healthy self-image, close relationships, and problem-solving skills vital to mental health. At the same time, a childhood history of insecure attachment styles compelled emerging adults to turn to suicidal behaviours to resolve or relieve mental pain.

Strengths and Shortfalls of Attachment Theory.

Attachment theory showed strong literature associated with suicidal behaviours and emerging adults' suicidal behaviours (Davaji et al., 2010; Goodman et al., 2018; Mandal & Zalewska, 2012). This theory links early family environment with later behaviour, mental health

and relationship problems (Cassidy et al., 2014; Marrone, 2014). However, it was not able to integrate the place of spirituality in emerging adulthood. Additionally, there were no clear guidelines for the prevention of suicidal behaviours among emerging adults.

Satir Model Theory

The Satir model was built on Virginia Satir's (1916 -1988) clinical work with families. (Satir et al., 1991; Koca, 2017; Mclendon & Miller, 2010). It was founded on a combination of psychodynamic and humanistic concepts, providing positive and empowering views of human beings (see. Koca, 2017; Mclendon & Miller, 2010; Corey, 2017, p. 408; Sommers-Flanagan & Sommers-Flanagan, 2015, p. 425). Satir contended that people possess resources, choices, and the ability to grow and change. She added that the ingredients for change were increased awareness, acceptance and resolving the unfinished business (Satir et al., 1991; Gehart & Tuttle, 2003; Goldenberg et al., 2017; Sommer-Flanagan & Sommer-Flanagan, 2015; Corey, 2017). So, individuals and families can change dysfunctional patterns by becoming more vulnerable, elastic and develop nourishing connections (Satir et al., 1991; Sommer-Flanagan & Sommer-Flanagan, 2015; Corey, 2017). Emerging adults seem to lack self-awareness, acceptance of realities and repress unfinished issues (Gehart & Tuttle, 2003; Goldenberg et al., 2017). These dysfunctional operation patterns developed in childhood and impaired emerging adults' ability to adjust to changing environments (Corey, 2017; Goldenberg et al., 2017). As a result, emerging adults became closed up, rigid and lacked meaningful relationships to support them towards psychological well-being.

Satir Model Concepts. The Satir model of therapy has several concepts that help to understand human behaviours, personalities, problem conceptualization, and clinical interventions. These concepts include a) the primary survival triad, b) the body, mind, and

feelings, c) communication, d) self-worth, e) personal iceberg, f) survival stances, and g) hope (Satir et al., 1991; Goldenberg et al., 2017).

Primary Survival Triad. Satir et al. (1991) argued that the family shapes children's worldviews based on parent-child interaction, also known as the primary survival triad. This relationship was the foundation of social interaction, gratifying relationships, self-worth and value for others (Goldenberg et al., 2017). Parents or parental figures shape children's identity by participating, approving, punishing, and the expectations placed on the child (Corey, 2017). In addition, the primary survival triad was responsible for nurturing a child's communication stances applied in stressful situations (Gehart & Tuttle, 2003). In short, self-image and communication perspectives evident in emerging adulthood were cultivated in childhood through parent-child interaction (Satir et al., 1991; Goldenberg et al., 2017). Hence, suicidal behaviours among emerging adults result from a collection of thoughts, feelings and expectations developed from one's experiences through interactions with parents or parental figures.

Body, Mind and Feelings. In the Satir Model, the body, mind, and feelings represent how people communicate and interact verbally and nonverbally (Goldenberg et al., 2017). The body helps the mind to express feelings through physical behaviours (Gehart & Tuttle, 2003; Goldenberg et al., 2017). Behaviour, thoughts, and feelings were core components of the Satir iceberg, identified as the body, mind and feelings (Gehart & Tuttle, 2003; Sommer-Flanagan & Sommer-Flanagan, 2015). Suicidal behaviours were bodily activities expressing one's thoughts and feelings that emerging adults were unaware of and unaccepted (Allen et al., 2022).

Communication. The body, mind and feelings were communication channels encompassing one's behaviour, body movements, use of organs and words (Satir et al., 1991). People use incongruent or congruent communication patterns. Incongruent communication

patterns were verbal and nonverbal discrepancies responsible for the dysfunctional interpersonal transaction in distress (Baldwin, 2013; Gehart & Tuttle, 2003). Satir et al. (1991) claimed that incongruence was resolved by embracing congruent communication, increasing the awareness of self, others and the context. Thus responding genuinely to the mind, body and feelings in light of self, others, and the context. Baldwin (2013) identified congruent communication as being open in sharing thoughts, truthful emotions, and actions. Such individuals aligned their words, meaning and actions (Baldwin, 2013). Emerging adults displayed incongruence evident in social media, where they posted happy photographs while struggling with painful thoughts and emotions. No wonder families, peers and lecturers could not reconcile if an exultant emerging adult engaged in suicidal behaviours.

Self-Esteem. Self-worth or self-esteem was seen as one's opinion of a personal value obtained from internal judgment and social interactions (Gehart & Tuttle, 2003; Sommer-Flanagan & Sommer-Flanagan, 2015). Individuals with high self-esteem expressed self-compassion, which assists them in accepting both personal strengths and weaknesses (Gehart, 2010). Satir et al. (1991) view self-worth as the key to one's feelings and behaviours. Satir argued that individuals with low self-esteem embraced negative beliefs about themselves and risked developing suicidal behaviours. On the contrary, a person with high self-esteem responds to maturity, creativity, lovely, and self-respect even after making mistakes (Loeschene, 1991; Baldwin, 2013; Gehart & Tuttle, 2003; Sommer-Flanagan & Sommer-Flanagan, 2015). Hence, emerging adults with low self-esteem were prone to suicidal behaviours because they held negative beliefs about themselves, causing them to act in ways that were uncompassionate, unloving and lacked creativity in solving prevailing problems.

Personal Iceberg. Satir's model applied the iceberg metaphor to explain observable and subtle human behaviours (Gehart, 2017; Capuzzi & Stauffer, 2021). The personal iceberg connects individual thoughts, communication, and behaviour (Capuzzi & Stauffer, 2021). Congruent communication was associated with increased self-awareness, acceptance and expression of the mind correctly, physically and emotionally (Baldwin, 2013). Satir et al. (1991) observed that people have internal and external lives evident in three interactional levels; the interpersonal, the intrapsychic, and the universal-spiritual. The external level was the intrapersonal life represented by behaviours and communication stances at the tip of the iceberg (Sommer-Flanagan & Sommer-Flanagan, 2015). The internal life hosts intrapersonal and universal-spiritual interactions, which are submerged below the water as the largest part of the iceberg (Baldwin, 2013). The intrapersonal level comprises feelings, feelings about feelings, perceptions, expectations, and yearnings (Capuzzi & Stauffer, 2021). At the same time, the universal-spiritual level consists of the expression of self as a spiritual being with value and purpose (Satir et al., 1991; Baldwin, 2013). Therefore, drivers of emerging adults' suicidal behaviours were intrapersonal universal-spiritual conflicts unearthed from beneath the iceberg in interpersonal interaction. The only way to eliminate suicidal behaviours is through awareness, acceptance, congruent expression and acceptance of self, others, and the context (Goldenberg et al., 2017).

Survival Stances. Survival or coping stances are the external behaviours used to deal with internal distress (Goldenberg et al., 2017). Gehart and Tuttle (2003) noted that coping stances were patterns of behaviours applied to protect one's self-worth against real or perceived verbal and nonverbal threats. For Satir et al. (1991), survival stances are observable in communication, interpretations, and responses to internal and external situations. Satir et al.

(1991) identified four dysfunctional survival stances commonly applied in distress and one functional stance that balanced human communication, interpretations and responses without ignoring self, others, and the content in distress.

Based on Satir's work, the dysfunctional survival stances were: placating, blaming, super-reasonable, and irrelevant (Goldenberg et al., 2017; Gehart, 2017; Sommer-Flanagan & Sommer-Flanagan, 2015). According to Satir, placating stance disregarded self but acknowledged the needs of others and the context and blaming stance acknowledged self and the context but discounted others (Sommer-Flanagan & Sommer-Flanagan, 2015). The super-reasonable stance accepted the context while downplaying the self and others, while the irrelevant stance employed unrelated and destructive behaviours responses that neglected the self, others and the context. (Satir et al., 1991; Goldenberg et al., 2017; Gehart, 2017; Sommer-Flanagan & Sommer-Flanagan, 2015). No wonder emerging adults who applied these dysfunctional stances found it hard to address issues constructively.

While congruence was the functional survival stance attained after balancing the self, other and contextual needs in distress (see. Satir et al., 1991; Goldenberg et al., 2017; Gehart, 2017; Sommer-Flanagan & Sommer-Flanagan, 2015). Emerging adults engaged in the congruence stance possess the highest level of human communication, which consolidated the needs of self, others and the context (Satir et al., 1991; Gehart, 2017; Gehart & Tuttle, 2003; Mclendon & Millar, 2010). Survival stances also developed in early childhood as emerging adults interacted with the primary figures and captured the frequent communication patterns in the family (Gehart, 2017). Children who learnt to use any of the four incongruent survival stances were at risk of suicidal behaviours in emerging adulthood because they could not consolidate the needs of self, others, and the context.

Hope. The Satir Model viewed hope as a fundamental component influencing human behaviour (Satir et al., 1991). Hope was a crucial goal in Satir's family therapy, and it was cultivated from real or perceived interpretations of personal experiences with self, others and the world (Zagelbaum & Carlson, 2011). Gvion and Apter (2012) observed that mentally healthy people looked forward to a better future regardless of the prevailing life challenges. At the same time, lack of hope was associated with mental pain resulting from frustration or disillusionment of unmet needs for love, control, protection of self-image, security, and avoidance of shame, guilt, or humiliation (Gvion & Apter, 2012). Suicidal behaviours were negative and ineffective ways of dealing with mental pain as they robbed emerging adults of hope of a better future (Gvion & Apter, 2012). Satir et al. (1991) claimed that hope was a vital component that stimulated people to develop the ability to change. It is a strong belief that things will change for the better (Gvion & Apter, 2012). That explained why increasing feelings of hopelessness among emerging adults were significantly associated with suicidal behaviours.

Satir Model and Suicidal Behaviours

Satir's model considered incongruence, low self-esteem and the inability to make choices as responsible for physical and mental health problems (Mclendon & Millar, 2010; Loeschene, 1991). Emerging adults were experiencing life events threatening the internal and external life that required them to be congruent, self-confident and make wise choices in dealing with life events (Capuzzi & Stauffer, 2021). Mclendon and Millar (2010) observed that emerging adults' constant use of incongruent survival stances was responsible for the prevailing physical and mental health problems. Based on Satir's model, suicidal behaviours were interpersonal behaviours expressed through incongruent survival stances learnt in childhood with the primary triad (Capuzzi & Stauffer, 2021). Underneath suicidal behaviours were unexplored and

unaccepted intrapsychic and universal-spiritual issues (Golden & Englander-Golden, 2014). Lum et al. (2002) conclude that the incongruent survival stances hinder the emerging adult from coping with relationships, obtaining personal growth, and accessing life energy to heal self. Thus emerging adults result in suicidal thinking, planning, attempting suicide and self-harm as alternatives to dealing with distressful situations in the university.

The Satir Model held that the family of origin was central to developing one's self-esteem, interpersonal skills, coping and problem-solving skills, and survival stances (Loeschene, 1991; Satir et al., 1991; Gehart & Tuttle, 2003). An early family environment characterized by a disorganized family structure, abuse, rigidity and unmet expectations was responsible for emerging adults' unresolved hurt, bitterness, and incongruent problem-solving skills (Lum et al., 2002). As a result, emerging adults developed a negative self-image that contributes to persistent feelings of sadness, worthlessness, hopelessness, fear and a sense of inadequacy (Mi et al., 2019; Allen et al., 2022). These feelings were associated with suicidal behaviours among emerging adults.

The Satir model was an empirically tested method of suicide prevention among emerging adults (Adreas, 1999; Lum et al., 2002; Macgowan, 2004; Banmen, 2008; Smith, 2010; Koca, 2017; Carlock, 2017; Allen et al., 2022). Lum et al. (2002) showed that the Satir model was successfully examined for intervention for emerging adults with suicidal behaviours. Lum et al. (2002) intervened in the internal world of suicidal emerging adults using the personal iceberg and helped them access, understand, reflect, interact, and transform these behaviours. Furthermore, the personal iceberg was used to examine and identify emerging adults at risk of suicidal behaviours (Lum et al., 2002; Smith, 2010). However, more studies linking Satir Model with early family environment and suicidal behaviours among emerging adults were necessary.

Suicidal behaviours were the interpersonal behaviours at the tip of the iceberg hiding the emerging adult's internal world of feelings, perceptions, expectations, yearnings, and the self that are unexplored, unaccepted and inexperienced (Mclendon & Miller, 2010; Lum et al., 2002). Suicidal behaviours were masks representing emerging adults' internal world of unmet needs and unresolved childhood issues which need to be unearthed using the personal iceberg (Smith, 2010). Hope was a preventative factor supporting change by congruently harmonising the emerging adult's internal and external life (Satir et al., 1991; Zagelbaum & Carlson, 2011). Therefore, the Satir model helped assess the influence of early family environment and suicidal behaviours among emerging adults.

Strengths and Shortfalls of Satir Model Theory

The Satir Model provided a strong association between parent-child and suicidal behaviours (Corey, 2017; Goldenberg et al., 2017). It supported the understanding of spirituality and problem-solving skills in reducing suicidal behaviours among emerging adults (Capuzzi & Stauffer, 2021; Golden & Englander-Golden, 2014). Thus providing a framework for prevention and clinical interventions for suicidal behaviours among emerging adults through the personal iceberg (Mclendon & Miller, 2010; Lum et al., 2002). The theory was limited in identifying early family and prevailing psychological stressors associated with suicidal behaviours, thus the need to combine the three theories. The three theories helped this study to examine the four objectives and suggest possible theory-based prevention and clinical interventions.

Empirical Review

An Overview of Family Environment and Emerging Adults' Suicidal Behaviours

Global Review. Emerging adults are increasingly engaged in suicidal behaviours to cope with personal and academic demands in the university (Horgan et al., 2018). As a result, these

suicidal behaviours are a global public health problem (Hawton et al., 2012). These suicide reports revealed that suicide was the second leading cause of death for young people aged 15–29 globally (World Health Organization and Food Agriculture Organization, 2019; WHO, 2016; Hawton et al., 2012). Further meta-analysis reports in Europe, America, and Australia, concluded that suicidal behaviours were the leading cause of death and serious injury in Asia and Oceania (Asarnow & Ougrin, 2019). This showed that suicidal behaviours among emerging adults were on the rise. It was noted that suicide deaths are evidence of continued suicidal behaviours, suicide ideations, plans, attempts and self-harming activities (Musci et al., 2016; Nkansah-Amankra, 2013). Until there is a significant decline in suicide behaviours among emerging adults, further research on this topic is inevitable (Hawton et al., 2012 WHO, 2014; Tucker et al., 2015; Klonsky et al., 2016). Besides, it was critical to expand the scope of research by examining the influence of early family environment on emerging adults' suicidal behaviours (Zhai et al., 2015). The reason being early family environments were the breeding ground for emotionally and socially healthy emerging adults (Valdez et al., 2013). This prompted studies to explore aspects of early family environments that acted as risks and preventative factors for suicidal behaviours among emerging adults.

Several studies on suicidal behaviours among emerging adults focused on the university and individual environments of the students (Horgan et al., 2018; Othieno et al., 2014; Ram et al., 2018; Valdez, 2013). In a longitudinal study between 2010 and 2018 on suicide deaths among university students, Mclaughlin and Gunnell (2020) argued that specific individual and university environments were risk factors for suicide among university students. Mclaughlin and Gunnell's results showed that being male and having financial problems were individual risk factors for suicidal behaviours. In addition to having academic difficulties marked by repeating

years, changing courses and having academic suspensions were university environment risk factors for suicidal behaviours (Mclaughlin & Gunnell, 2020). Although this study agreed with Mclaughlin and Gunnell (2020) that individual and university environments were risk factors for suicidal behaviours, these factors depended on a student's early family environmental factors (Zhai et al., 2015). Zhai et al. disagreed that the university environment was a significant risk factor for suicidal behaviours among emerging adults. Based on their study, Zhai et al. (2015) observed that poor family structures and relationships, financially unstable parents, and improper parenting styles were associated with suicidal thinking among emerging adults. Therefore, individual and university risk factors are shaped by early family environments, such as self-esteem and problem-solving skills, which influence emerging adults' responses to psychological stressors.

Studies show that such early family environments, like adverse childhood experiences, change the brain structure and stress-response cycle, creating vulnerability to stress in later life, evidenced in impaired assessment and response to ongoing stress (Karatekin, 2018; Sachs-Ericssons et al., 2016). This predisposes emerging adults to respond negatively, as in suicidal behaviours, because they are ill-prepared to manage personal and university challenges in readiness for adult responsibilities (Zhai et al., 2015). They revert to self-destructive behaviours, which are irrational and harmful. So, downplaying the early family environment hinders the possibility of addressing the underlying risks and university-related stressors linked to suicidal behaviours among emerging adults (Karatekin, 2018). Therefore, examining the early family environment factors associated with suicidal behaviours among emerging adults was a priority.

In America. A study associating early family environment and suicidal behaviours was conducted in the U.S.A. by Wilcox et al. (2010). The study examined the prevalence and

predictors of suicide ideations, plans and attempts among first-year students at the university. The results revealed that ten students planned or attempted suicide in the first year of university. Wilcox et al. (2010) identified early family environment factors such as low social support (family relations), childhood or adolescent exposure to domestic violence, maternal depression (childhood stressful life events) and high depressive symptom (lack of personal problem-solving skills) as a risk for persistent suicidal ideation. Wilcox et al. (2010) showed that family experiences in childhood and adolescence were connected to first-year university students. Nonetheless, it was unclear if this study was generalizable to university students outside the U.S.A and in other years of study.

In Europe. Another study in Sweden by Lageborn et al. (2017) compared emerging adults' suicidal behaviour between those in university and those out of university. The results of this comparative study revealed that students in university were at a greater risk of suicidal behaviours than those out of university. Lageborn et al. (2017) concluded that the university environmental factors were a risk for suicidal behaviours due to the demands placed on students to achieve good grades. Though Lageborn et al. (2017) were right in that the university environment was a stressful environment for emerging adults. Still, they seemed to ignore the fact that not all emerging adults in the same university environment were engaged in suicidal behaviours. Thus, this study sought to identify the early family environment features associated with suicidal behaviours; among emerging adults. These features included family relationships, personal development and specific stressful life events before 12 years.

In Asia. A study in Asia correlated the current family environment and suicidal ideations of university students in China (Zhai et al., 2015). The results showed a significant relationship between the family environment and suicidal ideation in university students. Specific factors like

poor family structure, relationships, and inadequate parenting styles were risk factors for suicidal thinking among emerging adults. The conclusions drawn by Zhai et al. (2015) argued that emerging adults who were transiting from their family of origin needed support to invest in education and relationships to avoid negative family influences. This study provided knowledge of aspects of the early family environment associated with suicidal behaviours for university students. However, one wonders whether this study was replicable to students outside the Chinese context and would obtain similar findings and recommendations supporting family interventions for emerging adults with an unhealthy early family environment.

In Africa. The interplay of early and prevailing family environments were areas of interest in examining risk factors associated with suicidal behaviours among emerging adults, as seen in two African studies. A study in Ethiopia by Abdu et al. (2020) explored suicidal behaviours and associated factors among university students in one Ethiopian university. The results revealed that suicidal thinking and suicide planning were prevalent among university students throughout their university life. In their study, Abdu et al. further observed that poor social support, family history of suicidal behaviour, lifetime use of alcohol, rural residency, and inconsistent spiritual practices are significantly associated with suicidal behaviours. Here, Abdu et al. (2020) alluded that early family environments and the prevailing family environments were associated with suicidal behaviours in university students. However, it was unclear which early family environments were associated with emerging adults' suicidal behaviours.

A study in Uganda examined suicidal ideation among youth living in Kampala slums (Culbreth et al., 2018). The study conducted a logical regression and determined psychosocial factors associated with youth suicidal ideations. The results revealed that early and prevailing family environments, such as having many unmet basic needs, drinking problems, imprisonment,

and adverse childhood experiences like physical abuse, orphaned, homelessness, and rape, were risks for suicidal behaviours (Culbreth et al., 2018). Culbreth et al. (2018) exposed some early family environments and suicidal behaviours. However, the study population involved adolescents in the slums conveniently sampled. Both studies by Abdu et al. (2020) in Ethiopia and Culbreth et al. (2018) in Uganda pointed to the need to address early and prevailing family environment factors to reduce suicidal behaviours among university students. Nevertheless, it was unclear it these findings were generalizability among Kenyan emerging adults in the university.

In Kenya. A study in Kenya by Wanyoike (2015) examined the cause, implications and intervention for suicide among university students in six universities. The findings revealed that suicide was likely among emerging adults pursuing a university education. Furthermore, suicidal behaviours among university students in Kenya, according to Wanyoike (2015), were numerous, complex and psychological. The study revealed the causes of suicidal behaviours as; depression, hopelessness, uncontrolled anger, loneliness and unresolved conflicts. Although Wanyoike's (2015) conclusions focused on the individual's environment as the cause of suicidal behaviours, these factors did not stand alone. The causes were precipitated by early family, unexplained in Wanyoike's study. Valdez et al. (2015) disagreed with Wanyoike's assumptions that emerging adults' present psychological stresses caused suicidal behaviours because emerging adults were reliving experiences of formative family stresses.

It was childhood family stresses like parental conflicts, divorce, illness and abuse by a family member which tended to disrupt emerging adults from identity formation and alignment in adult roles (Wong et al., 2019; Duprey et al., 2019; Valdez et al., 2015). Although Wanyoike's (2015) study recognized the impact of families on suicidal behaviours, it was silent on the early

family environment's influence on emerging adults' suicidal behaviours. Therefore, examining the association between the early family environment and suicidal behaviours would help prevent and intervene for such behaviours.

Besides, several media reports in Kenya observed that suicidal behaviours among emerging adults were an interaction between individual, university and prevailing family environments. These reports sought to understand the reasons for increased suicidal behaviours among Kenyan students in universities (Nyamori, 2015; Wakesah, 2019; Wanjohi, 2019; Owiti, 2019). The summary of risk factors for suicidal behaviours among emerging adults based on these reports was; depression, substance use, poor parenting, inadequate preparation for adult responsibilities, inability to deal with life challenges, relationship problems, financial problems, being diagnosed with Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS), family and academic pressures like missing marks. According to these reports, suicidal behaviours were a means of resolving overwhelming feelings associated with family, relational and academic distresses (Nyamori, 2015; Wakesah, 2019). Though these media reports were insightful on why emerging adults were engaging in suicidal behaviours, they lacked empirical support obtained through research. Moreover, these reports did not explore the possible relationship between early family environment and suicidal behaviours in emerging adults.

Prevalence of Suicidal Behaviours among Emerging Adults

Globally. A report by the World Health Organization (WHO) (2016) showed that suicide was the second leading cause of death among emerging adults ages 15 to 29 years old (World Health Organization [WHO], 2016). There were gender differences in suicidal behaviours among emerging adults. Previous studies showed that more men engaged in suicidal behaviours with

intentions of dying while more women were engaged in suicidal behaviours without the intention of dying; where 75% of men were likely to die by suicide and one in five women had a lifetime of self-harming behaviour (Borschmann & Kinner, 2019; O'Conner 2018; Sivertsen et al., 2019; WHO, 2018). The upward trend of suicide behaviours among emerging adults was highest in Europe, Africa, South East Asia, America, Western Pacific and Eastern Mediterranean, where suicide deaths were on the rise (WHO, 2016). However, it was unclear whether these reports were representative prevalence of suicidal behaviours among emerging adults in Kenya. The reviewed prevalence studies on suicidal behaviours among emerging adults in the universities were disturbing.

In America. A study in the USA by Wilcox et al. (2010) on 'prevalent and predictors of persistent suicide ideation, plan and attempts during college' revealed that 1100 students die by suicide annually. The results showed that 12% of the students had suicidal ideations during their university years, 25% had multiple suicide ideation episodes, 1.78% had persistent suicide ideations, and 0.9% had planned and/or attempted suicide. A meta-analysis study by Mortier et al. (2017) on 'The Prevalence of Suicidal Thoughts and Behaviors among College Students' in 36 colleges revealed a lifetime and 12 months prevalence for suicidal ideations, plans and attempts. The results revealed a lifetime of 22.3% of suicidal ideation, 6.1% of plans, and 3.2% of attempts. Further findings on the 12-month prevalence of 10.6% suicidal ideations, 3.0% plans and 1.2% attempts. Comparatively, a study on 'Suicidal Behaviours and Psychological Distress in University Students: A 12-Nation Study' by Eskin et al. (2016) recorded that American university students had higher lifetime rates of suicidal thinking 27.4% and 3.3% of suicidal attempts than Mortier et al., (2017) study. Besides, a study by Marie (2016) on non-suicidal behaviours among university students. The results revealed that 37.5% of university students in

the U.S.A were engaging in self-harm with non-suicidal goals. Mackenzie et al. (2011) explored the prevalence of 'Depression and Suicidal Ideation among Students Accessing Campus Health Care' in four clinics in Canada, the Midwest and the Northwest U.S.A. The results revealed that 25% of male students and 26% had depression symptoms, and 13% of male and 10% of female students had suicidal ideations. These studies revealed high rates of suicidal thinking. Meaning students engaged more in self-harm than in suicidal thinking. Both Wilcox and Mortier's studies revealed high rates of suicidal ideations, evidence that more emerging adults were struggling with suicidal thinking. More male students struggled with suicidal thinking (Mackenzie et al., 2011). These findings revealed that emerging adults in North American universities were engaged in suicidal thoughts, plans, attempts and self-harm throughout their university life. It was disheartening to imagine that these students get by each academic year without interventions to address the underlying reasons for these suicidal behaviours. Each suicidal behaviour episode posed a risk of suicide, death, or severe injury for the emerging adult.

In Europe. A study in Scotland by O'connor et al. (2018) on 'Suicide Attempts and Non-Suicidal Self-Harm National Prevalence Study of Young Adults' revealed that young adults aged 18-34 years were frequently engaged in suicidal thinking, attempts and self-harm. The results recorded a lifetime of 20% suicidal thinking, 11.3% suicidal attempts and 16.2% self-harm. Although this study included young adults outside the university, it revealed that young adults are engaged more in suicidal thoughts and self-harm. However, a lifetime rate of 11.3% on suicidal attempts was a risk for death and serious injuries. An early study on 'Suicidal Behaviours and Psychological Distress in University Students: A 12 Nation Study' by Eskin et al. (2016) captured the lifetime rates of suicidal ideations and attempts in Austria, the United Kingdom and Italy. The results revealed that university students in Austria recorded 47.6% in

suicidal ideation and 3.3% in suicidal attempt; in Italy, the results recorded a rate of 19.4% in suicidal ideation and 2.6% in suicidal attempt and in the United Kingdom, the results revealed a prevalence rate of 39.3% in suicidal ideation and 7.3% in suicidal attempt. The findings recorded the highest rates of suicidal ideation among university students in Austria, 47.6%; the United Kingdom, 39.4% and Italy, 19.4%. Suicidal thinking was the highest form of suicidal behaviour recorded in the three countries. It was noted that the United Kingdom had the highest rate of suicidal attempts, 7.3%. A study on self-harm titled 'A Qualitative Exploration of Students Self-harm and Experiences of Support-seeking within a UK University Setting' by Edwards-Bailey et al. (2022) revealed that self-harm was a way students tried to cope with university challenges such as academic stresses, shame, loneliness and the increasing social demands. It was noted that university students in Europe were at risk of suicidal thinking.

In Asia. Several studies on suicidal behaviours among university students in Asia revealed an increase in suicidal thinking, attempts and self-harm. A study in two state universities in Turkey on 'Self-harm, Suicidal Ideation and Suicidal Attempt among College Students' by Toprak et al. (2011) revealed that more students engaged in self-harm 15.4%. Another 11.4% had suicidal ideations, and 7.1% attempted suicide. Another study carried out in Turkey on 'Mental Health, Suicidaligy and Hopelessness among University Students in Turkey' by Oyekcin et al. (2017) recorded a lifetime rate of 15.1% in suicidal ideation. More findings based on Oyekcin et al. were that university students recorded high rates of mental symptoms; 33.1% anxiety and 28.2% depression. The two studies revealed that university students in Turkey have hight rates of self-harm and suicidal ideations in addition to symptoms of depression and anxiety, which might be associated with these suicidal behaviours.

Increased rates of suicidal ideation and attempts were confirmed by a study on" Suicidal Behaviours and Psychosocial Distress in University Students: A 12-Nation Study' by Eskin et al. (2016) that involved seven countries in Asia. The results revealed the highest rates of suicidal ideation were: Iran at 29.7%; Japan at 25.9%; Turkey at 24.2%; Palestine at 22.2%; Jordan at 22.0%; China at 21.8%; and Saudi Arabia at 17.7%. Whereas the highest rates of suicidal attempts were recorded in Saudi Arabia at 20.0%; Jordan at 15.8%; Palestine at 11.5%; Turkey at 8.6%; Iran at 4.5%; China at 3.5%, and Japan at 2.9%. Going by these findings, it was clear that university students in Asia were engaging in suicidal thinking and attempts at an alarming rate. Such knowledge is very important as it provides the bases for continental and national interventions.

In Africa. Prevalence studies on suicidal behaviours among university students in Africa were limited. Available studies revealed that African students in the university were at risk of suicidal thinking, planning, attempts, and self-harm, just like their counterparts in other continents. A study in Ghana by Owusu-Ansag et al. (2020) on 'Suicide among university students' prevalence, risks and protective factors' revealed that 1,003 university students were involved in some form of suicidal behaviour. The majority of the students, up to 24.3% struggled with death wishes, 15.2% had suicidal ideation, 6.3% attempted suicide, and 6.8% made suicidal plans. The study confirms a global trend where students recorded high rates of suicidal thinking. However, from the Ghanian study, slightly more students engaged in suicidal plans than suicidal attempts and more students struggled with death wishes than with suicidal attempts and plans combined. Other nerve-wracking trends in suicidal behaviours among emerging adults in the university were recorded in Ethiopia. A study by Abdu et al. (2020) on 'suicidal behaviours among university students at Mettu University'. The findings revealed that 58.3% of students

battled suicidal ideation, 37.3% planned suicide, and 4.4% attempted suicide in a year. The rates of suicidal ideations and plans among university students in Ethiopia were more than double those recorded in Ghana. Both studies, the Ethiopian and Ghanaian, agreed that most students in the university were struggling with suicidal thoughts. Still, a significant number planned suicide, and others attempted suicide. In other words, Abdu et al. (2020) showed that over fifty per cent of students in the university had suicidal thoughts and close to forty-per cent planned suicide; thus, the study painted a disturbing picture of suicidal activities among emerging adults.

Another study by Asfaw et al. (2020) on 'prevalence and associated factors of suicidal ideation and attempt among undergraduate medical students of Haramaya University Ethiopia: A cross-sectional study' revealed that medical students are at risk of suicidal behaviours. The prevalence rates of suicidal ideation were 23.7% and 3.9% for suicidal attempts. Although these rates are lower than Abdu et al. (2020) study, they confirmed the increased rates of suicidal thinking in Ethiopia. One of the African countries included in the 12 Nations in the study by Eskin et al. (2016), 'suicidal behaviours and psychological distress in university students: A 12 nation study', was Tunisia. The results revealed a prevalence rate of 20.9% in suicidal ideation and 5.4% in suicidal attempts. These rates were lower than those in Ghana, two Ethiopian studies. In the same breath, a study on 'self-harming behaviour among univesity students: A South African case study' by Walt (2016) showed that 19.4% of the students engaged in self-harming behaviours at least once in their campus life. The majority of the students engaging in self-harm had mental pain, 23.4%. In addition, Walt claimed that most of the students engaged in self-harming behaviours were female. The Ghanaian, Ethiopian and South African studies concluded that students in African universities were engaged in suicidal behaviours: suicidal thinking, suicide planning, suicide attempts and self-harm. Although the numbers differed,

suicidal thinking was the most common form of suicidal behaviour among emerging adults in the university.

In Kenya. A study in Kenya by Nyangwencha and Ojuade (2022) on 'correlates of suicidal behaviours & co-existing mental health conditions among undergraduate university students in Kenya: A web-based cross-sectional correlation survey' revealed high rates of suicidal behaviours. Results from this web-based study involving 138 undergraduate students recorded 29.7% in suicidal ideation, 48.5% suicidal plans and 13.8% suicidal attempts. This study was one of the few empirically obtained prevalence rates in the Kenyan context that have been rare. However, it was a web-based study in one university, and it involved a small sample population. The focus was the correlation between suicidal behaviours and mental health conditions. In addition, the study did not provide the prevalence rates of self-harm among university students. A study by Ndetei et al. (2022) on 'socio-demographic, economic & mental health problems were risks for suicide ideation among Kenyan students ages 15 Plus' revealed a rate of 22.6% of suicidal ideation in Kenyan students. Ndetei et al. study did not focus on emerging adults. It involved high school, college and university students. In addition, the authors, in their limitation, admitted that it was not a study on suicidal behaviours. Therefore, the need for more studies that focus on emerging adults and on suicidal behaviours.

The media in Kenya has continued to highlight an increase in suicide, meaning there are some unreported narratives of suicidal behaviours. According to a web-based report, nearly 1408 Kenyans commit suicide yearly (Wekesah, 2019). Furthermore, a report on The Standard Newspaper reported suicide deaths among the four students; three were from different universities in different counties, namely, Nairobi, Kiambu, and Uasin Gishu counties. All three are male undergraduates and final-year students pursuing various degree programs (Nyamori,

2015). A similar media report, “Campus Suicides” (2018), presented documented cases of twenty university students in Kenya who committed suicide from 2014 – 2018. The “Campus Suicides” report highlighted eight cases of suicidal behaviours, three were fourth-year students, and two were second-year students. Although these reports are informal, they indicate emerging adults increasingly engage in suicidal behaviours. Thus the need for more empirical studies investigating the prevalence and reasons students in Kenyan universities were engaging in suicidal behaviours.

As an illustration, Palmer (2011) and Wakesah (2019) argued that in some African Countries, engagement in suicide behaviours was a criminal offence; therefore, reporting these behaviours was challenging due to the legal implications, negative cultural views and family shame. Although there are alarming cases of suicidal behaviours among emerging adults in the universities, Kenya still maintains a criminal law against suicidal behaviours. Thus, it is difficult to obtain accurate figures for suicidal behaviours. Moreover, these laws cause stigmatization and fear of criminalization or judgmental treatment among university students (Palmer, 2011; Wakesah, 2019). There was a need to examine the prevalence rates of these behaviours to capture the extent, causes, and preventions directed at managing the trends.

Early Family Environment and Suicidal Behaviours

Generally, negative early family environments were significantly associated with suicidal behaviours, although there was no single cause for suicidal behaviours among emerging adults (Omar et al., 2010; Zhai et al., 2015: Savitha et al., 2016; Salakangas et al., 2020). However, unhealthy negative factors in early family environments are associated with suicidal behaviours among emerging adults in the university. Studies reveal that early family relationships are instrumental in forming a healthy view and interaction with self, others and the world through

daily interaction with family members (Mi et al., 2019; Allen et al., 2022). This is because early childhood is a formative period and is geared to prepare individuals to be mature, healthy and well-adjusted adults (Goldenberg et al., 2017). The development of a strong, confident and healthy emerging adult was achieved through loving, accessible, responsive, and caring relationships with adults (McGoldrick et at., 2014). These qualities inherent in nurturing family relational traits act as protective factors against suicidal behaviours and mental disorders in emerging adulthood (Allen et al., 2022; McGoldrick et al., 2014; Walsh, 2016). The United Nations Children's Fund [UNICEF] (2004, 2011) agreed that safe adults were a protective factor against future suicidal behaviours in emerging adults; if they create a secure, safe and stimulating family environment void of violence, abuse, neglect and exploitation.

Hirsch et al. (2019) disagree that early family environment was significantly associated with suicidal behaviour in emerging adults. Instead, Hirsch et al. argued that perceived stress, depression and mental health stigma were significant risk factors accounting for the increased rates of suicidal behaviours among university students. However, it is common knowledge in the field of psychology that the early family environment breeds both mental and behaviour disorders (Valdez et al., 2015). Therefore, although they were taken from different vantage points, both McGoldrick et al. (2014) and Hirsch et al. (2019) conclusions were correct. McGoldrick et al. took a broad view that accounted for mental and behaviours disorders developed in an unhealthy early family environment. At the same time, Hirsch et al. took a closer view of specific factors associated with emerging adults' suicidal behaviours.

Family Relations Dimension. A healthy early family environment is characterized by five traits: close relationships; support for personal growth; system maintenance; adaptability, and few or no childhood stressful life events (Viner et al., 2012; Omar et al., 2010; Prime et al.,

2020). In such a family, the parent-child relationship is securely characterized by warmth, safety and proximity (Miniati et al., 2017). The child feels loved, accepted and validated because their needs were met, the parent was emotionally stable, responsive and fought against being separated from the child (Cassidy et al., 2014; Marrone, 2014). This secure attachment is cultivated through close-secure relationships that allow for congruent emotional expression, responsiveness and management of conflict between members (Miniati et al., 2017; Prime et al., 2020). Furthermore, the family understands and adjusts to the changing physical and emotional structure of launching the emerging adults to differentiate while remaining connected (Valdez et al., 2013) because the emerging adult feels in between a child and an adult (Arnette 2015). The parenting style is adjusted by increasing autonomy, responsibility and interacting from an adult-to-adult perspective because parents see them as capable of dealing with age-related challenges (Goldenberg et al., 2017). Emerging adults from healthy early family environments enjoyed a strong, open, responsive, flexible and satisfying relationship with their parents, who employed congruent communication in their interactions (Satir et al., 1991). Therefore, a strong and open parent-child relationship in healthy early family relationships nurtured mentally and socioemotionally healthy emerging adults.

On the contrary, unhealthy early family environments groomed emerging adults at risk of behavioural and psychological disorders (Brodsky, 2016; Karatekin, 2018). Unhealthy early family environments cannot maintain cohesive family relations, fail to support personal growth and experience multiple stressful life events in one's childhood years (Walsh, 2016; McGoldrick et al., 2014; Goldenberg et al., 2017). The parental figures in these families were unsafe, distant, unaccommodating, disorganized, non-communicative, and held differing beliefs that nurtured vulnerable children at risk of suicidal behaviours in emerging adulthood (Viner et al., 2012;

Prime et al., 2020). unhealthy early family environments affect how emerging adults respond to distress in ways that do not support self-regulate, tolerance and problem-solve (Robinson et al., 2019; McLafferty et al., 2020). Therefore, understanding the family relations dimension associated with suicidal behaviours among emerging adults was indisputable.

Comparatively, dominant studies in early family environments and suicidal behaviours are from America, Australia and Europe (Mars et al., 2014; Quarshie et al., 2020). Families are culturally defined; for example, family life in Africa was unique in structure, relationships, interconnectedness and adapting to transitional and life challenges (Palmier, 2011). The emerging adults in Sub-Saharan Africa who grew up during political, economic and technological changes were influenced by their upbringing, which was less traditional and more postmodern (Arnett, 2011; Bigombe & Khadiagala, n.d). So, more studies exploring the influence of early family environment on emerging adults' suicidal behaviours in the changing socio-cultural contexts in Africa are vital (Zhai et al., 2015). A study by Palmier (2011) examined the prevalence and correlations of suicidal behaviours among adolescent students in Sub-Saharan Africa. Palmier's study revealed that negative family environments produced suicidal behaviours. He identified unhealthy early family environments in Africa as polygamy, physical violence, breadwinning adolescents, divorce, separation, hunger, early sexual involvement, and poverty. These early family environments were risk factors for suicidal thinking among urban adolescents (Palmier, 2011). Based on Palmier's study growing up in urban areas, being impoverished and being an underage breadwinner were at risk of suicidal behaviours in emerging adulthood. However, suicidal behaviours among emerging adults have been observed among students brought up in rural areas, in average and up social class and those

whose parents have faithfully provided. Thus the need for a study to understand other risk factors outside Palmier's scope of the study.

Family life in Africa has continued to change due to immigration in search of education, and employment, causing both parents to work outside the home (Anyanwu et al., 2020). Such family changes impact the family structure, roles and function (Sooryamoorthy & Makhoba, 2016). The quest to provide a decent lifestyle, such as primary health care and education, overshadowed the need to nurture emotionally and socially healthy children (Anyanwu et al., 2020). These social changes impact parent-child relationships, such as absconding parental responsibilities to protect and train children to cope with life's challenges, predisposing them to suicidal behaviours in emerging adulthood (Nyamori, 2015). In addition to the complexities of postmodern life, such as parental marital problems, family conflicts, financial struggles, chronic illness, and losses of one or both parents were risk factors for suicidal behaviours in emerging adults (Owiti, 2019; Anyanwu et al., 2020)). In short, these studies highlighted that families were constantly shaped by their sociocultural contexts. These contexts contributed to unhealthy early family environments that predisposed emerging adults to suicidal behaviours.

Personal Development Dimension. A second quality of an enabling early family environment is support for a child's personal development. According to Omar et al. (2010), families that support children's personal development are keen on developing; positive self-esteem, self-regulation, problem-solving skills and personal spirituality. This is nurtured in securely attached parents whose parent-child relationship remains close, responsive, reliable and supportive in the presence or absence of distress (Davaji et al., 2010; Miniati et al., 2017). Moreover, healthy early families meet the children's needs by adjusting family roles, interactions and expectations in the changing world (McGoldrick et al., 2014). Adjustment is vital in

supporting children to achieve physical, emotional and social tasks to develop, cope and thrive in life (Berge et al., 2011; White et al., 2019). The goal of every healthy early family environment is to support positive self-perception, safety, individuation, acceptance, fitting in, tractability, renewal and expression of personal standards (McGoldrick et al., 2014). In addition, early healthy families understand the value of resilience in their children, so they cultivate in them enduring beliefs, open to change, and solid problem-solving skills (Goldenberg et al., 2017). Building resilience is done through polite interactions with clear feedback, increasing self-awareness and congruent communication in distress (Satir et al., 1991; Baldwin, 2013). That is how children brought up in such a family were able to deal with life challenges void of suicidal behaviours.

Conversely, an unhealthy early family environment is disorganized, has unclear roles and responsibilities, rigid, divisive, disrespectful, and unprepared for transitional and life stressors (McGoldrick et al., 2017; Walsh, 2016). These families developed children with low self-esteem, undifferentiated, poor self-regulation, few friends outside the family, and inadequate problem-solving skills (White et al., 2019). Moreover, unhealthy families lacked balance in meeting children versus family needs, disagreed on rules of operation, had no shared family activities, kept many secrets and unutilized members' resources (McGoldrick et al., 2017; Goldenberg et al., 2017). Furthermore, such families are prone to stress due to a lack of readiness to manage developmental transitions and stressful life events, like maltreatment, sexual abuse, divorce or separation, generated by the unhealthy family interactional patterns (Goldenberg et al., 2017; McGoldrick et al., 2014).

Although both healthy and unhealthy early family environments experience expected and unexpected stressors, the difference is that unhealthy family environments lack resilience and are

unprepared (Walsh, 2016). Walsh (2016) agreed with Omar et al. (2010) that healthy families cultivated ways that helped children adapt, become flexible, cope and stay hopeful. Many psychologists hold that unhealthy early family environments are associated with emerging adults' difficulties in emotional processing and social competence when faced with life stressors (McGoldrick et al., 2017; Goldenberg et al., 2017; Walsh, 2016; Valdez, 2013). This situation arises because emerging adults were unskilled in distress; instead, the distress generated self-doubt, diminished self-worth, hopelessness, helplessness, poor emotional regulation and rigid coping methods when confronted with personal, academic and relational challenges (Bruffaerts et al., 2018; Christoffersen, 2009; Walsh, 2016; Valdez, 2013). The reviewed literature overlooked individual factors like personality, unique life experiences and safe attachments outside that might cause emerging adults who grew up in unhealthy family environments to be resilient. While emerging adults are brought up in healthy early family environments to engage in suicidal behaviours.

Childhood Stressful Life Events. Apart from the three early family environments: family relations, and personal growth, childhood stressful life events impact on emerging adults' emotional and behaviour problems. Childhood stressful life events, commonly known as adverse childhood experiences ACEs, are the hallmark of an unhealthy early family environment (Hartanto et al., 2020; Merrick et al., 2017; McLafferty et al., 2019). They have firmly been associated with mental disorders and suicidal behaviours in emerging adults. Palmer (2011) and Doan et al. (2012) observed that stressful childhood life events include mental illness in the family, family losses, low family support, disruptions, conflicts, separation, divorce, rejection, neglect, maltreatment and sexual abuse. These adverse childhood events caused emotional hurt and trauma, which, if unaddressed, led to suicidal behaviours in emerging adults (Pournaghash-

Tehrani et al., 2019; Wang et al., 2019). Walsh (2016) agreed that childhood adversities like traumatic events, unresolved conflicts, family secrets and losses resulted in destructive behaviours. Nonetheless, the impact of stressful life events on emerging adults depends on the age, number of events, frequency and family support in addressing them (Pournaghash-Tehrani et al., 2019; Wang et al., 2019; Walsh, 2016). Severe behaviour and psychological disorders in emerging adults were associated with exposure to stressful life events at a younger, extensive, multiple incidences and the absence of family resources to cope with these experiences (TFAH, 2019; Wang et al., 2019).

A study by Pournaghash-Tehrani et al. (2019) in Iran, revealed a significant relationship between stressful life events and adverse childhood experiences associated with suicidal behaviours in university students in Iran. They observed that maltreatment, dysfunctional family relationships, family losses and sexual abuse were associated with suicidal behaviours. The study further showed that emerging adults who witnessed verbal violence during childhood were at risk of up to 68.8% engaging in suicidal behaviours. This is compared with those who witnessed divorce or separation and were at a risk of 6.2% for suicidal behaviours. Another study by Salokangas et al. (2020) in Finland indicated differences in childhood physical abuse and emotional neglect in association with adult mental disorders like depression, maniac, anxiety and substance misuse disorders. These mental disorders were, by extension, expressed in signs in emerging adults who engaged in suicidal behaviours.

Children who experienced adverse events under the supervision of insecure parents and an inflexible family atmosphere doubted if anyone could support them in difficult times (Goldenberg et al., 2017). That was why Walsh (2016) concluded that emerging adulthood was a period to showcase and test one resilience and problem-solving skills learnt through the family of

origin. Studies cited that more and more emerging adults lack the necessary skills at this stage, such as help-seeking, resilience, coping, communication and problem-solving skills that help with endurance in distress (Hartanto et al., 2020; Merrick et al., 2017; Goldenberg et al., 2017). The lack of coping and problem-solving skills was linked to the stress-response cycle activated due to the stressful life events resulting in the prevailing ineffective ways of handling problems (Karatekin, 2018; Sachs-Ericsson et al., 2016). The victim of childhood stressful life events had impaired brain and body functioning seen in their low levels of distress tolerance and reduced emotional regulation linked to suicidal behaviours (Robinson et al., 2019; McLaffery et al., 2020). So, these findings supported the need to carry out a study that tied together the influence of early family environments, stressful life events and parenting styles on suicidal behaviours among emerging adults. This study was needed given the increased rates of suicidal behaviours in the universities.

Psychological Stressors and Suicidal Behaviours

Emerging adulthood is a transitional period comprising numerous psychological stressors resulting in psychological distress that might lead to suicidal behaviours (Auerbach et al., 2016; Bruffaerts et al., 2018; Goldenberg et al., 2017). Psychological stressors were prevailing events and experiences in emerging adults' social and physical environments that caused them psychological distress (Hirsch et al., 2019; LAbate, 2012; Monroe & Slavich, 2016). LAbate (2012) contended that emerging adulthood presented abrupt changes in lifestyle, social identity, social network and social support that threatened their psychological well-being. Moreover, transitioning to university was one step towards adulthood associated with intensified stress due to increased academic demands and new social relationships (Oketch-Oboth & Okunya, 2018; McGoldrick et al., 2017; Goldenberg et al., 2017; Friedlander et al., 2007). A study by

Friedlander et al. (2007) observed that students with academic difficulties and relationship stressors had more psychological distress associated with suicidal behaviours. Further studies on suicidal behaviours among emerging adults showed several psychological distresses connected to suicidal behaviours: hopelessness, loneliness, isolation, lack of control, negative self-image, depression and anxiety (Auerbach et al., 2016; Bruffaerts et al., 2018; Mortier et al., 2017; Tucker et al., 2015; Wanyoike, 2015). These studies revealed significant relationships between psychological distresses and suicidal behaviours in this population. However, the studies did not show the psychological stressors that caused the psychological distresses.

Although emerging adults were propelled to engage in suicidal behaviours by multiple factors, specific psychological stressors were more likely to lead to threatening behaviours (Mortier et al., 2017). Several studies agreed that mental disorders, university-related stresses and responses to psychological stressors were interrelated to suicidal behaviours among emerging adults in university (see, Abi-Joaude et al., 2020; Lageborn et al., 2017; Mortier et al., 2017). However, Lengvenyte et al. (2019) disagreed, saying interpersonal difficulties and social exclusions were the main psychological stressors that increased the risk for suicidal behaviours. Talwar & Mohd-Fadzil, (2013) concurred that social support from family and friends was significant for emerging adulthood in the university as it acted as a protective factor against the psychological stressors associated with physical and mental health challenges. This points to why more studies were necessary to examine specific psychological stressors rather than the psychological distresses related to suicidal behaviours among emerging adults. Doing so increased avenues for managing these psychological stressors as a prevention and intervention for suicidal behaviours.

Mental Disorder Symptoms. Anxiety, depression and hopelessness are common mental disorder symptoms in numerous studies associated review linked with suicidal behaviours among emerging adults in the university (see more, Auerbach et al., 2016; Krasnova et al., 2015; Bruffaerts et at., 2018). Studies showed that mental disorders symptoms were common among emerging adults in the university in Belgium by Mortier et al., (2017), in Kenya by Nyangwencha and Ojuade, (2022) and Othieno et al., (2014). Emerging adults presented with depression, anxiety, substance abuse, hopelessness, loneliness, lack of control, desperation and negative self-image (Mortier et al., 2017; Othieno et al., 2014; Nyangwencha and Ojuade, 2022). These symptoms positively corresponded with psychological distress reported by emerging adults participating in suicidal behaviours (Mackenzie et at., 2011; Nadorff et al., 2011; Auerbach et al., 2016; Krasnova et al., 2015; Bruffaerts et at., 2018). Such a relationship was seen in Mortier et al. (2017) in a meta-analysis on the risks for persistent suicidal thoughts and behaviours during college. Mortier et al. revealed that one in four university students in the United States and Canada had depressive symptoms, while one in ten had suicidal thoughts. Revealing what appeared like a co-occurrence where the presence of depressive symptoms was linked to suicidal behaviour. Logically, this makes sense because suicidal thinking is a vital sign of depression and bipolar disorders. However, Debczak (2019) challenged the idea that mental disorders cause suicidal behaviours among emerging adults. Debczak added that most emerging adults engaged in suicidal behaviours possessed mild to moderate psychological aches that were untreated. So, it does not mean every emerging adult with mental disorder symptoms has a clinical mental disorder diagnosis. Instead, they suffered mild or moderate psychological distresses triggered by one or more psychological stressors.

Studies conducted in Botswana, South Africa, and Kenya concurred that emerging adults in the universities presented with depressive symptoms, loneliness, and anxiety symptoms (see more, Bantjes et al., 2019; Kasomo, 2013; Korb & Plattner, 2014; Othieno et al., 2014; Wanyoike, 2015; Nyangwencha and Ojuade, (2022). They noted that 35.7% of students had moderate depressive symptoms, and 5.6% had severe symptoms likely to be diagnosed as major depressive disorder. Othieno et al. (2014) debated that depressive symptoms were common in first-year university students. Those with academic problems, residing away from home, manage increased freedom, build healthy peer relationships, and choose whether to use tobacco and binge drink (See, Korb & Plattner, 2014; Othieno et al., 2014; Bantjes et al., 2019). These were apparent psychological stressors are likely to produce depressive symptoms in emerging adults in the university. It seemed like mental disorder symptoms were mediating factors for suicidal behaviours because psychological stressors were poorly managed, thus mental distress symptoms alongside suicidal behaviours.

University Life Related Stress. Another mediating factor related to suicidal behaviours among emerging adults in the university was coping with the academic and social demands of university life (Arnett, 2011). University life allowed emerging adults to individuate and test their life skills to support them in transitioning to adulthood (McGoldrick et al., 2017; McLaughlin & Gunnell, 2020). Although university years presented excess freedom, fun and experimentation, on the contrary, it presented multiple stressors ranging from personal challenges, peer pressure, family pressures, academic demands, cost of education, and demand for graduates in the job market (Gudo et al., 2011; McLaughlin & Gunnell, 2020; Oketch-Oboth & Okunya, 2018). These challenges produced psychological distress, causing conditions like anxiety, hopelessness, and low self-esteem, which led to suicidal behaviours (see more,

McLaughlin & Gunnell, 2020; Oketch-Oboth & Okunya, 2018). It is understandable for emerging adults with limited coping skills to develop mental disorder symptoms under these kinds of pressure.

Two studies on suicidal behaviours among university students, by Hirsch and Barton (2011) in USA and Lageborn et al. (2017) in Sweden, observed that emerging adults pursuing university education had an increased risk for suicidal behaviours than their age mates out of university. A review by McLaughlin & Gunnell, 2020 on suicide deaths among university students in the UK from 2010 to 2018 revealed that students experiencing academic and financial difficulties were at greater risk of death by suicide. Academic pressures and problems with peers, parents and lovers unsurprisingly increased stress levels that drove students towards suicidal behaviours (McLaughlin & Gunnell, 2020; Owiti, 2019). In addition, Wang et al. (2019) noted that university students with intense suicidal thoughts felt isolated from peers, rejected and emotionally neglected—however, not every emerging adult under similar pressures engaged in suicidal behaviours. Some preventative factors helped some students remain resilient, cope and manage university challenges healthier (Oketch-Oboth & Okunya, 2018; Studentshare, n.d.). This study sought to identify these protective factors against suicidal behaviours among emerging adults in the university.

The reviewed literature seemed to categorize university-related psychological stressors into academic and non-academic. A documentary by Owiti (2019), ‘Gone too soon: The Rate at Which Kenyan Students Commit Suicide on the Rise’, on reasons for increased suicidal behaviours in the university confirmed the categorization. Owiti (2019) identified academic stressors associated with emerging adults’ suicidal behaviours as academic struggles, missing marks, administrative issues, and financial problems. While non-academic stressors linked with

emerging adults' suicidal behaviours were parent-child conflicts, death of parents and relationship issues and loss of parents were drives to suicidal behaviours Owiti (2019). Nyamori (2015) argued that suicidal behaviours among university students were linked more to non-academic stressors. Nyamori agreed that emerging adults were overwhelmed by academic demands and multiple non-academic issues like romantic relationships, poor problem-solving skills, low self-esteem, and sexual identity. He concluded that students engaged in suicidal behaviours seeking relief from psychological pain and needing to resolve these problems permanently (Nyamori, 2015). Studies showed that high stress levels negatively impacted emerging adults' academic performance and psychological health (Oketch-Oboth & Okunya, 2018; Studentshare, n.d.). Unmistakably university years were filled with stressors that drove emerging adults to suicidal behaviours. Still, unresolved early childhood stressors were unveiled due to the demands of the university environment (Palmer, 2011; Nyamori, 2015). The stressors overwhelmed the emerging adults' personal resources for coping with stress causing them to engage in suicidal behaviour (Nyamori, 2015). Based on these reviews, it was not the academic demands alone linked to suicidal behaviours in students but the impaired coping skills associated with early family environments. That was the reason this study sought to confirm. There was a need for empirical literature on psychological stressors associated with suicidal behaviours in Kenya.

The Role of Spirituality and Suicidal Behaviours

The subject of spirituality and suicidal behaviour among emerging adults needs more study to provide empirical literature on the risks and protective factors. Emerging adulthood is a stage of development where forming a personal spiritual identity is key to a healthy self (McGoldrick et al., 2014; Arnett & Jensen, 2015). This task is accomplished if a student can

form independent spiritual beliefs, devote themselves to spiritual values and be attached to a community of faith (Arnett & Jensen, 2015; McGoldrick et al., 2014). Although this study focused on spirituality, most studies revealed used the term religion interchangeably (Eskin et al., 2019; Cook, 2014; Nkansath-Amankra, 2013; Koening, 2012; Nelson & Padilla-Walker, 2013). Moreover, Taylor et al. (2015) argued that spirituality is expressed through religious and cultural practices. Therefore, both terms were reviewed in light of emerging adults' suicidal behaviours.

Parenting and Emerging Adults' Spirituality. Several studies revealed that parents played a key role during childhood in helping emerging adults form spiritual values and morals (Svob et al., 2018; Arnett & Jensen, 2015; Bengtson & Putney, 2013; Leonard et al., 2013). Emerging adults who experienced warmth and support in the parent-child relationship, with either the father or mother, were likely to develop religious affiliations and beliefs similar to their parents (Arnett & Jensen, 2015). Moreover, parenting styles were significant indicators of whether the child would take after the parents' beliefs and apply them in emerging adulthood (Bengtson & Putney, 2013). Based on Bengtson and Putney's study, it was noted that close, warm and affirming parenting was associated with the religious continuity of the parent in emerging adulthood. Whereas cold, distant, authoritarian, ambivalent and preoccupied parenting nurtured children who were unlikely to be religious, let alone continue with the parent's religious beliefs (Bengtson & Putney, 2013). It was essential to examine the relationship between parenting styles and emerging adults' suicidal behaviours.

Spirituality in Daily Family Life. Emerging adults were spiritually socialized through daily interactions with family members around spiritual values and practices (Svob et al., 2018; Bengtson & Putney, 2013; Leonard et al., 2013). Children who grew up in families where religious practices were applied daily were likely to form a moral worldview and continue with

these religious beliefs (Bengtson & Putney, 2013; Arnett & Jensen, 2015). The parents intentionally taught religious principles, prayed and read the sacred book and communicated openly based on their religious principles (Benftson & Putney, 2013). Although the role of parenting and emerging adults' spiritual formation was clear, there was a need to identify ways faith was intentionally taught in day-to-day family interactions.

Spirituality and Emerging Adults' Wellbeing. Empirically, spirituality was helpful in medical and psychiatric health as it assisted patients in coping with illness and stresses of life (Nkansah-Amankra, 2013; Koenig, 2012; Smith, 2003). Although spirituality works differently for people, it helped reduce depression and suicidal behaviours in some university students (Nkansah-Amankra, 2013). Shek et al. (2019) claimed that spirituality was a strong safeguard against mental health problems because it enhanced character development and strength. Furthermore, character strength was a protective factor against internalizing and externalizing problems, evidenced in depression and suicidal behaviours (Shek et al., 2019). If spirituality was a protective factor against medical and psychiatric problems, this study sought to know if spirituality was a protective or risk factor for suicidal behaviours in emerging adulthood.

Attending Religious Meetings. A spiritual community is critical in emerging adulthood as it provides the peer with whom they can form deep relationships, explore purpose, be accountable, form good social networks and grow holistically (Drovdahl & Keuss, 2020). Therefore, attending religious gatherings was associated with positive outcomes (Cook, 2018; Eskin et al., 2019; Drovdahl & Keuss, 2020). However, there seemed to be other factors in addition to attending religious gatherings associated with better health outcomes. Studies revealed that attending church together as a family was associated with suicidal behaviours compared to holding on to parental beliefs in spirituality (Kuentzel et al., 2012; Svob et al.,

2018). The results were constant whether or not the emerging adults had differing spiritual beliefs or differing ones (Svob et al., 2018; Kuentzel et al., 2012). Another study showed that attending religious meetings was a protective factor against suicidal behaviours among emerging adults if only they attended these meetings at least twenty-four times annually (Cook, 2018). Although the study stated the relationship between attending religious meetings frequently, it did not account for the factors that made attending religious meetings frequently a protective factor.

Religious Affiliations in Emerging Adulthood. Emerging adulthood is a transitional stage when adolescents are developing their own moral and religious or spiritual identities (Barry & Abo-zena, 2014; Drovdahl & Keuss, 2020). They have the freedom to choose whether to affiliate with their parents' religion or spirituality or cultivate their own path of religious affiliation or spirituality (Nelson & Padilla-Walker, 2013; Drovdahl & Keuss, 2020). A study by Eskin et al. (2019) revealed that being affiliated with Hinduism, Orthodox Christianity, and Catholicism reduced psychological distress. While being affiliated with Islam was associated with an increased risk for psychological distress. Another study showed that being that Catholics and Seventh-day Adventists were protective factors for suicidal thinking but being Hindu was a risk factor for suicidal attempt (Toussaint et al., 2015). In addition, being an atheist, agnostic and a nonbeliever were considered risk factors for suicidal behaviours among emerging adults (Svob et al., 2018). Specifically, female emerging adults who held their family affiliation or spiritual values were at a lower risk of engaging in suicidal behaviours than male children (Svob et al., (2018). Therefore, spirituality was seen as a protective factor for emerging adults' suicidal behaviours when dealing with distressful situations at university (Nelson & Padilla-Walker, 2013). A study by Okello et al. (2021) on 'Psycho-Spiritual Perspective on the Challenge of Suicide Prevention in Kenya' revealed the need to engage the religious leaders to support the

families who lose loved one's through suicide to ease the non-disclosure burden. Okello et al. do not expound the how psycho-spiritual perspectives can be employed in the prevention of suicidal behaviours among suicidal behaviours. This was a need this study sought to fill. Furthermore, it was unclear whether these conclusions were generalizable in the Kenyan context. Thus, this research was able to clarify.

Spirituality and Emerging Adults' Suicidal Behaviours. There were contradictory and inconsistent associations between spirituality and poor health outcome (Shel et al., 2019; Toussaint et al., 2015) conclusions on the value of spirituality on suicidal behaviours among emerging adults. Studies showed that spirituality was a proactive factor against some suicidal behaviours but not others (Taliaferro et al., 2010; Askin et al., 2019; Lawrence et al., 2016). Taliaferro et al. (2010) revealed that existential well-being rather than spiritual well-being was a preventative factor against suicidal ideation among emerging adults in colleges. On the contrary, other studies showed that spirituality was a risk factor for suicidal behaviours (Eskin et al., 2019; Lawrence et al., 2016; Teevale et al., 2016). A multinational study by Eskin et al. (2019) observed that being affiliated with Islam and Orthodox Christianity was associated with suicidal ideation, while being affiliated with Buddhism and Catholicism had a low risk for suicidal attempt, but being Islam was a risk for suicidal attempt. A review on spirituality and suicide risk by Lawrence et al. (2016) observed different interactions between spiritual factors like affiliation, participation and adherence to doctrine with suicidal ideation, attempts, and completion. Lawrence argued that spiritual affiliation and regular attendance of spiritual gatherings protected emerging adults against suicidal attempt.

Nonetheless, it did not protect those who attended spiritual gatherings from suicidal ideation. Lawrence et al. (2016) concluded that spirituality was a preventative factor against

suicidal attempt but not suicidal thinking, planning or self-harm. It was uncertain what made spirituality a protective factor for suicidal attempt but not other suicidal behaviours. In addition, there was a need to understand the interaction between spirituality and suicidal behaviours in a cultural context because spirituality impacts people's beliefs and values in the context in which the behaviours were born.

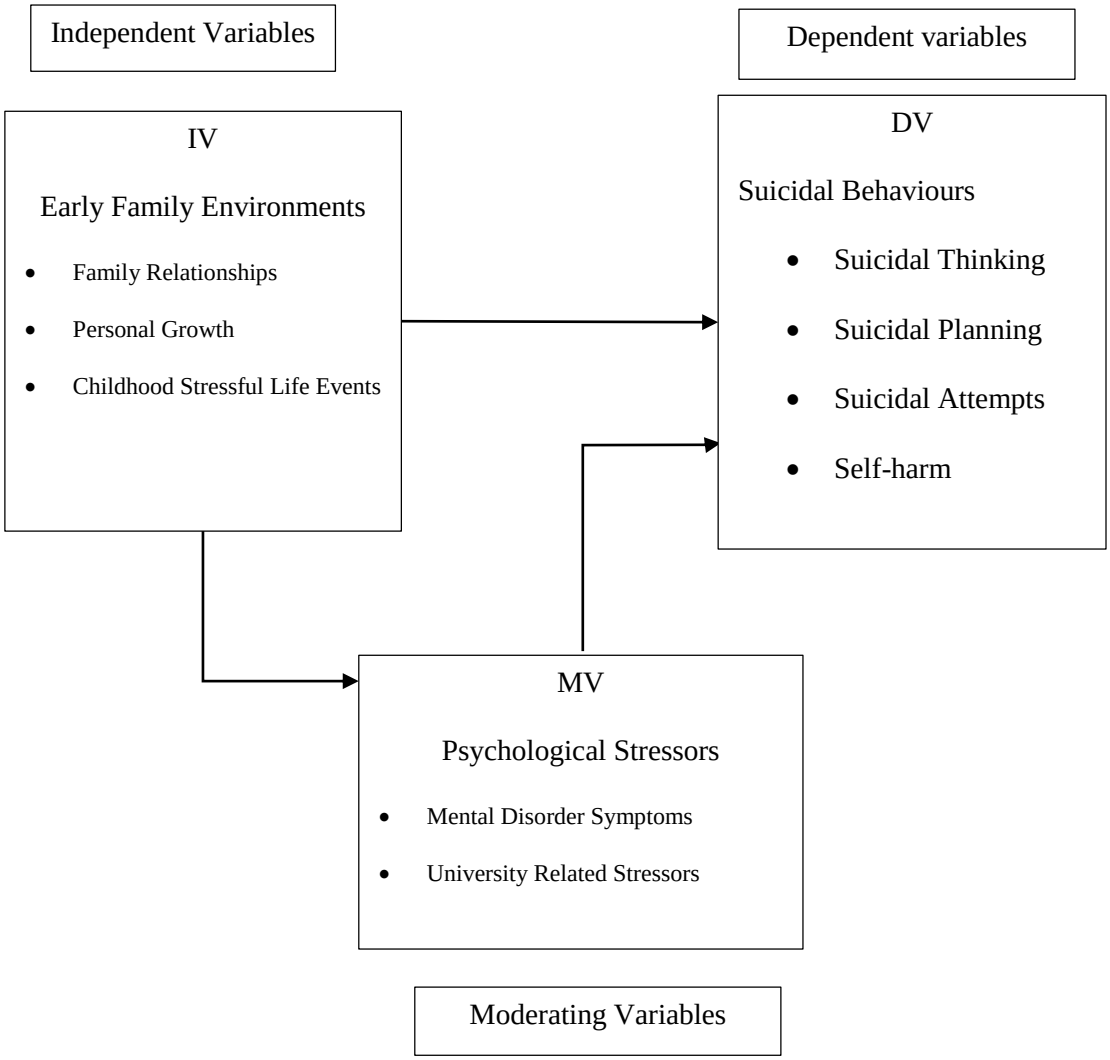
Conceptual Framework

Conceptual frameworks are structured, logical narratives and pictorial presentations of key variables showing their assumed relationship (Adom et al., 2018). The conceptual framework of this study was grounded on three integrated models of family therapy: The Life Course Development, Attachment Theory, and the Satir model, as well as the literature reviewed.

The study explored two variables; the independent variable and the dependent variables. The independent variables were the early family environments comprising family relations, personal growth, and stressful life events. The dependent variables were suicidal behaviours consisting of four behaviours: suicide thinking, suicide planning, suicide attempt and self-harm. The moderating variables were other factors outside of the independent variables that affected the relationship between the independent variables, early family environment and dependent variables, suicidal behaviours among emerging adults (see Figure 1)

Figure 1

Conceptual Framework



Note. The assumed relationship between the independent, dependent and moderating variables.

As evidenced in the literature review and the three theories reviewed, significant associations helped understand the relationship between early family environments and emerging adults' suicidal behaviours. However, this relationship may not be evident due to the moderating variables revealed in prevailing psychological stressors, university-related stressors and mental

disorders symptoms. These variables were more prominent in emerging adults' lives as the reasons for suicidal behaviours. On the contrary, these psychological stressors seemed to overwhelm emerging adults who have insecure family relationships, are ill-equipped with problem-solving skills, and have unresolved stressful childhood events. Therefore, these challenges in the early family environment were presumed to cause emerging adults psychological stress when faced with university stressors evident as mental disorder symptoms.

Synthesis of the Research Gaps

Based on the literature review, there was a disturbing rise in suicidal behaviours among emerging adults in the university globally. Although studies demonstrated a significant relationship between early family environment and suicidal behaviours among emerging adults, most studies focused on the university environment. The literature reviewed in Kenya showed a contextual gap that required more data-driven studies on the influence of early family environment on emerging adults' suicidal behaviours. Additionally, the available literature in the Kenyan context was based on informal reports and quantitative research. Therefore, there was a need for a mixed-method empirical study to confirm the informal reports, increase knowledge, and provide objective wisdom to stakeholders on the prevention and intervention of suicidal behaviours among emerging adults in Kenya. Moreover, there was a need to examine the conceptual framework on the influence of early family environments on emerging adults' suicidal behaviours in Kenyan universities. The knowledge obtained would inform early family settings, parenting patterns, and the systemic nature of suicide prevention and intervention for emerging adults in the universities.

Chapter Summary

This chapter reviewed the literature and theoretical framework for anchoring this study. It reviewed literature and theoretical frameworks on the study topic and the study objectives beginning with the prevalence of suicidal behaviours among emerging adults in the university. In addition, literature on the influence of early family environments, psychological stressors and the role of spirituality on emerging adults' suicidal behaviours was reviewed. The chapter discussed the study's conceptual frameworks grounded on the theoretical and literature review using a figure and narrative to explain the theorized relationship.

Chapter Three

Research Methodology

This chapter describes the method applied in the research study. The research methodology comprised the study design and strategies, the study location, the study population, and sampling procedures. In addition, the chapter discussed the type of data collected, the data collection instruments used, the reliability and validity indices and the protocol. The chapter discussed the data analysis strategies, relevant ethical issues considered in the study and a summary of the chapter.

Research Design

Convergent Mixed Methods Research Design

The researcher employed a mixed methods design. The mixed methods research design combines quantitative and qualitative methods in data collection and analysis (*see* Clark et al., 2008; Jeanty & Hibel, 2011; Molina-Azorin, 2016; Kaushik & Walsh, 2019). The specific research strategy used for this research was the convergent mixed methods design that allowed for concurrent data collection and analyses for the quantitative and qualitative data. The qualitative data was gathered from an open-ended questionnaire, while the quantitative data was collected using a closed-ended questionnaire to capture multiple perspectives of the research questions (Creswell, 2014). The qualitative data was gathered through focus group discussions and one Delphi questionnaire.

As observed by Zheng (2015), the mixed methods research designs allowed for multiple data, where the qualitative data amplified and enhanced the findings from the quantitative data. The reason is that the quantitative data aimed at describing the general trends and the relationships between the variables, such as the prevalence of suicidal behaviours and the

features in the early family environment linked to suicidal behaviours. While the qualitative data described the beliefs, attitudes and behaviours of the participants through focus group discussions and Delphi interviews (Zheng, 2015), in this study, the qualitative aspect of this design helped the researcher to understand the psychological stressors associated with suicidal behaviours and the role of spirituality on emerging adults' suicidal behaviours. Therefore, the mixed methods study design enabled the researcher to capture the respondents' viewpoints as well as validate the theoretical framework and the literature reviewed (Tucker et al., 2015; Jeanty & Hibel, 2011) in order to make meaning of the suicidal behaviours emerging adults in the selected universities in Kenya.

Suicidal behaviours among emerging adults are a human problem associated with socio-cultural issues. Therefore, the convergent mixed methods study design was the best-suited research design to examine suicidal behaviours among emerging adults (see more, Wong et al., 2011; Halliburton et al., 2021; O'Donohue et al., 2021). Furthermore, this study design is appropriate for family studies as it helped the researcher to answer the research questions using both quantitative and qualitative methods of inquiry (Sprenkle & Piercy, 2005; Gambrel & Butler, 2011; Westwater et al., 2020; Mendenhall et al., 2014; Lange et al., 2023). Although there were documented reasons for suicidal behaviours among emerging adults, a mixed research design helped the researcher to place the participants' qualitative views in perspective in light of the quantitative data (Kaushik & Walsh 2019).

Pragmatism Paradigm. The convergent mixed method research design is grounded on the pragmatism paradigm (Creswell, 2014; Jeanty & Hibel, 2011). A paradigm is an organized way of observing the world based on set beliefs, principles and overviews held by a community of specialists about obtaining truth and understanding (Kaushik & Walsh, 2019). Pragmatist

researchers use quantitative and qualitative methods to answer research questions in a given area of study (Jeanty & Hibel, 2011; Molina-Azorin, 2016; Kaushik & Walsh, 2019). The pragmatism paradigm is commonly used in social science research because it captures beliefs and experiences that give a deeper understanding of human behaviour (Morgan, 2014; Kaushik & Walsh, 2019). Moreover, a pragmatism paradigm focuses on problems arising from actions, situations, and human consequences emerging from people's social, historical and political contexts (Jeanty & Hibel, 2011; Creswell, 2014).

Study Population

The study population referred to the bigger population targeted for the study. The sample population of 216 students and two university counsellors were drawn from the public university. Another 215 students and four university counsellors were drawn from the private university. The selection of two universities for the study was informed by previous studies where two universities were involved in three studies by Becker et al. (2018), Wang et al. (2019) and Lew et al. (2019). Furthermore, two studies by Silverton et al. (2019) and Ogachi et al. (2019) informed the categorisation of private and public universities.

Sample Size

The researcher selected a sample size of 200 students from the public university and 199 students from the private university for this study. The sample size was informed by Sprenkle and Piercy (2005), who contended that a sample size of 150 -200 participants is sufficient in mixed methods survey research in marriage and family therapy because it helped manage error margins from negatively impacting the results. This was supported by other studies that argued that a minimum of 100 subjects are sufficient in a survey (Anthoine et al., 2014; Kock &

Hadaya, 2018; Tomczak et al., 2014). Besides, a similar study by Ongachi et al. (2019) in two universities sampled 400 students, where 200 students were drawn from each university.

The number of students selected to respond to the survey questionnaires were those available in the universities on the day and time the researcher was authorized to collect the data. Mertens and McLaughlin (2004) contended that survey research required at least 100 observations from each major group and 20 to 50 for minor groups; this study met the 90% threshold for sample selection by year of study. A sample of 200 students was surveyed from the public university. Those selected from each year of study were: 13 in first-year, 35 in the second year, 50 in the third year, 68 in the fourth year and 34 in the fifth year and above. In the private university, a sample of199 students were involved in the study, where 37 in first-year students, 36 in second-year students, 59 in third-year students, 58 in fourth-year and nine in fifth-year and above. Few students were in the private university in their fifth-year of study because most courses took four years.

In addition, a sample size of 16 participants from each university was involved in one of two focus group discussions. In each focus group discussion, eight participants were involved in the study. This number of participants was selected based on Hennink's (2014) recommendation that six to eight participants are recommended in focus group discussions because they allow all the participants to contribute to the discussion. The sample population included students in each year of study.

In addition, six university counsellors were recruited to provide an expert consensus on the study objectives. The requirements for being included in the panel of experts included: a three-year experience in the counselling or psychotherapy practice, currently working as a university counsellor or therapist and was willing to be involved in answering three Delphi

questionnaires. Previous Delphi studies informed the number of university counsellors involved in the study. Shariff (2015) and Rossi et al. (2021) argued that a minimum of five to 10 experts were sufficient for a Delphi study. Additionally, a Delphi study has to engage in at least two to four rounds of responding to questionnaires on the same topic (Rossi et al., 2021; Shariff, 2015). This study involved six university counsellors who answered three Delphi which questionnaires, which were done fully online.

Sampling Procedures

This study employed multiple sampling procedures in the five phases of sample selection. The first phase was the selection of the universities for the study. A simple random sampling procedure was used to select the private university. The public university was selected using purposive sampling owing to the fact that it is the only public university in Kasarani Constituency (see Table 1).

Table 1

The Study Population of the Universities

University Type	Number of Universities In Kasarani Constituency	Number of Universities Selected
Public Universities	1	1
Private Universities	4	1
Total	5	2

Note: The number and university type in Kasarani Constituent selected for this study.

After selecting the universities, the data collection process began by seeking authorization from these universities in order to gather data. Both universities recommended the use of research assistants for this process. Four research assistants from each institution were availed to the researcher, and a two-hour training was conducted for each group.

The second phase of the sample selection was to select the students according to their year of study. A stratified sampling method was used to select participants from five categories informed by the years of study. The researchers employed a stratified random sampling procedure to select five classes from the university's timetable according to the year of study taught on the day assigned for data collection. The class codes by year of study were written on pieces of paper and put in a big bowl. The researchers mixed up the papers in the bowl and picked one paper without replacement to select two classes per year of study to participate in the study. Nine classes were selected in each university for this study.

The third phase of the sample selection involved the selection of students to participate in the study. In each of the selected classes, a simple random sampling was done where all the students were counted, and then those assigned odd numbers were selected for the study leaving out those with even numbers. The students were informed about the study, and consent was sought to engage in the study. Those willing to participate in the study were invited to sign the consent form and fill out the self-administered questionnaire. The participants were free to drop out of the study at any point. The participants were required to report any negative psychological effects resulting from participating in the study immediately. Such students were directed to the counselling centre for psychological care and support. The following students were selected for the study: in the first-year, 18 participants were selected from one class and 19 from the other; in the second-year, there were 18 from each class; in the third-year, 30 students were selected in one class and 29 students from another classs; and in the fourth-year, 29 students were selected from the two classed selected. Only one fifth-year class was selected. A senior class was identified where ten students were identified to have been on campus for more than four years.

The ten were willing to engage in the study, although, during the process, one student dropped out, leaving nine students to make a total of 199 participants.

Another day was selected to gather data at the public university. The same sampling procedure was used to select the students from the public university. The same sampling procedures used in phases two and three to select participants in the private university were utilized in selecting participants in the public university. In phase two, a stratified random sampling procedure was used to select classes by year of study. The researcher and the research assistants identified the ongoing classes by year of study. The course codes were written on a piece of paper, all the courses on the timetable by year study, and they were put in a big bowl and mixed up. Two classes each were selected without replacement from the second-year to the fifth-year of study. Only one first-year class was available for selection, with 25 students. Only 13 students agreed to participate in the study. In the third phase, participants were selected using a simple random sampling procedure. Each student in the class was assigned a number by counting all the students according to their seating arrangement. The students with the odd numbers were selected for the study. The second-year classes had 17 and the other 18 students; in the third year, there were 25 students each in the two classes; there were 34 students each in the two fourth-year classes; and 17 students each in the two fifth-year classes selected. The students were informed of the study and allowed to consent if they were willing to participate. The participants were free to drop out of the study at any point. The participants were required to report any negative psychological effects resulting from participating in the study immediately to be directed to the counselling centre for psychological care and support. The majority of the student consented and filled in the survey questionnaire. A total of 200 participants from the

public university were involved in the survey. At the end of the exercise, one student exhibited emotional distress and was directed to the counselling centre for counselling.

The fourth phase of the sample selection involved the selection of participants in the focus group discussion. Convenience sampling was used to select 16 students per university to participate. Convenience sampling was considered the favourite way to select participants willing to discuss this difficult topic. Furthermore, similar studies employed the same method to select focus group discussion members (Sharpe et al., 2013; Shaw et al., 2022). After selecting the participants from each class by year of study, the researchers asked for volunteers from those students with even numbers to be involved in one Zoom focus group discussion for each university. In the private university, two students volunteered to participate in the study from first-year to fourth-year from each selected class. In the public university, two students from second-year to fourth-year from each class volunteered to participant in the focus group discussion. But in the first-year and fifth-years, one student from each year of study per class volunteered to participate in the focus group discussions. The researchers took the students contact of the 16 students and randomly assigned them to two groups of eight participants per university. A date was set for each group to meet on Zoom. At the beginning of each focus group discussion meeting, the researcher informed the students of the purpose of the study and allowed the students to consent. The researcher also sought consent to record the meeting. The researcher used the semi-structured questionnaire to obtain emerging adults' attitudes, thoughts, feelings and experiences to answer the objective questions. The focus group discussions were recorded, transcribed and organized around themes.

The fifth phase of the sample selection was the selection of the university counsellors. A snowballing sampling procedure was used to select the university counsellors for this study.

Delphi study samples are obtained mostly through snowballing as the sample requires expertise in the subject of study which means training and experience (Leavy, 2017). Two counsellors helped the researcher with contacts of university counsellors from the university counsellors' social network forum. Six university counsellors completed the three rounds questionnaire. Three university counsellors were selected from the public university, two from the public university and one from another private university. These university counsellors met the criteria set for experts to be involved in this study; they had three years of experience in counselling or psychotherapy, worked as university counsellors, and were willing to be involved in this study. The first round of the Delphi contained seven semi-structured open-ended questions for the counsellors to write down their opinions and experiences. The researcher emailed the Delphi round one tool to the counsellor, who emailed their responses back to the researcher. The researcher then compiled and organized into similar themes from the counsellors' responses to form the round two structured closed-end Delphi questionnaire. The questionnaire was a Google form document whose link was sent to the university counsellors to complete. The Google form responses were received and analyzed to capture the consented responses. The least popular responses were deleted from this Google form which became the third round of structured closed-ended questionnaires. Once the responses were delivered from the third Delphi questionnaire, the results were analyzed, on the Google form, to obtain the summary of the counsellors' consensus in graphs.

Types of Data

This research study used primary data. Surveys were used to gather both quantitative and qualitative data. A survey was appropriate for a suicide study because it allowed participants to share experiences, perceptions, feelings and opinions (Mental Health First Aid Australia, 2016).

The quantitative data was collected directly from the participants using structured closed-ended questionnaires. The researcher used self-administered questionnaires and two Delphi questionnaires to collect quantitative data.

The qualitative data was gathered using the focus group discussions and round-one of the Delphi interview and semi-structured open-ended questions. Focus group discussions are used in psychology to gather data from a group of people who, through discussion, provide insight into a social convern by sharing experiences, beliefs, attitudes and perspectives (Nyumba et al., 2018). Focus group discussions provided the researcher with a contextual view of suicidal behaviours among emerging adults in the selected universities in Kenya.

A Delphi survey is a research method used in social sciences, especially in family studies, to answer research questions by consulting with experts or professionals on the subject to obtain consensus on a given topic. Delphi studies use open-ended and closed-ended questionnaires to reach a consensus on research objectives (Keeney, Hasson, & Mckenna, 2011). The responses from the self-administered questionnaires, focus group discussions and the Delphi questionnaire were merged, triangulated, compared and interrelated the findings to validate and cross-validate the research study (Hesse-Biber, 2010). Therefore, both quantitative and qualitative data were gathered.

Data Collection Instruments

The study used several data collection instruments to capture the four objectives of the study. The tools used for collecting quantitative data were adopted (80%) from standardized tools and adjusted (20%) to explore the conceptual and theoretical frameworks in order to answer the research objectives. The key questions were adopted as in the tools, while the number of questions and the organization were self-developed. Most of the tools were free to use, and they

did not require permission from the developers. The standardized tools used were: Family Environment Scale (FES), the Stressful Life Events Screening questionnaires (SLESQ), Emerging Adult Stress Inventory (EASI), the Suicide Assessment Five Steps Evaluation – Triage (SAFS-T), Columbia-Suicide Severity Rating Scale (C-SSRS), the Non-Suicidal Self-Injury Assessment Tool (NSSI-AT), Religious Commitment Inventory-10 (RCI-10), and the Satir Iceberg (Omar et al., 2010; Whitlock & Purington, 2014; Murray et al., 2020; Worthington et al., 2003; Yershova et al., 2016; Satir et al., 1991; Lum et al., 2002).

The self-administered questionnaire was divided into five sections. The first section captured the emerging adult demographic data, which was compared to the emerging adulthood stage. The second section used two of the three Family Environment Scale (FES) to explore emerging adults' early family environment. The two dimensions examined were family relations and personal development. In each dimension, statements were given describing the early family environment for the respondents who picked one alternative on a 5-Likert scale where never (1) and regular (5). In addition, a list of 14 stressful life events experienced before the age of 12 years was adopted from the Stressful Life Events Screening Questionnaire (SLESQ). Participants were expected to indicate no (1) or yes (2).

The third section of the questionnaire examined the level of engagement of the emerging adult in suicidal thinking, planning, attempts, and self-harm. The study adopted the questions from the Suicide Assessment Five Steps Evaluation-Triage (SAFS-F), Columbia-Suicide Severity Rating Scale (C-SSRS), and the Non-Suicidal Self-Injury Assessment Tool (NSSI-AT). A list of five statements on each suicidal behaviour was provided for participants to indicate if they had thought or engaged in any of the suicidal behaviours in the last 12 to 24 months. The

responses provided were no (1) or yes (2); if yes, the participant was asked to write down the number of times they engaged in suicidal behaviour.

The fourth section explores the prevailing psychological stressors compelling emerging adults to engage in suicidal behaviours. The tools adopted were the Emerging Adult Stress Inventory (EASI) and the Satir Iceberg metaphor to examine the responses to stress resulting in distress as seen in the survival stances, the feelings, beliefs, and expectations of self, other and the context. A list of 10 stressors was provided for participants to indicate whether they were having these experiences no (1) or yes (2) and how they were responding to them.

The final section examined the spirituality of emerging adults based on Satir's Universal-Spiritual and the Religious Commitment Inventory-10 (RCI-10), both of which helped examine the intrapersonal and interpersonal spirituality in relation to emerging adults' suicidal behaviours. Participants were presented with Satir's universal yearning and spiritual beliefs to indicate whether these desires and beliefs were untrue no (1) or true yes (2) of them. The open-ended questionnaires, both the focus group discussion and the Delphi interview, explored the same topic: early family environment, prevalence of suicidal behaviours, psychological stressors, and spirituality.

Test Retest

The researcher used the test-retest method of reliability testing to determine whether the questionnaires were reliable and valid in examining the study objectives (Bujang & Baharum, 2017). A test-retest was conducted among 22 university students from Pan Africa Christian University (PAC University). Bujang and Baharum (2017) recommended that a minimum number of 10 to 22 participants was adequate for obtaining the reliability of a research instrument. The participants filled in the survey questionnaire and then retook the same test a

second time with a one-week gap. The scores of the two tests were obtained to assess the consistency of the results and the reliability indices. After the results of the two testes were calculated using the Pearson Product Moment Correlation, a score of r= .83 was obtained. The researcher concluded that the test was reliable because the results were greater than r >.80, the acceptable reliability indices.

The content validity, construct validity and internal validity were obtained by availing the questionnaires to the research supervisors and another two lecturers in the Psychology department at PAC University, who reviewed the content measures to confirm the variables were measuring what they were intended to measure. In addition, peers were recruited and reviewed the questionnaire. The researcher adjusted the questionnaires based on the test-retest results, supervisors, psychologists and peer reviews.

Data Analysis Methods

The data collection methods used in this study were quantitative and qualitative.

Based on the nature of the data, the Statistical Package for Social Sciences (SPSS) statistics version 27 was used to analysis the quantitative data. Specifically, the researcher used descriptive statistical methods to describe and summarize data using frequencies, measures of central tendency like the mean and inferential statistics (Leavy, 2017). The relationship between independent and dependent variables was obtained using multivariate statistics (MANOVA). In this study, mean score indexes were obtained when calculating the frequencies of suicidal behaviours among emerging adults. 5-scale indexes measured suicidal thinking, suicidal planning, and suicidal attempts and 6-scale indexes measured self-harm. A mean score of one meant that the participants engaged in one incident of suicidal thinking, planning and attempts. A mean score of five meant that the participants had engaged in all five incidences of suicidal

thinking, planning and attempts. Indexes and scales are used in social studies, especially psychology, to measure personal behaviour (Fogarty, 2019). Tables and graphs were used to summarize the research results. Further statistical analysis presented the correlation and significance between the independent and dependent variables using multivariate analysis of variance (MANOVA) (Sprenkle & Piercy, 2005, p. 227; Asthana, H. S., & Braj, H. 2016; George, D. & Mallery, P. 2020). The equation of the correlation used was: $Y_i = \alpha_i + \beta_1 X_{1i} + \beta_2 X_{2i} + \cdots + \beta_k X_{ki} + \varepsilon_i$

- Where Y represented the dependent variables of suicidal behaviours: suicidal thinking, suicidal planning, suicidal attempts or self-harm.
- X represented the predictor, explanatory, and independent variables which are included in the models separately depending on the objective/theory/hypothesis which were tested
- β represented the coefficients of association being estimated between the dependent and independent variables
- Ɛ represented the error term in the measurement.
- α represented the Y-intercept, interpreted as the value of the dependent variable without the influence of the independent variables included in this regression model.

The use of p-values to measure the level of confidence was at $p< 0.5$, and R-squares were used to determine the coefficient direction and relationship strength. The qualitative data collected from the focus group discussions and the Delphi were coded, categorized thematically and interpreted using NVIVO version 12, a Computer-assisted qualitative data analysis software to sort, structure and analyze large data. This allowed the researcher to interpret the written and recorded data using the analysis. The researcher obtained the NVIVO software, which assisted in coding, organizing and analysis qualitative data collected through mixed methods (Bazeley & Jackson 2013). The data collected was concurrently triangulated using both theoretical and data triangulation. Theoretical triangulation assisted the researcher in interpreting the research data

using the three theories the research was grounded on. While in the data triangulation, the data collected using quantitative and qualitative methods were examined and reported (Leavy, 2017). Then the comprehensive findings were merged and compared in the final report.

Ethical Issues

The researcher addressed potential risks participants were prone to during the research. This study addressed five ethical issues based on Standard V titled; Research and Publication in the American Association of Marriage and Family Therapists (AAMFT) ethical code (AAMFT, 2015). These ethical issues were institutional approval, protection of research participants, informed consent to research, right to decline or withdraw from participation and confidentiality of the research data.

Authorization

The researcher obtained multiple permissions to carry out the study. First institutional approval, the researcher obtained clearance from the Pan Africa Christian University research ethical board before proceeding with the study. The researcher sought a research license from the National Commission of Science, Technology and Innovation (NACOSTI), which directed the researcher to obtain additional clearance from Nairobi County to conduct the research. The permission obtained from the Nairobi County included: authorization from the Governor's office, County Commissioner and County Education Social and Gender. The research obtained the relevant authorization to carry out research in the universities.

Protect Research Participants

The researcher ensured high levels of ethically acceptable work through relevant supervision and the training of research assistance in order to protect research participants. The benefits and risks of participating in this research were also discussed with the participants.

Potential Risks.

Participants under mental treatment were excluded from managing potential risks, or adverse effects could have been trigged during the study. The participants who experienced distress or discomfort due to participating in the research were debriefed by the research assistants and directed to the counselling centre. In addition, the research assistants debriefed the participants after participating in the study.

Potential Benefits

The study was designed to benefit many stockholders such as parents or guardians, families, universities, counsellors and the general public by providing empirical knowledge. The knowledge has informed stockholders on the risk factors, protective factors and interventions for suicidal behaviours among emerging adults in the university. The participants benefited from the self-exploration exercise and found a safe forum to talk openly on a taboo topic. This helped participants to gain perspective of the universality of the challenges they are facing in the university.

Informed Consent

Turning to informed consent, the researcher, through the research assistants, informed the participants of the purpose of the research, the expected length, and the procedure to obtain consent. The participants could decline or withdraw from participating in the research at any time.

Confidentiality

Anonymity was observed as the researcher securely stored the information obtained from the participants by securely storing the research documents, questionnaires, recordings and virtual correspondence. There was no need to withdraw confidentially because no participant had

the plan to harm self or another. To enhance the confidentiality and anonymity of the universities and the participants, the researcher assigned code numbers to conceal the real identities of the universities and the participants.

Chapter Summary

This chapter discussed the study design, and the strategies the researcher used to conduct the study were elaborately discussed. Furthermore, the chapter described the study location, population, the sample and the sampling procedure used in selecting participants. The methods of data collection and analysis were deliberated. Finally, the researcher expounded on ways the validity, reliability, and ethical standards of this study.

Chapter Four

Data Presentation, Analysis, Interpretations and Discussions

This chapter presented the results, analysis, interpretation and discussion of the findings on the Early Family Environment and Suicidal Behaviours among Emerging Adults in selected universities in Nairobi County, Kenya. The findings were based on the data gathered through convergent mixed methods. The data was drawn from a survey questionnaire, focus group discussions, and Delphi questionnaires. The quantitative and qualitative results were concurrently presented, analyzed, interpreted, and discussed. The quantitative results described the characteristics, frequencies, and relationships between the variables and answered the study objectives. The qualitative results described emerging adults' beliefs, attitudes, and behaviours concerning the variables and study objectives. The two data sources were merged and triangulated to generate this report. A summary of the chapter was presented.

Demographic Data

A sample of 431 participants were involved in this study. The survey participants were 399 undergraduate university students. The sample was drawn from one public university and one private university, represented by 200 and 199 respondents, respectively, as shown in Table 2. The public university sample constituted 115 (57.5%) male students and 85 (42.5%) female students, while the private university sample consisted of 123(61.8%) female students, 74 (37.2%) male students, and two (0.5%) of other gender. Another sample of 32 students participated in the focus group discussions, and six university counsellors responded to three rounds of Delphi questionnaires.

Table 2

Number of Participants by University Type

	Frequency	%	Cum
Private University	199	49.87	49.87
Public University	200	50.13	100.00
Total	399	100.00	

Note. This was the sample distribution by university type.

Emerging Adults' Profile

Physical and Psychological Characteristics. The average age of emerging adults in the university was 20 – 25 (79.2%) of the respondents. As shown in Table 3, 128 (32.1%) were 22-23 years old; 122(30.6%) were 20-21 years old; students between 24-25 years-old were 66 (16.5%); 43 (10.8%) of the students were 26 years old and above and 40 (10%) of the students were 19 years and below.

Table 3

Participants by Age

	Frequency	%	Cumulative Frequency
18 and below	2	0.50	0.50
18-19 years	38	9.52	10.03
20-21 years	122	30.58	40.60
22-23 years	128	32.08	72.68
24-25 years	66	16.54	89.22
26 and above	43	10.78	100.00
Total	399	100.00	

Note. The description of participants by age.

These results were similar to those recorded from the Delphi consensus that students in the university were 18 – 29 years-old. The counsellors described emerging adults as appearing to be strong, fit and energetic with an adult's body shape. These findings are similar to Tanner & Arnett (2016) and Arnett (2011; 2018), who defined emerging adulthood as 18 -25 years-old. Similar conclusions were made by Frey (2018) and Jasmin (2019), who observed that emerging adulthood is between ages 18-29 years when adolescents are transiting to adulthood.

Furthermore, the university counsellors added that emerging adults have unique psychological and social characteristics. Psychologically they were making important education and career choices, changing support systems from family to peers, exploring an independent identity apart from their family, and desired to appear ‘normal’. Moreover, emerging adults identified themselves as male, female and another gender.

Table 4

Participants by Gender

Gender	Frequency	%	Cumulative. Frequency
Male	189	47.37	47.37
Female	208	52.13	99.50
Other	2	0.50	100.00
Total	399	100.00	

Note. The description of participants by gender.

The gender characteristics of the survey participants are presented in Table 4. The sample comprised 189 (47.4%) male students, 208 (52.1%) females and two (0.5%) of the other gender. A sign that they faced gender identity challenges is a reality of their environment. These were consistent with Arnett et al. (2011) views that emerging adults face demands to form a stable identity, be responsible and be realistic with life.

Table 5

Participants by Year of Study

Years	Freq.	Per cent	Cum.
1st year	50	12.53	12.53
2nd year	71	17.79	30.33
3rd year	109	27.32	57.64
4th year	126	31.58	89.22
5th year and above	43	10.78	100.00
Total	399	100.00	

Note. The description of participants by year of study.

In addition, the results revealed that the majority of the participants were fourth-year and third-year students, 126 (31.6%) and 109 (27.3%), respectively. Whereas 71(17.8%) were

second-year students, 50(12.5%) were first-year students, and a minority, 43 (10.8%), were students in their fifth year and above (See Table 5).

These findings imply that this stage is full of internal and external stressors that might compel emerging adults to suicidal behaviours. They need support to navigate these stressors and become healthy adults. A view supported by Valdez et al. (2013), encouraging the family and parents to support emerging adults to develop healthy coping skills for the prevailing challenges.

Social Characteristics. The findings revealed that emerging adults were transitioning from dependency on parents/guardians to being independent. There was decreasing parental interaction as the majority, 67.2%, lived away from home in various hostels; 34.1% lived in hostels around the university, 16.8% lived in hostels away from the university, and 16.3% lived in hostels within the university. Only 32.8% of the students lived at home, as seen in Table 6.

Table 6

Participants Residence

Living Arrangement	Frequency	%	Cum
At Home	131	32.8	32.8
Hostel around the University	136	34.1	66.9
In the University hostels	65	16.3	83.2
Hostels away from the University	67	16.8	100.00
Total	399	100.00	

Note: Description of students' residence when the university was in session.

Besides, as shown in Table 7, the study showed that when the university was in session, most students lived alone, 40%; 29% lived with a schoolmate, and 4.5% had an intimate partner. The remaining students lived with a family member; 21% lived with parents/guardians and siblings, 3.8% lived with a sibling only, and 2.5% lived with a parent/guardian only.

Table 7

Partivipants Living Arrangments

Living Companion	Frequency	%	Cum
Parents/Guardians and siblings	82	20.6	20.6
School Mate	114	28.6	49.2
Parent/Guardian only	10	2.5	51.7
Siblings Only	15	3.8	55.5
Alone	160	40	95.5
Intimate Partner	18	4.5	100.00
Total	399	100.00	

Note: Description of whom the students resided with when the university was in session.

In addition, as shown in Table 8, the majority of the emerging adults confided in peers 32.3%, 16% confided in no one, 11% confided in siblings, and 1.3% in pastors/religious leaders. Still, some students confided in family members, especially their mothers. 27.6% and 5% confided in their fathers.

Table 8

Participants Confided in

Confidant	Frequency.	%	Cum
Mother	110	27.6	27.6
Father	20	5	32.6
Sibling (brother/sister)	44	11	43.6
Relatives	7	1.8	45.4
Peers/friends	129	32.3	77.7
Pastor/religious leader	5	1.3	79.0
No one	64	16	95.0
Other	20	5	100.0
Total	399	100.00	

Note. The breakdown of who the students confide in.

According to this study, emerging adults interacted less with their parents and family while interacting more with peers. The Delphi findings were convergent to the survey findings in that they described emerging adults as active users of multiple social media, influenced by peer opinions, and experimenting with alcohol and drugs. This profile matched Cater and McGoldrick's (2005) description of young people leaving home to pursue education and careers. Sivertsen et al. (2019) echoed the same thoughts that emerging adults had decreased time for parental guidance as they were adjusting to university life, increasing access to risky behaviours and making decisions concerning career and intimate relationships.

This means there is a need to strengthen the peer support system to identify and connect each to resources that support non-aggressive and healthy problem-solving skills. Moreover, the hostels are busy hubs where students could find psychological support as they would have medical contacts to call on in times of need. However, parents and siblings remain a key support system for emerging adults to call on in times of need.

Spiritual Characteristics. As revealed in Table 9, emerging adults were religiously affiliated with Protestant 204 (51.1%), Roman Catholic 111 (27.8%), Muslim 26 (6.5%), Hindu 1 (0.3%), Atheistic 15 (3.7%) and other religions 42 (10.5%). Religious affiliations were a sign of a spiritual identity.

Table 9

Participants Religious Affiliations

Spirituality	Frequency	%	Cum
Roman Catholic	111	27.82	27.82
Muslim	26	6.52	34.34
Protestant	204	51.13	85.46
Hindu	1	0.25	85.71
Atheist	15	3.76	89.47
Other	42	10.53	100.00
Total	399	100.00	

Note. The description of the students according to their religious affiliations.

This study concurs with King et al. (2013), who argued that religious participation was a better measure of a person's mental health than spirituality with unclear beliefs and practices. The focus group discussions revealed that many emerging adults whose families emphasized religious practices at home continued with these practices. Thus emerging adults' spirituality was a familial, cultural and personal choice, although, for some students, their spiritual views were similar to those of their family of origin. These findings reinforced the views of Bengton and Putney (2013) and Arnett and Jensen (2015), who observed that emerging adults who grew up applying religious practices at home continued these religious beliefs in emerging adulthood.

On the contrary, Arnett (2018) observed that emerging adults in recent generations were less interested in spirituality or religion. That explained the lack of moral and spiritual resources

necessary for advancing an emerging adult at this stage of life. The implication of these findings was the need for families and religious communities to find ways of strengthening the spiritual discovery and establishment of emerging adults. This has the potential to protect emerging adults from suicidal behaviours by providing them with a healthy identity, meaning of life and a community of support.

Emerging Adults' Family Profile

Family structure. The study captured the participants' family profile, including family structure, parents' highest education level and parenting styles. The findings revealed in Table 10 an overwhelming majority of the participants, 289 (72.4%), were drawn from two biological parent families, single female parent 63 (15.8%), blended families 21 (5.3%), single male parent families 17 (4.3%), guardian headed families 7 (1.8%), and sibling headed families 2 (0.5%).

As logically expected, female students were more likely to engage in suicidal attempt having thought and made plans to end their lives. This study revealed that female students were more likely to: a) come close to taking away their lives (female 13% and male 4.3%), b) abandon an attempt to take away their lives (female 12% and male 6.4), c) tell someone of a suicide attempt (female 10.1% and male 5.8%), d) interrupt an attempt to take away their lives (female 9.6% and male 3.2%) and e) attempted to take away their lives (female 9.1% and male 3.2%).

Table 10

Participants Family Structure

Family Structure	Frequency	%	Cum
Single parent male only parent	17	4.26	4.26
Single parent female only parent	63	15.79	20.05
Both biological parents (mother and father)	289	72.43	92.48
Blended family	21	5.26	97.74
Brother/sister only	2	0.50	98.25
Guardian	7	1.75	100.00
Total	399	100.00	

Note: The breakdown of students' demongraphic data by family structure.

Participants' Birth Order. Concerning the participants' position in the family, the results showed that the majority, 144 (36.1%), were first born in their families. There were 101 (25.3%) were second born, 65 (16.3%) were third born, another 42 (10.5%) were fourth born, 24 (6%) were fifth born, and 23(5.6%) were sixth born and above (see Table 11). Meaning that most parents were launching emerging adults for the first time, while another 25% were experiencing emerging adulthood as parents for the second time.

Table 11

Participants Birth Order

Birth Order	Frequency	%	Cum
1st Born	144	36.1	36.1
2nd Born	101	25.3	61.4
3rd Born	65	16.3	77.7
4th Born	42	10.5	88.2
5th Born	24	6	94.2
6th Born and beyond	23	5.8	100.00
Total	399	100.00	

Note: The breakdown of the students' demographic data by birth order.

Parents' Highest Education level. The study further concentrated on the parent/guardian's highest education levels. The findings revealed that the majority, 289 (72.4%) of the emerging adults' parents, had a college or university education. As revealed in Table 12, (26.6%) of the parents were university graduates, (23.3%) had attained post-graduate education, another (22.6%) were college graduates, (19%) had a high school certificate, (5%) had a primary school certificate, and (3.5%) did not complete primary school.

Table 12

Parents Highest Education Level

Parents' Highest Education Level	Frequency	%	Cum
Post-graduate Education	93	23	23.0
University Graduates	106	26.6	49.6
College Education	90	22.6	72.2
Secondary/High School	76	19.3	91.5
Primary Certificate	20	5	96.5
Did not finish primary school	14	3.5	100.0
Total	399	100.00	

Note: The breakdown of the students demongraphic data by the parents' education level.

Parenting Style. Another aspect of the family profile captured in the study, as presented in Table 13, was the parenting styles of emerging adults. The majority, 240 (60.2%) of the parents, employed democratic parenting, while 85 (21.3%) were controlling parents, 48 (12.0%) were very easy parents, and 26(6.5%) were uninvolved parents.

Table 13

Parenting Style

Parenting style	Frequency	%	Cum
Controlling	85	21.30	21.30
Democratic	240	60.15	81.45
Uninvolved	26	6.52	87.97
Very easy	48	12.03	100.00
Total	399	100.00	

Note. Participants' perception of their parents parenting styles.

The Prevalence of Suicidal Behaviours among Emerging Adults

The first objective of this study was to examine the prevalence of suicidal behaviours among emerging adults in the university. The respondents were asked to indicate whether they had engaged in suicidal thinking, planning, attempts, and self-harm in the last 12 to 24 months. The study captured five questions under suicidal thinking, planning, and attempts to obtain the prevalence of these behaviours. Six questions explored the prevalence of emerging adults' self-harm. The prevalence was obtained using mean scores computed on a five-scale index for suicidal thinking, planning and attempts and a six-scale index was used to measure the prevalence of self-harm. The use of scale index remains a common practice in social sciences, especially in psychology (Fogarty, 2019).

The scale interpretation was that respondents with a mean scale index-one meant they had engaged in one suicidal behaviour on the scale. While respondents at a mean scale index-five meant they had engaged in all five or six suicidal behaviours (see Table 14). Therefore, the respondent with a mean score index of one was less engaged in the stated suicidal behaviours, while those with a mean score index of five or six were highly involved in the stated suicidal behaviour.

Table 14

Prevalence for Suicidal Behaviours and the Mean Score Indices

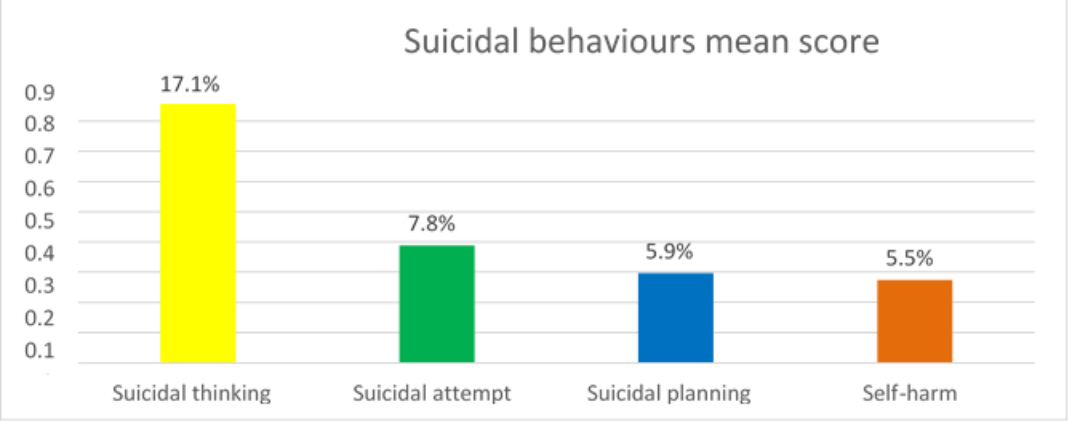
		Mean score indexes frequencies in percentage					
Suicidal behaviours	Statements capturing suicidal behaviours	1	2	3	4	5	6
Suicide Thinking	I have felt that life is not worth living. I have wished myself dead. I have thought dying is better than living. I have browsed online for ways to end my life. I have told someone my thoughts of ending my life.	26	15	25	20	14	x
Suicide Planning	I have planned on how to end my life. I have sort, visited or purchased an item with a plan to end my life. I have had a specific plan on how to end my life. I have abandoned a set plan to kill myself. I have told someone how I plan to end my life.	38	12	12	19	19	x
Suicidal Attempt	I have come close to taking away my life. I have attempted to take away my own life. I have interrupted an attempt to take away my life. I have abandoned an attempt to kill myself. I told someone I had attempted to take away my life.	36	20	12	10	22	x
Self-Harm	Cutting Biting Piercing with a sharp object Burning Overdosing on a drug or alcohol Others	58	20	15	1	1	6

Note. The participants' frequency of engagement in suicidal thinking, planning, attempt, and self-harm.

As evidenced in Figure 2 below, the findings revealed that a majority, 61.6% of emerging adults, are not engaged in suicidal behaviours, whereas 38.4% are engaged in one or multiple forms of suicidal behaviours. The study captured the mean scores indexes of respondents who engaged in suicidal behaviours as: 0.857 (17.1%) had suicidal thoughts, 0.296 (5.9%) planned suicide and 0.388 (7.8%) attempted suicide in the past 12 to 24 months. Besides, 0.273 (5.5%) of the respondents had engaged in one or more forms of self-harming behaviours within the same period. These findings showed higher suicidal behaviour rates than similar studies reviewed and lower rates of suicidal behaviours than other studies reviewed.

Figure 2

Prevalence for Suicidal Behaviours Among Emerging Adults in the University



Note. The prevalence of suicidal behaviours in a percentage of the mean score indexes.

Prevalence for suicidal thinking. The findings revealed that 17.1% of emerging adults in two selected Kenyan universities engaged in suicidal thinking in the past 12 -24 months. These findings were slightly higher than similar studies in the USA, Turkey, Canada, Ghana and China. A by Mortier's et al. (2017) in the USA noted that 13% of students had suicidal thinking. At the same time, two studies in Turkey by Oyekin's et al. (2017) and Toprak's et al. (2011) recorded students' rates of suicidal thinking at 15.1% and 11.4%, respectively. A study

conducted in Canada, the Midwest and the Northwest of the USA recorded male suicidal rates of 13% and females at 10% (Mackenzie et al., 2011). A study in Ghana by Owusu-Ansah et al. (2020) documented that 15.2% of the university students in the study had death wishes, and 6.3% had suicidal ideations. The lowest rate of suicidal thinking comparatively to this study finding was recorded in China by Zhai et al. (2015), with a rate of 9.2%. This means students in the selected universities had more suicidal thinking than students in the USA, Canada, Turkey, China, and Ghana.

However, Kenya recorded lower rates of suicidal thinking than those recorded in similar studies in Kenya, 12 Muslim countries, Ethiopia, and Botswana. A study by Nyangwencha and Ojuade (2022) recorded 29.4% of students' suicidal ideation. A study among female students in 12 Muslim counties recorded a 22% rate of suicidal thinking. Besides, Abdu et al. (2020) in Ethiopia recorded 58.3% of suicidal thinking among students in one university. Another study in Botswana recorded a 47.5% rate of suicidal thinking among university students. This means that although the rate of suicidal thinking among emerging adults in the two selected universities in Kenya was higher than in some countries, these rates were lesser than that of students sampled in Kenya, 12 Muslim countries, Ethiopian, and Botswana.

Prevalence for Suicidal Planning. This study revealed that 5.9% of students in the two selected universities had planned suicide. These rates were higher than those recorded by Wilcox et al. (2010), whose study recorded a 0.9% in suicidal thinking. Considering that Wilcox et al. study is older, these rates might differ. However, three other studies recorded higher rates of suicidal planning than the findings in this study. A Kenyan study by Nyangwencha and Ojuade (2022) recorded 48.5% of suicidal planning, while a Ghanan by Owusu-Ansah et al. (2020) recorded 6.8% in suicidal planning, and an Ethiopian study by Abdu et al. (2020) recorded

37.3% in suicidal planning among emerging adults in their universities. Hence, this study in the two selected universities in Kenya revealed that students planned suicide less than those sampled in Nyangwencha and Ojuade's study, as well as students in Ghana and Ethiopia.

Prevalence for Suicidal attempt. Findings from two selected universities in Kenya revealed that more students were engaged in suicidal attempt than in suicidal planning and self-harm. A significant 7.8% of the students had engaged in suicidal attempts. These rates were higher than those in Wilcox et al. (2010) study in the USA, with 0.9% of suicidal attempts, in Turkey which were 7.1% (Torprak et al., 2011), in Ethiopia the rate was 4.4% (Abud et al., 2020), and in Ghana the rates were 6.8% (Owusu-Ansah's et al., 2020). Moreover, these rates were lower than the 13.8% recorded by Nyangwencha and Ojuade (2022) in a similar study in Kenya.

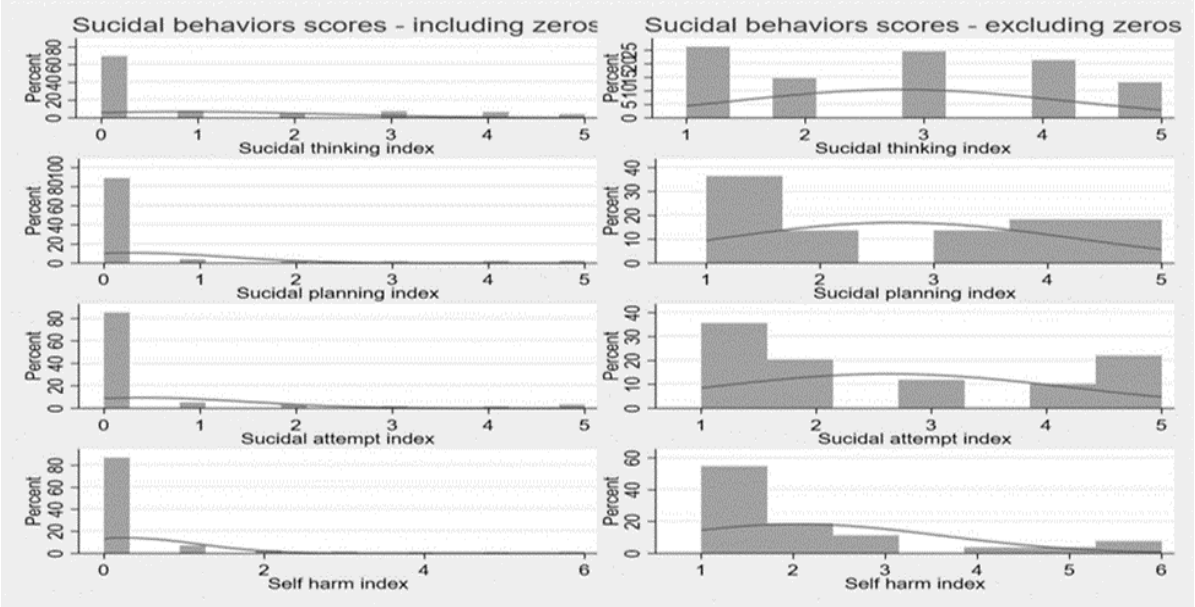
Nonetheless, the two selected universities studied had a lower rate of attempting suicide than university students from Scotland 11.2% (O'conner et al., 2018), 12 Muslim countries 8.6% and in Botswana 28.7%. This means that students in the two selected universities were engaging in suicidal behaviours less than students in the USA, 12 Muslim Counties, Botswana, and a previous study in Kenya. On the other hand, the Kenyan emerging adults were at risk of losing students by suicide than in the USA, Ethiopia, Turkey, and Ghana.

Prevalence for self-harm. The findings revealed that emerging adults in the two selected universities in Nairobi, Kenya had a 5.5% rate of self-harm. This was the lowest rate compared to five studies reviewed on self-harm among emerging adults in the university. Three studies in the USA recorded high rates of self-harming behaviours; 37.5% (Marie (2016), 17% (Whitlock et al., 2006), and in Scotland, 16.2% of students were self-harming (O'connor et al., 2018). A study in Turkey recorded a rate of 15.4% (Torprak et al., 2011), and in South Africa, a rate of

19.4% in self-harm was recorded (Walt, 2016). It was noted that emerging adults in selected universities in Kenya had the lowest rates of self-harm compared to emerging adults in the USA, Scotland, Turkey and South Africa. Although this was positive, there was a need to reduce the rates of self-harming behaviour among emerging adults in Kenya.

Figure 3

Suicidal Behaviour Prevalence Mean Scores



Note. The prevalence mean score indexes for suicidal behaviours and excluding zero mean scores.

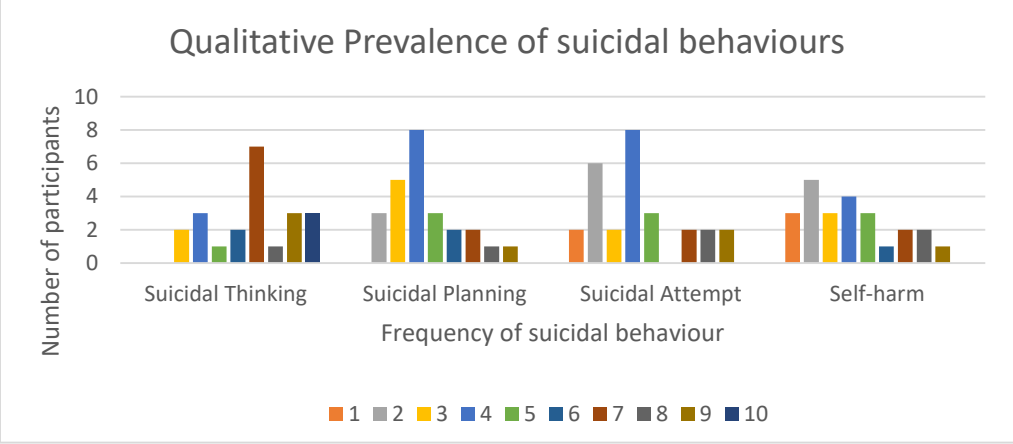
Suicidal Thinking Mean Score Indices and Frequencies. Further descriptions of the findings on suicidal behaviours, as seen in Figure 3, revealed the mean scores indexes of each suicidal behaviour by including and excluding zero values. A majority, 68%, of the respondents indicated a zero mean score index for suicidal behaviour. This means they did not think about suicide compared to 32% of the respondents who had thought about suicide one-to-five times in the past 12 to 24 months. When the zero score index was excluded, the study showed that 26% of the respondents had thought of suicide once, 15% of the respondent had a two mean score index

on suicidal thinking, and 25% of respondents had a three mean score index on suicidal thinking as earlier seen in Table 14. Still, another 20% recorded a four mean score index on suicidal thoughts. The remaining 14% had a mean score index of five. These findings are similar to Wilcox et al. (2010), who observed that 25% of students at the university have multiple suicidal thoughts, and 1.7% had persistent suicidal thoughts. This means that these emerging adults with multiple suicidal thoughts are at risk of proceeding to suicidal planning, attempts and even self-harming behaviours.

These findings were complemented by the findings drawn from the focus group discussions. During the discussions, the students were asked to indicate on a scale of one to ten, where one indicated that the suicidal behaviour rarely happened and ten indicated that the suicidal behaviour happened frequently.

Figure 4

Open Ended Questionnaire Prevalence for Suicidal Behaviours



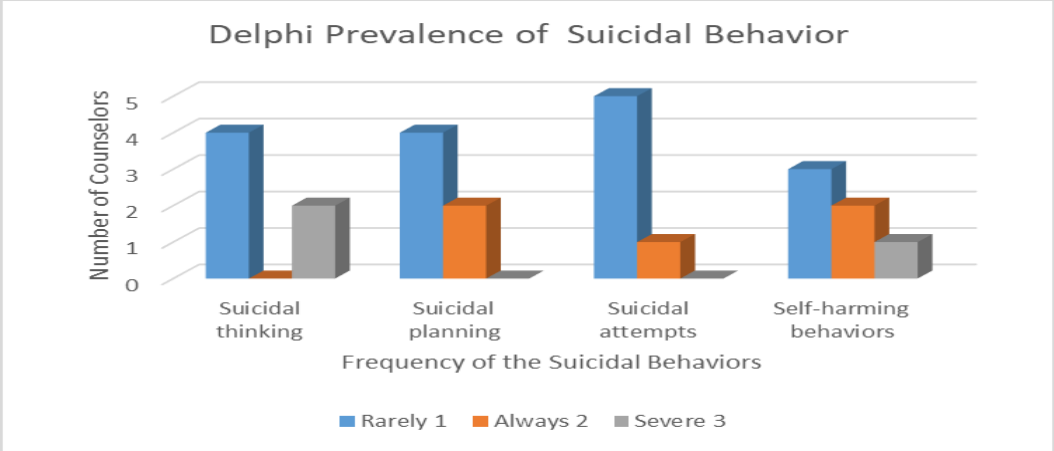
Note. The frequency of suicidal behaviours among university students according to the focus group discussion.

As shown in Figure 4, seven students out of 32 (21.9%) indicated that university students were at a scale of seven in suicidal thinking. However, six respondents indicated that the

behaviour was severe on a scale of three, another three rated suicidal thinking on a scale of nine and another three on a scale of ten. The focus group discussion revealed that suicidal behaviour was the highest-rated suicidal behaviour rated on a scale of three to ten.

Figure 5

Delphi Consensus Prevalence for Suicidal Behaviours



Note. The frequencies of suicidal behaviours among emerging adults, according to the Delphi Survey.

These findings were divergent from the university counsellors' opinions, as shown in Figure 5. The majority of the counsellors, four out of six, indicated that the prevalence of suicidal thinking among students was rare, and only two out of four considered the pattern severe.

Suicidal Planning Mean Score Indices and Frequencies. Turning to suicidal planning, findings revealed that an overwhelming 90% had a zero mean score index in planning suicide against the mean score index of 10% who engaged in suicidal planning. As shown in Table 14, 38% of the students agreed to one statement related to suicidal planning, another 12% agreed to two or three of the suicidal planning statements, and 19% agreed to four or five. As indicated in Figure 4, the findings drawn from the focus group discussions converged to the

survey findings. A majority of the participants, eight out of 32 (25%), rated suicidal planning on a scale of four out of ten. The respondent indicated that there were fewer university students engaged in suicidal planning. Only two students rated the frequency of suicidal planning at a ten. These findings converged to the university counsellors' consensus opinions, as indicated in Figure 5. Two out of four counsellors believed that suicidal planning among university students was frequent but not severe. At the same time, the remaining four counsellors said that suicidal planning was a rare behaviour among students.

Suicidal attempt Mean Score Indices and Frequencies. The mean scores for suicidal attempt revealed that a majority of 82% of the respondent obtained a zero mean score index on suicidal attempt, while 18% of the respondents had single or multiple suicidal attempt (as shown in Figure 3). Further analysis of the 18% engaged in suicidal attempt, as shown in Table 14, revealed that 36% of the emerging adults had a mean score index of one statement related to suicide attempts, and 20% had a mean score index of two statements. An additional 12% agreed to three statements, 10% agreed to four out of the five statements on suicidal attempt, and 22% agreed to all five statements related to attempts to end their lives. These suicidal attempt rates are worrying and require urgent interventions at multiple levels.

These findings converge with the focus group discussion findings, where respondents noted that students were engaging in suicidal attempt. Figure 4 shows that eight respondents out of thirty-two (25%) rated suicidal attempt at a frequency of four, while three participants rated suicidal attempt at a seven, another three at an eight and another three at a nine. However, findings from the university counsellors were divergent; the counsellors felt that students rarely engaged in suicidal attempt. A majority of five out of six counsellors indicated that students

rarely attempted suicide, and only one counsellor felt the suicidal attempt were more frequent, as seen in Figure 5.

Self-Harm Mean Score Indices and Frequencies. The prevalence for self-harm findings indicated that 82% of the respondents had a zero mean score index for self-harm, while 18% recorded at least one mean score index for self-harm (see Figure 3). Moreover, the study results revealed that a majority of 58% of emerging adults in the two selected universities had engaged in one self-harming activity, as evidenced in Table 14. Another 20% had engaged in two out of six self-harm activities, 15% engaged in three activities, 1% had a four score index, and another 1% had a five mean score index for self-harm. The remaining 6% engaged in all six self-harming activities in less than two years.

These findings concurred with the focus group discussions and the Delphi survey. These findings were convergent in that emerging adults were less engaged in self-harming behaviours compared to suicidal thinking, planning, and attempts. However, students engaged in self-harm had multiple experiences. As Figure 4 revealed, students had engaged in a variety of self-harming behaviours on a scale of one to ten. Five participants out of thirty-two (15.6%) indicated that university students were engaged in self-harming behaviours on a scale of two. At the same time, four participants rated the behaviour slightly above average on a scale of six.

Figure 6

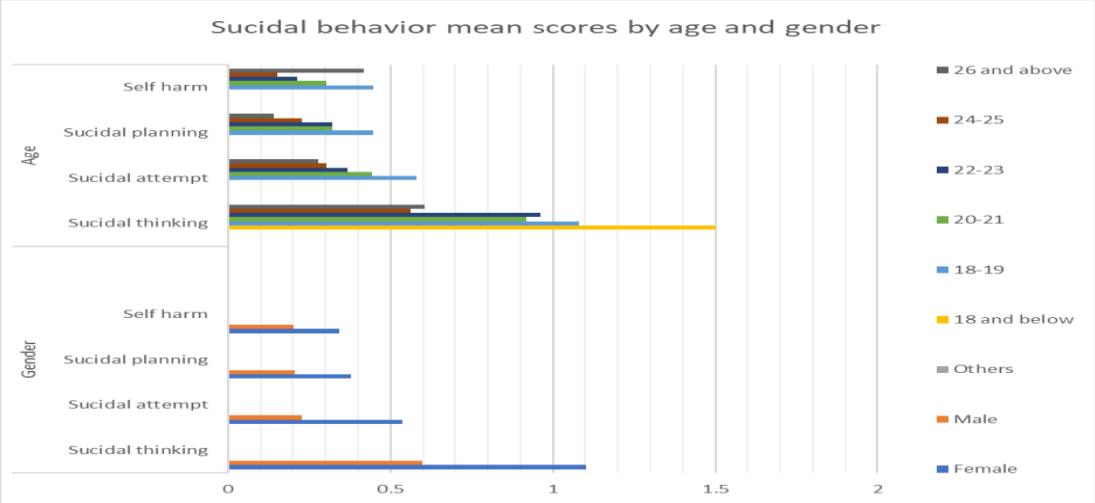
Ways Students Engaged in Self-harm

Note. The ways university students engaged in self-harming activities based on the focus group discussions.

In addition, as shown in Figure 6, participants in the focus group discussions identified ways students engaged in self-harm such as cutting, slitting wrist, burning, drug abuse, alcohol abuse and tattooing. As shown in Figure 5, the university counsellors' consensus shows that one counsellor thought self-harming behaviour was severe, two thought the behaviour was always happening, and three thought self-harming behaviours among university students were rare. At least three counsellors agreed that students were engaged in self-harm frequently.

Figure 7

Prevalence for Suicidal Behaviour by Age and Gender



Note. The prevalence rates for suicidal behaviours by age and gender.

Gender. The study sought to determine the prevalence of suicidal behaviours by age and gender of the respondents, as evidenced in Figure 7. The analysis revealed that female students in the university had higher mean score index rates on all suicidal behaviours than male students. This study revealed significant variations between gender, university type and suicidal behaviours among emerging adults. The study employed statistical significance testing that utilized a two-tailed test where a relationship was considered significant if the p-value scores were $p \leq .05$.

Table 15

Statistical Variations in Gender and University Type in Suicidal Behaviours

Variables	Overall		By Gender				By University Type			
	n	%	Male %	Female %	df	p <	Private %	Public %	df	p <
Panel A: Suicidal Thinking										
Feeling life is not worthy living	399	27.3	20.7	33.7	13.0	0.004	32.7	22.0	10.6	0.017
Wished myself dead	399	18.5	12.7	24.0	11.4	0.004	24.1	13.0	11.1	0.004
Thought dying is better than liv	399	20.8	14.3	26.9	12.7	0.002	27.7	14.0	13.7	0.001
Browsed online for ways to ending	399	7.0	3.7	10.1	6.4	0.013	9.6	4.5	5.1	0.049
Told someone of the thoughts of	399	12.0	8.5	15.4	6.9	0.035	15.1	9.0	6.1	0.063
Panel B: Suicidal Planning										
Planned how to end my life	399	7.0	4.8	9.1	4.4	0.089	8.6	5.5	3.0	0.235
Purchased an item to end life	399	4.3	2.1	6.3	4.2	0.043	5.6	3.0	2.6	0.212
Specific plan to end my life	399	6.0	3.7	8.2	4.4	0.063	8.1	4.0	4.1	0.09
Abandoned a set plan to kill myself	399	7.5	5.8	9.1	3.3	0.213	7.5	7.5	0.1	0.989
Told someone the plan to take aw	399	4.8	4.3	5.3	1.1	0.624	6.0	3.5	2.6	0.237
Panel C: Suicidal Attempt										
Came close to taking away my life	399	8.8	4.3	13.0	8.8	0.002	13.1	4.5	8.6	0.003
Attempted to take away my life	399	6.3	3.2	9.1	6.0	0.015	9.0	3.5	5.6	0.022
Interrupted the attempt to take	399	6.5	3.2	9.6	6.5	0.009	8.6	4.5	4.1	0.103

Variables	erall n	%	By Gender		df	p<	By Uni Type		df	p<
			Male %	Female %			Private %	Public %		
Abandoned an attempt to take away	399	9.3	6.4	12.0	5.7	0.052	12.0	6.5	5.6	0.056
Told someone a suicidal attempt	399	8.0	5.8	10.1	4.3	0.119	10.5	5.5	5.1	0.064
Panel D: Self-Harm										
Cutting	399	7.0	4.3	9.6	5.4	0.036	9.0	5.0	4.1	0.115
Biting	399	5.0	3.7	6.3	2.6	0.248	6.6	3.5	3.0	0.166
Piercing with a sharp object	399	4.5	3.2	5.8	2.6	0.215	5.6	3.5	2.1	0.331
Burned	399	3.0	2.6	3.4	0.7	0.676	4.5	1.5	3.0	0.077
Overdosed on a drug/substance	399	4.5	3.2	5.8	2.6	0.215	5.6	3.5	2.1	0.331
Other	399	3.3	3.2	3.4	0.2	0.915	4.0	2.5	1.5	0.394

Note. A statistical comparison of suicidal behaviours in gender and university types.

The results in Table 15 presented the differences in suicidal behaviours compared to gender and university type. Generally, female students were more likely than male students to engage in suicidal thinking at a mean score index of 22% for female versus 12% for male students, engage in suicidal planning at 7.6% for female versus 4.1% for male students, attempt suicide at a mean score index of 11% for female verse 4.6% for male students and self-harm at a mean score index of 6.8% for female verses 4.0% for male students. This study was similar to other studies that noted the prevalence of self-harm was lower than any other reviewed (Whitlock et al., 2006; Lageborn et al., 2017 & O'connor et al., 2018).

This study noted significant differences in prevalence rates between female and male students in the four suicidal behaviours. After analysis, these differences were seen to be

statistically significant. For instance, this study revealed that more female students engaged in suicidal thinking. More female students: a) felt that life was not worth living (female 33.7% and male 20.7%), b) thought that dying was better than living (female 26.9% and 14.3), c) wished themselves dead (female 24% and male 12.7%), told someone of their thoughts of ending life (female 15.4% and 8.5%), and browsed online for ways to end their life (female 10.1% and male 3.7%). Being female was a positively and statistically significant likelihood of engaging in suicidal thinking in all the five scale statements on suicidal behaviours, as shown in Table 9. Female students were more likely than the male students to a) feel life was not worth living ($t=13.0$, $p < .004$); b) wish themselves dead ($t=11.4$, $p<.004$); c) think dying was better than living ($t= 12.7$, $p<.002$); d) browse online for ways of ending life ($t=6.4$, $p<.013$) and e) tell someone of the thoughts of ending life ($t=6.9$, $p< .035$).

This study revealed that more female students had higher prevalence rates for suicidal planning. They were more likely than the male students to a) plan on how to end their lives (female 9.1% and male 4.8%), b) abandon a set plan of ending their lives (female 9.1% and male 5.8%), c) have a specific plan of ending one's life (female 8.2% and 3.7%) and d) purchase an item to end their lives (female 6.3% and 2.1%). This study recorded a statistically significant correlation between being female and purchasing an item to end one's life compared to male students. Furthermore, female students were more likely than male students to carry out plans to end their lives. There was a significant relationship between being female and purchasing an item to end one's life ($t=4.2$, $p<.043$).

As logically expected, female students were more likely to engage in suicidal attempt having thought and made plans to end their lives. This study revealed that female students were more likely to: a) come close to taking away their lives (female 13% and male 4.3%), b) abandon

an attempt to take away their lives (female 12% and male 6.4), c) tell someone of a suicide attempt (female 10.1% and male 5.8%), d) interrupt an attempt to take away their lives (female 9.6% and male 3.2%) and e) attempted to take away their lives (female 9.1% and male 3.2%). These differences between females and males on suicidal attempt were statistically significant for those who came close to taking away their lives, attempted to take away their lives, interrupted an attempt to take away their lives, and abandoned an attempt to take away their lives. Further analysis of gender differences in suicidal attempt showed that female students were more likely than their male counterparts to engage in suicidal attempt. There was a statistically significant difference in being a female student in four out of the five scale statements associated with suicidal attempting behaviours. Significantly more female students were likely to: a) come close to taking away their lives ($t= 8.8$, $p< .002$), b) attempt to take away their lives ($t= 6.0$, $p< .015$), c) interrupt the attempt to take away their lives ($t=6.5$, $p< .009$) and d) abandon an attempt to take away their lives ($t=5.7$, $p< .052$).

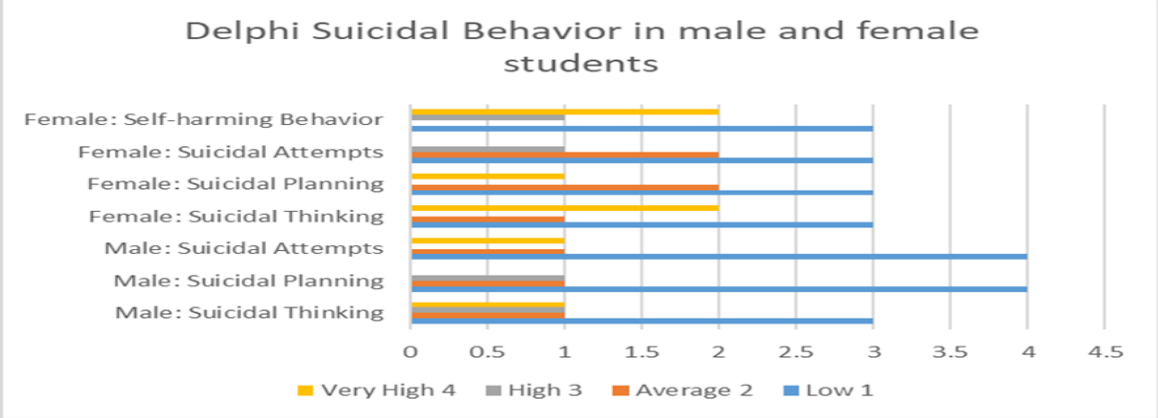
This study revealed four common ways emerging adults were engaged in self-harm, namely, cutting, biting, piercing with a sharp object, and overdosing on a drug or substance. This study highlighted that female students' higher prevalence rates on all four self-harming behaviours: cutting (female 9.6% and male 4.3%), biting (female 6.3% and male 3.7%), piercing with a sharp object (female 5.8 and male 3.2%) and overdosing on a drug/substance (female 5.8% and male 3.2%). In addition, more female students than male students were likely to engage in self-harming behaviours with a preference for cutting. There was a statistical significance of ($t=5.4$, $p<.036$) that female to engaged in cutting behaviours more than male students. These findings are similar to those obtained in a South African study that confirmed that most students self-harming were female (Walt, 2016). Unlike the popular thoughts that male

students do not engage in self-harm, this study confirmed that male students were engaging in self-harming behaviours, especially through drug abuse, alcohol abuse and tattooing.

The Delphi consensus complemented the survey findings. The counsellors' consensus revealed that female students engaged more in suicidal thinking, suicidal planning, suicidal attempt and self-harming behaviours. As shown in Figure 8, the consensus was drawn from a majority, four out of six counsellors, that male students were less engaged in suicidal planning and attempts. At the same time, three out of six counsellors agreed that male students had lower rates of suicidal thinking compared to female students in the university. The Delphi findings differed slightly from the survey analysis for the female students.

Figure 8

Delphi Consensus Prevalence Rates for Suicidal Behaviours by Gender



Note. The consensus presentation on the prevalence of suicidal behaviours among university students by university counsellors.

According to Figure 8, female students had the highest mean score average in all the suicidal behaviours. They had a mean score index of 22% versus 12% in male students. The mean average scores for suicidal planning revealed the same trend with female students at 7.8%

versus 4% among male students. The same was observed for suicidal attempt, where female students scored a mean average of 10% versus male students had four per cent. The female students were engaged in self-harming behaviours at a mean average of 6.6% compared to four per cent for the male students. Therefore, the female students were highly engaged in all suicidal behaviours, unlike the view of the majority of the counsellors. In addition, male students were engaged in suicidal behaviours, including self-harming, which all the counsellors left out. Male students engaged in self-harming activities, especially drug abuse, alcohol abuse and tattooing, as noted in the focus group discussions.

Therefore, the study revealed that female students had a strong and positive correlation to suicidal thinking and suicidal attempt than their male counterparts. Most reviewed studies showed that male students had a higher prevalence of suicidal behaviours (Mackenzie et al., 2011; Motamedi et al., 2016; "Campus Suicides", 2018; Goodman et al., 2018; Nyamori, 2015). However, this study revealed that female students in the university were more likely to engage in suicidal behaviours, findings parallel to those by Tang et al. (2018), Abdu et al. (2020) and Eskin et al. (2019).

Age. Turning to the prevalence of suicidal behaviours by age, the study revealed that being young was associated with suicidal behaviours among university students. The highest mean score index rate for suicidal thinking was 51.6% which was among students aged 19 years and below (see figure 7 above). Students aged 22-23 had a mean score index of 19%, and students aged 20-21 had a mean score index of 18%. The lowest mean scores for suicidal thinking by age recorded were in students aged 26 and above at 12% and students aged 24-25 years old, whose mean score index was 11.2%. These findings were similar to those of Nkansah-

Amankra (2013), who observed that young people aged 15 – 24 years were at risk of suicidal thoughts, suicidal planning and suicidal attempt.

The results on suicidal planning by age revealed a high mean score index of 8.9% among 18-19 year-olds, a 6.4% mean score index in 20-21 year-olds and 4.6% in 22-23 year-olds. Respondents aged 24-25 recorded a mean score index of 4.5%, and 26-year-olds and above had the lowest mean score index of 2.8% for suicidal planning. The highest mean score of 12% for suicidal attempt was recorded among18-19 year-olds, followed by 20-21year-olds at 8.9%; 22-23 year-olds at 7.3%; 24-25 year-olds at 6.1%, and 26-year-olds and above at 5.6%. The prevalence for self-harm by age revealed that 18-19-year-olds were more engaged in self-harm at the rate of 8.9%, followed by 26-year-olds and above at 8.4%; 20-21 year-olds at 6.1%, 22-23 year-olds at 4.2% and 24-25 year-olds at 3.0%. These findings were consistent with Graffin et al. (2018) study that revealed that the highest rates of self-harm were between 10 -24 years.

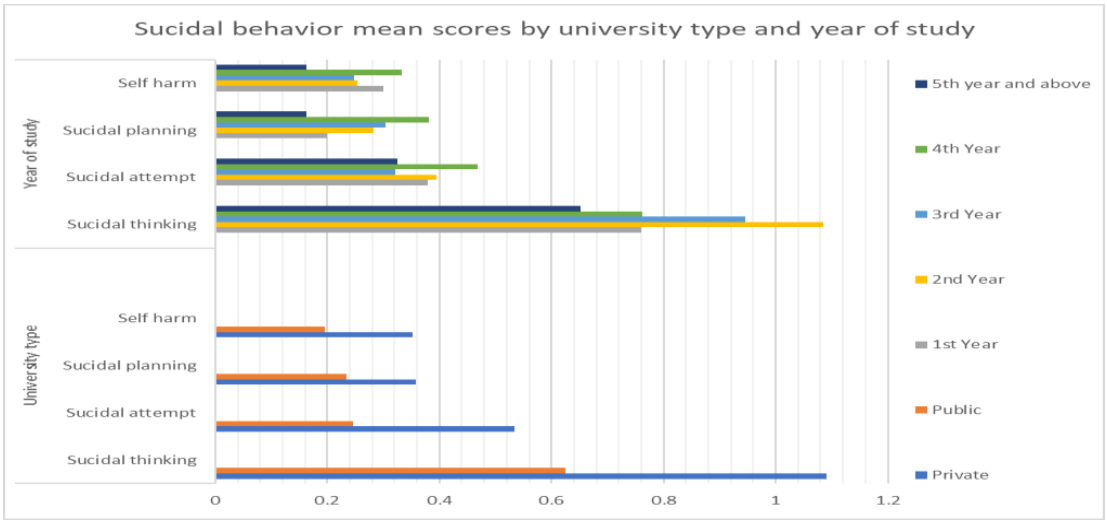
These findings are in agreement with other studies and reports that confirmed that young people aged 15– 29-year-old were engaging in suicidal behaviours (Hawton et al., 2012; WHO, 2016; World Health Organization and Food Agricultural Organization, 2019; Gastellvi et al., 2017; Britton et al., 2014). Thus the younger the emerging adult, the greater the risk of suicidal behaviours. This means that parents, university administrators and lecturers must support younger students joining the university to adjust better. In addition, churches or religious organizations must greatly help transition students joining the university and support them through the university years.

University Type. In addition, the outcomes on the prevalence rates for suicidal behaviours by university type revealed were presented in Figure 9. The results revealed that private university students had higher mean score indexes in all four categories of suicidal

behaviours. The specific mean score index for suicidal thinking was 22% in private and 13% in public universities. Similarly, students in the private university were more likely to attempt suicide at 11% compared to 5% in the private university. Furthermore, the study recorded a 7.1% prevalence rate for suicidal planning in private universities and 4.7% in public universities. The study showed that students in the private university had a 7% rate of self-harm while students in the public university had a 3.9% for self-harm.

Figure 9

Prevalence for Suicidal Behaviours by University Type and Year of Study



Note. The prevalence of suicidal behaviours among university students by university type and year of study.

This study revealed a significant difference between private and public universities on suicide behaviours, as evidenced in Table 8. There was a likelihood that students in private universities were more engaged in suicidal thinking and suicidal attempt than in public universities. Findings recorded a statistically significant relationship between being in a private university and suicidal thinking in a) feeling life was not worth living ($t=10.6$, $p<.017$), b)

wishing oneself dead (t=11.1, p< .004); c) thinking dying was better than living (t=13.7, p<.001) and d) browsing online for ways to end one's life (t=5.1, p<.049). Moreover, students in the private university were more likely to engage in suicidal attempt than their counterparts in the public university. The findings based on Table 15 revealed a statistically significant possibility that students in the private university: a) come close to taking away their lives (t=8.6, p< .003), b) attempted to take away their lives (t =5.6, p<.022) and c) abandoned an attempt to take away their lives (t=5.6, p< .05). There was no statistically significant difference in the students' suicidal planning and self-harm in the private and public universities. These findings imply that more preventative and intervention programs need to be considered in private universities to deal with prevalent suicidal behaviours. Parents, university administrators, lecturers and university counsellors need to understand further and address the risk for suicidal behaviours in private universities.

Year of study. As evidenced in Figure 9 above, suicidal thinking was prevalent in all the students in each year of study. The prevalence rates of suicidal behaviours by year of the study revealed suicidal thinking was the dominant suicidal behaviour prominent in students in all years of study among emerging adults. However, the highest mean score for suicidal thinking was recorded among second-year students at 22%. The third-year students followed closely with a mean score index of 19%, then first-year and fourth-year students with a mean score index of 15% each. The lowest mean score rate for suicidal thinking was recorded among fifth-year and above students at 13%. Therefore, if students from first-year to fifth-year plus were consistently thinking about suicide, it was logical to imagine that some students might translate these thoughts would into self-harm, planning or attempting suicide.

The results on suicidal planning showed that fourth-year students had the highest mean score of 7.6%, followed closely by third-year students at 6.1% and second-year students at 5.6%. The first-year and the fifth-year and above recorded mean score indexes of 4% and 3.3%, respectively. The results for suicidal planning showed that 4th -year students had the highest mean score of 7.6%, followed closely by 3rd-year students at 6.1% and 2nd -year students at 5.6%. The 1st and 5th years and above recorded mean score indexes of 4% and 3.3%, respectively. The highest mean score for suicidal attempt of 9.4% was reported among 4th year students. This figure was followed closely by 2nd year students who scored a mean score index of 8%. The third highest mean score index of 7.6% for suicidal attempt was recorded among 1st-year students. They were closely followed closely by students in their 5th year and above at 7%. The lowest mean score index by respondents' year of study for suicidal attempt was among the 3rd year students, which stood at 6.4%. Generally, there were lower mean scores for self-harm across all the different years of study. Still, the 4th year students documented the highest mean score index of 7% for self-harm. They were followed closely by 1st -year students at 6%, then 2nd year students at 5.1% and 3rd year students at 5%. The lowest mean score index for self-harm was recorded by students in the 5th year and above at 3.3%.

This study reveals that fourth-year students had the highest mean score indexes for suicidal planning, suicidal attempt and self-harm, which means that fourth-year students were at risk of attempting suicide. These findings corresponded to other studies reviewed (O'Conner, 2018; Silvertsen et al., 2019; Borschmann & Kinner, 2019). Moreover, these findings confirmed the newspaper reports in Kenyan media stating that fourth-year students were at a greater risk for suicidal behaviours (Nyamori, 2015; 'Campus Suicide', 2018). The transition from adolescence

to adulthood was demanding and filled with personal and emotional challenges calling for coping and problem-solving skills (Arnett et al., 2011, Tanner & Arnett, 2016; Arnett, 2018).

However, the demands of completing university, finding a job, settling in the family, and just being an adult provoke fear and psychological distress that might lead to suicidal behaviours (Arnett et al., 2011). These fears and distresses generated by unresolved childhood experiences, family conflicts, lack of support and problem-solving skills at this stage might result in suicidal behaviours (Gudo et al., 2011; Lageborn et al., 2017; Oketch-Oboth & Okunya, 2018; McLaughlin & Gunnell, 2020).

Therefore, 4th year students are transitioning to leave campus for the adult life of work and other responsibilities. It seemed that in the same way, students were unsettled as they entered university, they were unsettled again when leaving university, which means that students need to be prepared with life skills to support them to transition into university and to transition out of university as a preventative measure for suicidal behaviour. This includes intervening for students in 2nd and 3rd years because they continue to exhibit suicidal behaviours throughout life on campus.

Living Arrangement. The results in Appendix X revealed that living at home during sessions in the university was negatively correlated to all suicidal behaviours; suicidal thinking (r= -.015, R^2 =.278), suicidal planning (r = -.059, R^2 =.186), suicidal attempt (r = -.038, R^2 =.210), and self-harm (r =-152, R^2 = .170). In addition, living in the university hostels was negatively correlated to suicidal thinking (r = -.370, R^2 = .308) and suicidal attempt (r = -.076, R^2 = .233); but positively correlated to suicidal planning (r = .091, R^2 = .206) and self-harm (r = .005, R^2 = .188). Living at a hostel when the university was in session was positively associated

with all suicidal behaviours; suicidal thinking (r =. 252, R^2 = .231), suicidal planning (r = .033, R^2 = .154), suicidal attempt (r=.075, R^2 = .075) and self-harm (r = .007, R^2 = .141).

This means that living in the hostels was a risk factor for all suicidal behaviours among university students, and living in the university hostels was a risk factor for suicidal planning and self-harm but a protective factor for suicidal thinking and suicidal attempt. At the same time, living at home when the university was in session was a protective factor for all suicidal behaviours.

Meaning that the availability of basic needs like food, accommodation and the presence of social support provides emerging adults with better mental well-being; thus, they do not engage in suicidal behaviours. These findings are similar to those of Talwar and Mohd (2013), who observed that social support among university students resulted in better mental health. They noted that social support from family or friends provided students with responsiveness, concern, care, affection and confidence.

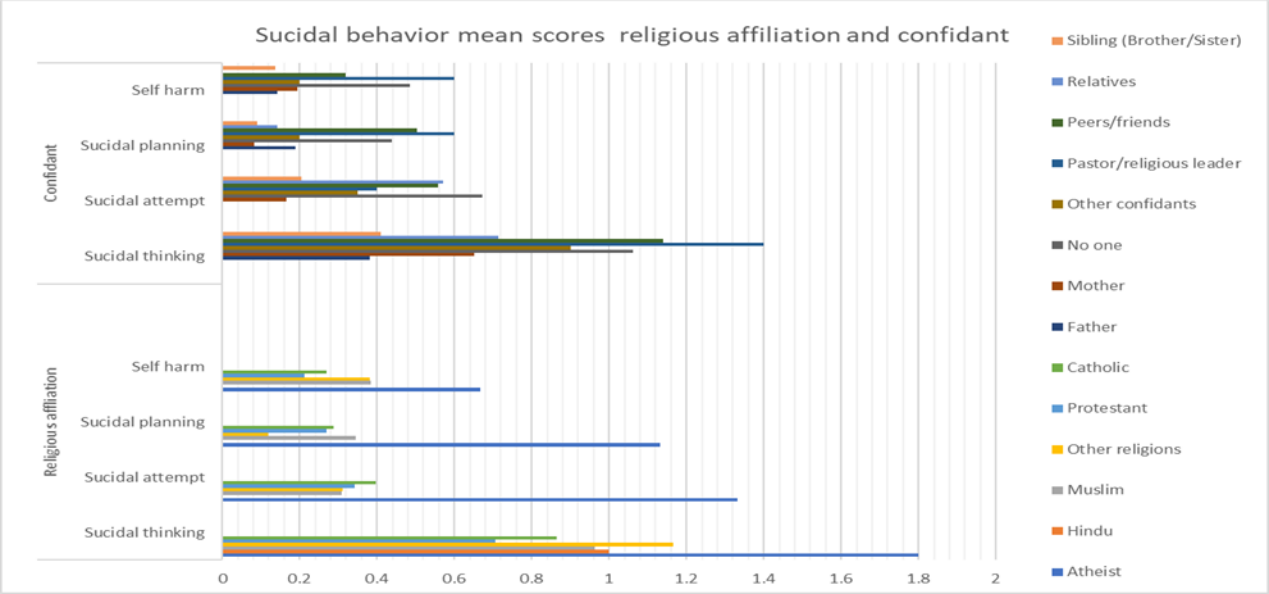
Living Companions. This study sought to examine whether living with someone when the university was in session reduced the rate of suicidal behaviours among emerging adults. The results revealed that living alone and with an intimate partner were risk factors for suicidal behaviours. As shown in Appendix X, living alone was positively associated with all suicidal behaviours: suicidal thinking (r=.563, R^2 = .541), suicidal planning (r=.333, R^2 = .361), suicidal attempt (r=.267, R^2 = .409) and self-harm (r=.112, R^2 = .330). Still, living with an intimate partner was positively linked with all suicidal behaviours: suicidal thinking (r=.490, R^2 = .623), suicidal planning (r=.400, R^2 = .416), suicidal attempt (r=.344, p<.471) and self-harm (r=.189, R^2 = .380). On the contrary, living with parents/guardians and siblings and living with a schoolmate was associated with suicidal thinking, suicidal planning and suicidal attempt but not

self-harm. Living with parents/guardians and siblings was positively linked to; suicidal thinking (r=.082, R^2 = .513), suicidal planning (r=.058, R^2 = .342), suicidal attempt (r=.067, R^2 = .388) but negatively associated with self-harm (r=-.129, R^2 = .313). Furthermore, living with a schoolmate was positively associated with suicidal thinking (r=.341, R^2 = .554), suicidal planning (r=.036, R^2 = .370) and suicidal attempt (r=.388, R^2 =.248). Living with a schoolmate was negatively correlated to self-harm (r=-.170, R^2 = .339). In addition, living with a sibling was positively linked with suicidal thinking (r=.178, R^2 =.641), suicidal attempt (r=.136, R^2 = .485) and self-harm (r=.172, R^2 = .391). However, living with a sibling was negatively associated with suicidal planning (r=-.130, R^2 = .428).

This implies that living with someone has an insignificant influence on emerging adults' suicidal behaviour. Living with another person was a risk factor for suicidal thinking, suicidal planning and suicidal attempt. While living with someone was a weak protective factor in self-harm and suicidal planning. Thus, it was not the company that mattered but the quality of social support provided by the people living with emerging adults. Social support expressed in guidance, emotional care and real support helps reduced stress in students going through the university (Talwar et al., 2013; Novotny et al., 2022).

Figure 10

Prevalence for Suicidal Behaviours by Religious Affiliation and Confidant



Note. The prevalence of suicidal behaviours among emerging adults based on their religious affiliations and whom they confide in.

Religious Affiliation. This study obtained the prevalence of suicidal behaviours by respondents' religious affiliation and whom they confided in, as captured in Figure 10. Generally, being an Atheist was associated with all four suicidal behaviours. The analysis of suicidal thinking by religious affiliation revealed an overwhelming mean score index of 36% among Atheist students, 23.3% among Muslim students, and 19% among students who identified with other religions not named in the study. The prevalence rates for suicidal thinking of 17.3% were affiliated with Roman Catholics, and 14.1% were affiliated with Protestants. The students affiliated with Atheism recorded the highest mean score index for suicidal planning at 22.7%, against six-point nine per cent among Muslim students, five-point eight per cent among students professing the Roman Catholic faith and five-point four among protestant students. The lowest

mean score index for suicidal planning was two-point four per cent among students affiliated with other unspecified religions.

Findings showed that students affiliated with Atheism had the highest means score index of 26.7% for suicidal attempt. The next closest mean score index was among students affiliated with Roman Catholic at seven-point nine per cent, then students affiliated with Protestantism at six-point nine per cent, and students affiliated with Islam recorded a six-point two per cent engagement in suicidal attempt. 6.2% of the students were affiliated with Islam. No significant mean score index was captured among students affiliated with other religions unspecified in this study. Students affiliated with Atheism reported the highest mean score index for self-harm at 13.4%. The other religious affiliation closely linked to self-harm was Islam at seven-point seven per cent and seven-point six per cent among students affiliated with other unspecified religions. The students with the lowest risk for self-harm by religious affiliation were those affiliated with the Roman Catholic faith at a mean score index of five-point four per cent and four-point two per cent among students affiliated with the Protestant faith.

The study examined the relationship between suicidal behaviours against participants' religious affiliation. The results revealed that those affiliated with Atheism and Roman Catholicism were at risk of suicidal behaviours. The relationship, according to this study, was excellently significant (see Appendix X). Being an Atheist was a risk factor for all suicidal behaviours: suicidal thinking (r=.374, R^2 = 1.538), suicidal planning (r=.705, R^2 = 1.027), suicidal attempt (r=1.158, R^2 = 1.164) and self-harm (r = .389, R^2 = 940). While being Roman Catholic was positively and significantly associated with all suicidal behaviours: suicidal thinking (r=.401. R^2 = 1.490), suicidal planning (r =.134, R^2 = .994), suicidal attempt (r=.532, R^2 = 1.127) and self-harm (r=.157, R^2 = .910).

The results further revealed that being Islam and Protestant were positively associated with suicidal planning, suicidal attempt and self-harm but not suicidal thinking. Being Islam was positively and strongly significantly associated with suicidal planning (r= .134, R^2 = .994), suicidal attempt (r=.532, R^2 1.127) and self-harm (r=. 157, R^2 = .910). While being Islam was negatively correlated to suicidal thinking (r=-.105, R^2 = 1.503). Being a Protestant was negatively and significantly linked with suicidal thinking (r=-.197, R^2 = 1.488). In addition, being a Protestant was positively and significantly associated with suicidal planning (r=.090, R^2 = .993), suicidal attempt (r =.454, R^2 1.125) and self-harm (r = .100, R^2 = .909). Moreover, the study showed that being affiliated with other religious beliefs was positively and significantly correlated to suicidal thinking (r=.355, R^2 = 1.501), suicidal attempt (r=.448, R^2 = 1.136) and self-harm (r =.281, R^2 =.917). However, being affiliated with other religions was negatively linked to suicidal planning (r=-.007, R^2 = 1.002).

This means that religious affiliation was a protective factor for suicidal thinking for Islam and Protestant students and self-harm for those affiliated with other religious beliefs. Based on this study, atheism and Catholicism were risk factors for all suicidal behaviours. This study concluded that religious affiliation was not a protective factor for suicidal behaviours, as seen in other studies by Teevale et al. (2016), Toussaint et al. (2015) and Nishi et al. (2017).

Confiding in. Moreover, the study captured the prevalence of suicidal behaviour by which participants confided and their suicidal behaviour, as evidenced in Figure 10. The results revealed that confiding in a pastor or religious leader was highly associated with students with suicidal thinking, suicidal plans and self-harm. Respondents who confided in no one scored high mean indexes on suicidal attempt. The results showed that 28% of emerging adults who confide in a pastor or religious leader had suicidal thinking, as compared to 22.8% of students who

confided in peers or friends, 21.3% confided in no one, and 18% confided in others unspecified in the study. In addition, 14.3% of students confided in relatives, 13% of those confided in their mothers, eight per cent who confided in siblings, and a minimum of 7.6% per cent who confided in their fathers had suicidal thoughts.

Concerning suicidal planning, the results indicated that the highest mean score index of 12% was reported by the respondents who confided in a pastor or religious leader. At the same time, a mean score index of 10.1% confided in peers or friends, 8.8 per cent for those who confided in no one and 3.8% for those who confided in their father. Lower mean score indexes were recorded among respondents who confided in: relatives at 2.9%, siblings at 1.8% and mothers at 1.7%. This study revealed that confiding in no one, confiding in relatives, and peers were strongly related to suicidal attempt. A majority mean score of 13.4% of students who attempted suicide confided in no one, 11.4% confided in relatives, and 11.2% confided in peers or friends. Another 8% confided in pastors or religious leaders, seven per cent confided in other confidants unspecified, 4.1% confided in siblings, and 3.3% confided in their mother. The respondents who confided in their fathers reported a mean score of zero on suicidal attempt.

This study revealed a high prevalence rate for students who confided to a pastor or religious leader, those who confided to no one and those who confided to peers or friends with self-harm. There was a mean score index of 12% rate for self-harm in students who confided in a pastor or religious leader, another 9.7% in students who confided in no one, 6.4% in students who confided in peers or friends and 4% risk for self-harm in students who confided in other unspecified confidants. Furthermore, this study revealed that students who confided in their mother, father and other relatives were less likely to engage in self-harming activities. A mean score index of 3.9% was recorded in respondents who confided in their mothers, and 2.9% in

respondents who confided in their fathers were engaged in self-harm. However, respondents who confided in relatives reported a zero mean score index on all self-harming activities.

This study examined the association between people emerging adults confided in and suicidal behaviours. The results revealed that confiding in peers, pastors/religious leaders was positively linked to all suicidal behaviours (see Appendix X). Confiding in a peer was positively associated with suicidal thinking (r=.274, R^2 =.584), suicidal planning (r=.394, R^2 =.390), suicidal attempt (r=.016, R^2 = .442) and self-harm (r=.472, R^2 = .357). Confiding in a pastor/religious leaders was positively related to suicidal behaviours: suicidal thinking (r=.815, R^2 = .897), suicidal planning (r=.652, R^2 = .599), suicidal attempt (r=.042, R^2 = .678) and self-harm (r=.895, R^2 = .548). Similarly, confiding in no one was positively correlated to suicidal behaviours: suicidal thinking (r=.162, R^2 =.597), suicidal planning (r=.321, R^2 = .398), suicidal attempt (r=.194, R^2 = .451) and self-harm (r=.613, R^2 = .364). Confiding in others, not mentioned in the study, was negatively linked to suicidal attempt (r=-.183, R^2 = .502).

Additionally, confiding in no one was positively associated with suicidal thinking (r=.050, R^2 = .664), suicidal planning (r=.223, R^2 = .443) and self-harm (r=.080, R^2 = .406). Moreover, this study revealed that confiding in one's mother and father was negatively related to suicidal attempt (r=-.094, R^2 = .0446), (r=-.270, R^2 = .495), respectively. While confiding in a mother was positively correlated to suicidal thinking (r=.094, R2 =.589), suicidal planning (r=.142, R2 =.393) and self-harm (r=.545, p<.360). Likewise, confiding in a father was positively correlated to suicidal thinking (r=.020, R2 =.654), suicidal planning (r=.249, R2 = .437) and self-harm (r=.464, R2 = .400). It was noted that confiding with as sibling was positively correlated to suicidal planning (r=.036, R2 = .410) and self-harm (r=.365, R2 =.375). Confiding a sibling was a protective factor for suicidal thinking (r=-.251, R2 =.614) and suicidal attempt (r=-.236, R2 = .465). This means confiding family members such as a mother, father and siblings was a protective factor for suicidal

thinking, suicidal planning, and suicidal attempt. These findings were similar to those by Whitlock et al. (2012), who noted that confiding in parents decreased the likelihood of proceeding with self-harming behaviours into suicidal behaviours. At the same time, confiding in peers, pastor/religious leaders, and no one was a risk factor for suicidal behaviour.

Prevalence for Suicidal Behaviours by Family Profile

Birth Order. This study sought to determine the relationship between the participants' birth and suicidal behaviours. As shown in Appendix X, the results revealed that being a firstborn was positively associated with suicidal thinking (r=.261, R2 = .337), suicidal planning (r = .016, R2 = .225), suicidal attempt (r=.116, R2 = .225), but negatively linked to self-harm (r=-.083, R2 = .206). Participants who were second and third-born in their families were less likely to engage in suicidal planning, attempt and self-harm. Being a second born in the family was positively associated with suicidal thinking (r=.261, R2 = .346) but negatively associated with suicidal planning (r=-.138, R2 =.231), suicidal attempt (r= -.028, R2 = .262) and self-harm (r=-.161, R2 = .211). While being a third born was positively associated with suicidal thinking (r=.215, R2 =.365) and negatively linked to suicidal planning (r= -.057, R2 = .244), suicidal attempt (r=-.063, R2 =.276) and self-harm (r = -.033, R2 = .223).

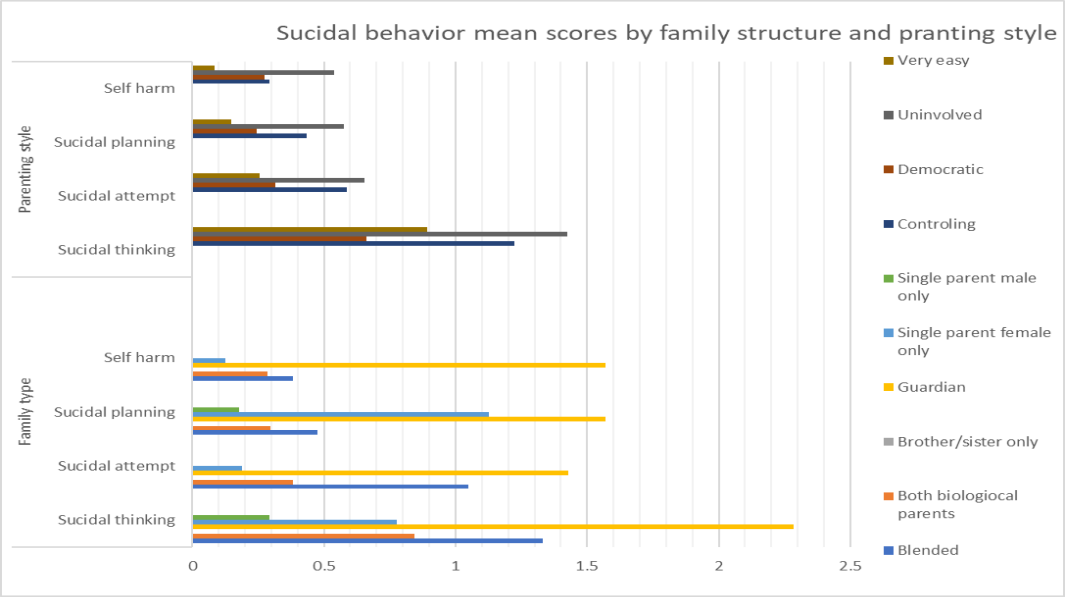
Furthermore, the results showed that being a fourth born was a protective factor against all suicidal behaviours. The relationship coefficient was: suicidal thinking (r = -.209, R2 = .385), suicidal planning (r=-.260, R2 = .291), suicidal attempt (r = -.329, R2 = .257) and self-harm (r=-.431, R2 = .235). Being a fifth born and other was positively correlated to suicidal thinking (r= .305, R2 = .438), suicidal attempt (r=.405, R2 = 331) and self-harm (r=.213, R2 = 268), but negatively linked to suicidal planning (r=-.209, R2 = .385). This means that being a firstborn and a fifth born and above was a risk factor for all suicidal behaviours. While being a second and third born was positively associated with suicidal behaviours. Being a fourth born was a protective factor for all suicidal behaviours. These findings agree

and disagree with Easey et al. (2019) conclusions that later-born children were at higher risk of suicidal attempt and psychological disorders. There was an agreement that fifth-year students were at risk of all suicidal behaviours. However, this was similar to firstborn children who were at risk of all suicidal behaviours. Meaning that middle-born children, like fourth the born, were less likely to engage in any suicidal behaviours.

Family Structure. The results on the prevalence of suicidal behaviours by family structure and parenting style are presented in Figure 12. Generally, the respondents from guardian-headed families had the highest mean scores for suicidal thinking, suicidal planning, and suicidal attempt. Whereas the respondents' families headed by siblings and single male parents had the lowest mean scores indexes on all four categories of suicidal behaviours. Turning on suicidal thinking, guardian-headed families recorded an overwhelming mean score index of 46%, followed by blended families at 27%, families led by both biological parents had a mean score index of 17%, and families led by a single female parent only recorded a mean score index of 16%. On the contrary, families led by single male parents recorded a mean score of six per cent on suicidal thinking and a zero mean scores index for suicidal attempt and self-harm. In contrast, families headed by siblings recorded zero mean scores indexes on all four categories of suicidal behaviours.

Figure 11

Prevalence for Suicidal Behaviours by Family Structure and Parenting Style



Note. The results on emerging adults' suicidal behaviours based on the family structure and parenting styles.

As shown in Figure 11, guardian-headed families recorded the highest mean score indexes of 31.4% for suicidal planning. It was closely followed by families headed by single female parents at 22.5%. The remaining families recorded a mean score index of 9.5% for blended families, 6% for families headed by both biological parents and 3.5% for families headed by single male parents. Furthermore, guardian-headed families reported a high mean score index of 29% for suicidal attempt. This is followed closely by blended families at a mean score index of 21%. Families led by both biological parents recorded a mean score of 8%, and families led by single female parents only had a mean score index of 4% for suicidal attempt. On self-harm, there were relatively low mean scores in all family structures. Blended families

documented the highest mean score of 8%, followed closely by families led by both biological parents at 6%, and 3% each for guardian and single female-only led families.

The study further examined the relationship between participants' family structure and suicidal behaviours (see Appendix X). The results revealed that families headed by guardian parents, both biological parents and blended families were at risk of all suicidal behaviours. Guardian-headed families recorded a positive and strong relationship to suicidal thinking (r=1.776, R2 =1.229), suicidal planning (r=1.103, R2 =.820), suicidal attempt (r=.854, R2 =.930) and self-harm (r=1.232, R2 = .751). While being in a family with both biological parents was positively correlated to all suicidal behaviours: suicidal thinking (r=.661, R2 = 1.095), suicidal planning (r=.072, R2 = .731), suicidal attempt (r=.054, R2 = .828) and self-harm (r=.003, R2 = .669). The results showed that emerging adults drawn from blended families were positively correlated to suicidal thinking (r=.852, R2 = 1.147), suicidal planning (r=.045, R2 =.765), suicidal attempt (r=.416, R2 = .867), but negatively linked to self-harm (r=-.008, R2 = 701).

Moreover, the study showed that single-parent male-only lead families were positively associated with suicidal thinking (r=.471, R2 = 1.155) and suicidal planning (r= .008, R2 =.771. However, they were negatively linked to suicidal attempt (r=-.133, R2 = .873) and self-harm (r=-.136, R2 = 680). On the contrary, being in a single parent female only headed family was a protective factor for suicidal planning (r=-.042, R2 = .743), suicidal attempt (r=-.170, R2 = .842) and self-harm (r=-.136, R2 = .680). But having a single female parent was positively linked to suicidal thinking (r=.539, R2 = 1.114).

The interpretation of these findings was that emerging adults from all family structures were at risk of suicidal thinking, and only emerging adults headed by single female-only parents were not at risk of suicidal planning. Furthermore, emerging adults in families headed by

guardians and both biological parents were at risk of self-harm. Whereas emerging adults whose families are headed by single parents, both male and female, were not at risk of suicidal attempt. Similarly, the parent-child relationship was a better predictor for suicidal behaviour than the family structure (Kuramoto-Crawford et al., 2017). The parent-child relationship was affected by parental separation, divorce or death, leading to single parenthood, blended families and guardian-headed families. Yurkowski et al. (2015) noted that the parent-child relationship had a greater impact on emerging adults' suicidal behaviours than the family structure. This study revealed that guardian-headed families, blended families and both biological parents were statistically at risk of all suicidal behaviour, which means that these families were more impacted by the quality of the parent-child relationship rather than the family composition and headship (Shafer et al., 2017; Yurkowski et al., 2015; Kuramoto-Crawford et al., 2017).

Parenting Styles. In addition, the study sought to find out the prevalence of suicidal behaviours by parenting style. Based on Figure 11, the results showed that the uninvolved parenting style had the highest mean scores on all four suicidal behaviour categories. On the contrary, the democratic parenting style had a relatively low mean score across the four suicidal behaviour variables. The analysis above showed a mean score index of 28.5% of the respondent who reported suicidal thinking grew up with uninvolved parents, 24.5% had controlling parents, 17.9% had very easy parents, and 13.2% had democratic parents.

Moreover, the uninvolved parenting style recorded a mean score index of 11.5% for suicidal planning, and the controlling parenting style reported a mean score index of 8.7%. The lowest mean score indexes for suicidal planning were recorded by democratic parenting at 4.9% and very easy parenting at 3%. Turning to suicidal attempt, the highest mean score index of 13.1% was recorded by respondents who had an uninvolved parenting style, 11.8% for a

controlling parenting style, 6.3% for democratic parenting style and 5.1% for a very easy parenting style. The findings on the prevalence of self-harming behaviour by parenting style revealed a mean score of 10.8% for uninvolved parenting style. Controlling parenting styles had a mean score of 5.9%, 5.5% for democratic parenting, and 1.7% for very easy parenting styles.

This study captured the relationship between parenting style and suicidal behaviour. The results presented the strength and direction of this relationship. The results in Appendix X on the social statistics revealed that controlling and uninvolved parenting styles were associated with suicidal thinking (r=.330, R^2 = 1.550) and suicidal attempt (r = .139, R^2 = 1.172). Besides, controlling parents were negatively and strongly associated with suicidal planning (r = -.029, R^2 = 1.055) and self-harm (r = -.393, R^2 = .947). Similarly, the uninvolved parenting style was positively correlated to suicidal thinking (r=.263, R^2 = 1.571) and suicidal attempt (r=.029, R^2 = 1.188). While democratic and very easy parenting styles were negatively and strongly linked to all suicidal behaviour. Democratic parenting style recorded a: suicidal thinking (r=-.198, R^2 = 1.548), suicidal planning (r=-.142, R^2 = 1.033), suicidal attempt (r=-.059, R^2 = 1.171) and self-harm (r=-.391, R^2 = .946). Very easy parenting style recorded a negative and strong relationship to suicidal thinking (r-=.145, R^2 = 1567), suicidal planning (r=-.340, R^2 = 1.046), suicidal attempt (r=-.261, R^2 = 1.185) and self-harm (r= -.692, R^2 = .957).

This means that controlling and very easy parenting styles were risk factors for suicidal planning and suicidal attempt. At the same time, democratic and very easy parenting styles were protective factors against all suicidal behaviour. These findings were similar to Hock et al. (2018), who argued that mothers who employed authoritarian (controlling) and neglectful (uninvolved) parenting styles were associated with their daughter's depression and controlling

mothers were associated with their son's depression. In addition, authoritative or democratic parenting styles were associated with high levels of female emerging adults' self-esteem and reduced psychological problems. However, Szkody et al. (2020) surprisingly concluded that mothers who applied authoritative or democratic parenting styles were at risk of nurturing female children with low self-esteem and psychological problem, including suicidal behaviours. This contradicted this study which revealed that democratic and very easy (laisse fair) parenting were protective factors for all suicidal behaviours.

Parents' Highest Education. This study explored the parents' highest education level and suicidal behaviours (see Appendix X). The finding revealed that the more parents were educated, the greater the risk for suicidal thinking (r=.032, R^2 =.061), suicidal planning (r=.061, R^2 = .041), suicidal attempt (r=.005, R^2 = .046) and self-harm (r=.002, R^2 = .038). This means that highly educated parents natured children at risk for suicidal thinking, suicidal planning, suicidal attempt and self-harm. These findings differed from Chen et al. (2022), who concluded that lower parental education levels were associated with suicidal attempt but not suicidal ideations in youth. Moreover, Padilla-Moledo et al. (2016) contended that parents with a university degree were associated with children with positive psychological health and lower medical problems.

This means that emerging adults brought up by more educated were at risk of developing both psychological and health problems. This study's findings were in a different cultural context from that of Padilla-Moledo et al. (2016), thus the differences. Assari et al. (2018) noted the impact of maternal education level on an individual's health due to racial relations with the educated mother. Therefore, higher levels of parental education were linked with increases in suicidal behaviours due to possible increased demands on social and academic performance.

Table 16

Attachment Styles and Suicidal Behaviours

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-harm
Attachment Styles				
Feel safe (secure)	-0.500**	0.195	-0.178	0.080
	(0.223)	(0.151)	(0.173)	(0.142)
Feel anxious (anxious)		Omitted due to collinearity		
Feel fearful (avoidant)	0.109	0.578***	0.186	0.116
	(0.292)	(0.198)	(0.226)	(0.186)
Feel unsure (ambivalent)	-0.281	0.251*	-0.160	0.068
	(0.223)	(0.151)	(0.172)	(0.141)

Note. The correlation between parent-child attachment styles and suicidal behaviours.

Attachment styles. This study also captured the relationship between parent-child attachment and emerging adults' suicidal behaviour. As shown in Table 16, the result revealed that secure attachment style was negatively linked with suicidal thinking (r=-.500, $p < .05$, R^2 = .223) and suicidal attempt (r=-.178, R^2 = .173). On the contrary, being securely attached was positively correlated to suicidal planning (r=.195, R^2 =.151) and self-harm (r=.080, R^2 = .142). Furthermore, participants that were fearful or anxiously attached were at risk of all suicidal behaviour: suicidal thinking (r=.109, R2 = 292), suicidal planning (r=.578, p<.01. R2 = .198), suicidal attempt (r=.186, R2 = .226) and self-harm (r=.116, R2 = 186). The ambivalent or unsure attachment style was positively associated with suicidal planning (r=.251, R2 = .151) and self-

harm (r=.680, R2 = .141). Besides, ambivalent or unsure attachment style was negatively linked to suicidal thinking (r=-.281, R2 = .172) and suicidal attempt (r=-.160, R2 =.172). This finding was similar to Goodman et al. (2018), who concluded that insecure attachment styles were associated with suicidal thinking among young men. Moreover, a study by Green et al. (2021) revealed that the avoidant attachment style was linked to suicidal thinking, while the anxious attachment style was associated with suicidal attempt. This was because of the disturbances or disruptions emerging adults might have experienced in childhood, resulting in insecure attachment and a risk for psychological problems and psychopathologies (Marrone, 2014).

The interpretation of these findings is that secure attachment with a parental figure in childhood was a protective factor for suicidal thinking and suicidal attempt but not suicidal planning and self-harm. It was clear from this study that anxious or fearful attachment was a risk factor for all suicidal behaviours. Still, the ambivalent parent-child relationship was a protective factor for suicidal thinking and suicidal attempt. On the other hand, it was a risk for suicidal planning and self-harm.

Early Family Environment and Suicidal Behaviours

The second objective explored in this study was the early family environment feature significantly associated with suicidal behaviours among emerging adults in the university. The association was tested using Multivariate Statistical Analysis (MANOVA). Specifically, the linear multiple regression analysis was used to correlate the independent variables with the dependent variables. The regression equation used was $Yi= \alpha_i+ \beta_1 X_1i+ \beta_2 X_2i+\cdots+ \beta_k X_ki+ \varepsilon i)$. Where Y represented the dependent variables which were the suicidal behaviours. X represented the independent variables defined in the study objectives and theoretical framework. The symbol β represented the coefficients of association being estimated between the dependent

and independent variables. While Ɛ represented the error term in the measurements, and α represented the Y-intercepts, interpreted as the value of the dependent variable without the influence of the independent variables included in the regression model.

The independent variables comprised two early family environments: a) family relations and b) support for personal growth. A third independent variable accommodated in the early family environment is the occurrence of stressful life events, also known as Adverse Childhood Experiences (ACEs). This study explored the stressful events that happened to emerging adults before they were 12. At the same time, the dependent variables were represented by four types of suicidal behaviours; suicidal thinking, suicidal planning, suicidal attempt and self-harm. The study employed the Person Correlation Coefficient to measure the strength and direction between the variables. Pseudonyms were used to present qualitative results from the focus group discussion.

Table 17

Early Family Environment and Suicidal Behaviours

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-Harm
Family Relations				
Strong Bond				
Strong bond with one or both parent/guardian(s)	0.029	0.145**	0.086	0.095*
	(0.081)	(0.056)	(0.062)	(0.051)
Felt loved and wanted	-0.149	-0.022	-0.013	-0.171**
	(0.111)	(0.077)	(0.086)	(0.070)
Expressiveness				
Allowed to express one's thoughts and feelings freely	-0.186**	-0.018	-0.074	0.019
	(0.092)	(0.064)	(0.071)	(0.058)
Openly voiced conflicts with one another	0.093	0.018	0.060	0.062
	(0.074)	(0.051)	(0.057)	(0.047)
Learnt to hide negative emotions	0.028	0.016	0.032	0.008
	(0.061)	(0.043)	(0.047)	(0.039)
Reliability				
Parents were reliable in what they promised	0.095	0.005	0.049	-0.004
	(0.093)	(0.065)	(0.072)	(0.059)
Encouraged to openly communicate wishes	0.058	-0.014	-0.039	0.016
	(0.094)	(0.065)	(0.073)	(0.059)
Maintained connection and communication in crisis	-0.100	-0.043	-0.136*	-0.085
	(0.099)	(0.069)	(0.077)	(0.062)
Responsive				
Family sought external help in times of need	-0.150**	-0.037	-0.042	-0.057
	(0.067)	(0.046)	(0.052)	(0.042)
Family was flexible and coped well with change	-0.158*	-0.026	-0.014	0.011
	(0.086)	(0.059)	(0.066)	(0.054)
Support for Personal Growth				
Self-esteem				
Supportive in developing a positive view of self	-0.022	-0.058	-0.096	0.023
	(0.101)	(0.070)	(0.078)	(0.064)
Self-Regulation				
Allowed to decide what I wanted to do like what to wear	0.031	0.048	0.062	0.005
	(0.066)	(0.046)	(0.051)	(0.041)
Encouraged to form close relationships outside the family	0.039	-0.047	-0.016	-0.010
	(0.075)	(0.052)	(0.058)	(0.048)
Learnt to manage negative emotions when angry, sad or disappointed	-0.043	0.049	0.050	-0.003
	(0.081)	(0.056)	(0.062)	(0.051)

	Suicidal Thinking	Suicidal Planning	Suicidal Pttempt	Self-Harm
Problem-Solve				
Conflicts were managed without blame	-0.086	-0.061	-0.086	-0.065
	(0.083)	(0.058)	(0.064)	(0.052)
Encouraged to solve problems constructively	0.057	-0.075	-0.020	-0.062
	(0.088)	(0.061)	(0.068)	(0.056)
Encouraged to seek help when in trouble or need	-0.128	-0.039	-0.023	-0.032
	(0.092)	(0.064)	(0.071)	(0.058)
Spiritual Values				
Morality was valued and encouraged	-0.035	0.053	0.040	0.007
	(0.106)	(0.074)	(0.082)	(0.067)
Religious practices were part of the family culture	-0.021	-0.024	-0.001	-0.031
	(0.083)	(0.058)	(0.064)	(0.052)
Faithfully attended religious meetings	0.057	0.061	0.049	0.014
	(0.086)	(0.060)	(0.066)	(0.054)
Family was hopeful in stressful life events	0.132	0.006	0.039	0.078
	(0.102)	(0.071)	(0.079)	(0.064)
Observations	397	397	397	397
R-squared	0.248	0.161	0.184	0.164

Note. The multivariate statistical analysis of the Early Family Environment features against suicidal behaviours. The Standard errors are in parentheses, and the asterisk *** p<.01, ** p<.05, * p<.1 represented the level of correlation. The correlation is significant at the 0.05 level.

As evident in Table 17, the study captured the correlation analysis between suicidal behaviours and eight phrases or statements capturing the two dimensions of family environment, namely: a) family relations feature divided into; strong bond, expressiveness, reliability and responsiveness and b) support for personal growth further expanded as; self-worth, self-regulation, problem-solving, and spiritual values. The analysis further captured the correlations between suicidal behaviours and c) childhood stressful life events involving fourteen stressful life events.

Family Relations

The study examined the correlation between suicidal behaviours and the four areas of family relations; strong bonds, expressiveness, reliability and responsiveness. The results revealed that some aspects of family relations were positively associated with suicidal behaviours while others were negatively associated with suicidal behaviours. The respondents in the focus group discussion defined the characteristics of family closeness; it treated children equally, had a positive view of them, modelled good behaviour, learnt what each one liked, was friendly, communicated honestly and had unbroken bonds.

Strong Bonds. This study examined the correlation between establishing a strong bond with one or both parents or guardians and feeling loved and wanted in the family environment.

Strong bonds with one or both parents/guardians. The study sought to explore the correlation between having strong bonds with one or both strong bonds with parents/guardians. The findings revealed that having a strong bond with one or both parents/guardians was positively linked to all suicidal behaviours. Growing up with parents/guardians who were strongly connected to the child was a risk to suicidal behaviours: suicidal thinking ($r=.029$, $R^2=.081$); suicidal planning ($r=.145$, $R^2=.056$, $p< .05$); suicidal attempt ($r= .086$, $R^2=.062$) and ($r=.095$, $R^2=.051$). The results showed a statistically significant correlation with a p-value of $p< .05$ between strong bonds with parents and suicidal planning (see Table 17). The university counsellors in the Delphi survey agreed that strong bonds with parent/guardian were not strong protective factors for suicidal behaviours. Meaning having a strong bond with parents only in childhood was a risk factor for suicidal behaviour, more so suicidal planning in emerging adulthood. These findings were similar to Freudenstein et al. (2011) and Saffer et al. (2015), who noted that parent-child bonds free of suicidal behaviours had increased care and reduced overprotection. Strong parent

bond alone was associated with suicidal behaviours. Secure parent-child bonds, along with friendliness, acceptance and closeness, were protective against suicidal behaviour (Miniati et al., 2017; Cassidy et al., 2014; Marrone, 2014).

In addition, the focus group discussion interviews confirmed that having a strong bond with parents/guardians was beneficial. The participants identified six qualities of a strong parent-child relationship: a) it helps children make decisions, b) teaches problem-solving skills, c) gives a sense of security, d) parents self-disclose about their struggles, e) requires open and honest communication and f) parents listen, understand and support their children.

This shows that having a strong bond with parents or guardians was insufficient to protect emerging adults from suicidal behaviours. The strong bond with parents/guardians needs to be accompanied by caring actions of open, honest and supportive interactions. "Luke", a 19-year-old first-year male student, shared his story to illustrate the value of a strong parent-child bond,

> "For example, as children, we were left with house helps as our parent went to work most of the time, leaving us alone. So we were left to deal with issues on our own. Even when our parents approached us, it was very difficult for us to share our stuff when we are now all grown. So there are high chances of falling into depression, having difficulty in opening up and expressing how we feel because we fear being judged by other people because there was no one there to help us and guide us along the way."

Participant "Caren", a 22-year-old second-year female student, stated it was "it is really important for a guardian or parent not just to have a strong bond with their child, but to have an open and honest communication with the child or children.*"* another respondent, "Jaden," a 25-year-old fourth-year male student, added that having a strong bond and open communication

with parents/guardian might help students because “come back and talk to their parents on what they are experiencing and they can get solutions. So it is important to have an open communication in addition to strong bonds*”. “*Mandi”, a 24-year-old third-year female student, said that “a strong parent-child relationship provides children with a sense of security. So they don’t feel alone in their problems and look for ways to self-harm. Rather they can share the problem with the parent and solve it together.”

These findings were parallel with Perquire et al. (2021), who contended that the parent-child bond that protects children from suicidal behaviour is a result of reduced conflicts, secure attachment, emotional accessibility, open interaction and high connectedness. Therefore, expressing care, friendship, acceptance, congruent communication, emotional safety and open interaction; were added qualities in a parent-child bond that protects emerging adults from suicidal behaviours (Prime et al., 2020; Goldenberg et al., 2017; Viner et al., 2012).

Feeling loved and wanted. The second area of strong bonds examined was the aspect of a child feeling loved and wanted. The results revealed that children who grew up feeling loved and wanted were negatively correlated to all suicidal behaviours. The study recorded; suicidal thinking ($r = -.149$, $R^2 = .111$), suicidal planning ($r = -.022$, $R^2 = .077$), suicidal attempt ($r = -.013$, $R^2 = .086$) and self-harm ($r = -.171$, $R2 = .070$, $p < .05$) (see Table 17). Although the strength of the association was insignificant for suicidal thinking, suicidal planning and suicidal attempt, there was a statistically significant relationship between self-harm and feeling loved and wanted in the family. This study revealed that feeling loved and wanted was a protective measure for all suicidal behaviours.

These results were convergent with the focus group discussion responses. They confirmed that feeling loved and wanted even by one parent is a protective factor against suicidal behaviours. “Asha”, a 25-year-old fourth-year female student, said,

> “… my personal experience is that I have not felt loved and wanted in my family. This is because my family was against me coming to this university to study. Yeah, that has affected me like I had to deal with the rejection like I had to. They said that in order for me to come to school, I had to, you know, go out or leave the house. And if I go then I should not come back to the house, and so I had to deal with that like yeah, that I'm on my own. The family detached me apart from my mother. She has been supportive and encouraging me not to let whatever happened and distract me from reaching my goals.”

These findings are parallel to McGoldrick et al. (2014) and Prime et al. (2020), who observed that growing up in a family that expressed love, appreciation, respect, and value reduced the risk of all suicidal behaviours. Thompson et al. (2019) noted that children who grew up without adverse childhood experiences in the family made children feel loved and wanted, thus reducing the risk for suicidal behaviours in emerging adulthood.

These findings imply that interacting with children in ways that make them feel loved and wanted will support them in finding self-value, which will protect them from suicidal behaviours. In addition, counsellors can restore value in emerging adults experiencing suicidal behaviours by creating a strong and positive therapeutic alliance where the client feels loved and wanted.

Expressiveness. Family expressiveness was the second aspect of the family relationship explored in this study. Participants were asked to indicate whether their families allowed them to

express their thoughts and feelings freely if they openly voiced conflict with other family members or learnt to hide negative emotions. Participants in the focus group discussion identified four things about their early family environment concerning honest emotional expressions. They noted that participants learnt to express emotions through parents' modelled and positive feedback, through encouragement to express oneself freely, how it affects their problem-solving skills and observed that men also need to learn honest emotional expression.

Expressing thoughts and emotions freely. The study revealed that being allowed to express one's thoughts and feelings freely in childhood was a protective factor against suicidal thinking, planning and attempts among emerging adults. The results showed that freely expressing one's thoughts and feelings was linked to suicidal thinking ($r= -.186$, $R^2 = .092$, $p<.05$), suicidal planning ($r= -.018$, $R^2 = .064$), suicidal attempt ($r = -.074$, $R^2 =.071$) and self-harm ($r= .019$, $R^2 = .058$) (see Table 17). The relationship between expressing one's thoughts and feelings freely was statistically significant at $p< .05$. However, families that allowed children to freely express their thoughts and feelings were still at risk of self-harm.

These findings were convergent to the focus group discussions. Based on the focus group discussions, there was a relationship between growing up in a family that allowed children to honestly express their thoughts and emotions and how they solve problems today. As noted by participant "Lydia" a 20-year-old first-year female student ", being allowed to be honest and emotionally expressive is a positive thing because it helps how emerging adults deal with life challenges". But "Dina", a 24-year-old fourth-year female student, voiced her concern about African parents' response to children who express themselves. She said that "our traditions don't know how to handle people who try to express their emotions*."* View that was agreed upon by two others "Ondiek" a 19-year-old first-year male student, who observed that "African parents

do not know how to deal with emotions and it prohibits men from expressing emotions'. "Kilonzi" a 26- year-old fifth-year student gave his personal example "right now as a man; honest emotional expressions are kind of looked down on because I grew up being told by my father that men don't cry or talk things out." Another male respondent shares their experience on the same "Ndirangu" a 23-year old third-year student added,

> "men in my family don't express their emotions. I think for me my dad and my brother, we go through challenges without verbalizing them. We keep our emotions in. Like when I came to university, I went through rejection when dating, and I had a huge challenge expressing my pain to my dad. So I thought to share with my mother maybe she will be empathetic. When I told her, she broke into laughter. That was very disappointing for my mother to laugh at me rather than be empathetic."

The counsellors, too, had convergent views that allowing children to express themselves emotionally was very important. Three out of six counsellors indicated that supporting children to express themselves emotionally might help them with better ways of dealing with challenges later.

However, this study found a positive correlation between being allowed to express one's thoughts and feelings openly. This finding was contrary to Jacobson et al. (2015), who observed that emerging adults who lacked emotional expressiveness were more at risk of engaging in self-harming activities. Most studies affirm that emotional expressiveness promotes emotional well-being as children admit and cope with negative emotions (Castro et al., 2015; Dunbar et al., 2017). The implication is that allowing children to express their thoughts and feeling freely

reduces the risk of suicidal thinking, planning and attempt. However, it might not protect them from engaging in self-harming behaviours.

Openly Voicing Conflict. The study explored the relationship between families where members learnt to voice their conflicts with each other openly. Surprisingly, openly voicing conflict with other family members was positively associated with all suicidal behaviours. As revealed in Table 17, this study recorded the relationship analysis as suicidal thinking (r=.093, R^2 =.074), suicidal planning (r = .018, R^2 =.018), suicidal attempt (r=.060, R^2 = .057) and self-harm (r =.062, R^2 =.047). The study revealed that learning to voice conflict with family members openly was a risk factor for all suicidal behaviours. Meaning that voicing conflict with each other was not helpful may be due to how it was done. Family members that use incongruent communication patterns of blaming, placating, super reasonable and irrelevant increase the chances of engaging in suicidal behaviours. Allen et al. (2022) agree that congruent communication with family members was more dependable in training to cope with challenges, thus reducing suicidal behaviours.

Hide negative emotions. Another aspect of family expressiveness examined in this study was the relationship between learning to hide negative emotions and suicidal behaviours. The results revealed that hiding negative emotions was positively correlated to all suicidal behaviours. The analysis shown in Table 17 revealed that hiding negative emotions was correlated to suicidal thinking (r=.028, R^2 = .061), suicidal planning (r=.016, R^2 =.043), suicidal attempt (r=.032, R^2=.047) and self-harm (r=.008, R^2 =.039).

The focus group discussion shed light on why emerging adults learnt to hide positive and negative emotions. “Juma’ a 26-year-old fourth-year male student, said, “Honest emotional expression is a good life skill to have for emerging adults deal with life challenges. However,

right now, as men, honest, emotional expression was kind of looked down on by my family." Some respondents felt that hiding negative emotions kept them safe in their families because, in the past, they were hurt when they shared these emotions. "Koli," a 21-year-old second-year female student said,

> "…but to be able to share negative emotions with your family members honestly; about how you're feeling depends on the feedback you have received in the past. To get good feedback and to get support from them encourages you to do that. I think it is best to be able to comfortably do that because none of us knows how the trajectory of our lives will go. It's constantly drilled into us that family is the one thing we can trust and everything. But some of us honestly don't trust our families. Some of us can't talk to the people that we grew up with because they have betrayed us, and that's where the intense feeling of loneliness comes from."

Insecurely attached parents-child patterns that are dismissive, inconsistent, abusive and unresponsive nurture emerging adults to hide negative emotions (Miniati et al., 2017; Davaji et al., 2010). Dunbar et al. (2017) approved that parents taught children to hide negative emotions through punitive or minimizing responses in their interactions, which resulted in emerging adults hiding negative emotions as a risk to well-being. This is evident in this study. Meaning that emerging adults who learnt to hide negative emotions lack healthy ways of accepting and coping with negative emotions. Thus they are at risk of engaging in suicidal behaviours.

Reliability. Another aspect of family relations explored in this study was reliability. The study sought to examine the relationship between; parents' reliability in what they promised, encouragement to openly communicate wishes and maintaining connection and communication and suicidal behaviours. In addition, the focus group discussion put up a six-point description of

reliable family support. They said that a family providing reliable family support; a) communicates verbally and non-verbally, b) maintains a positive attitude towards each other, c) appreciates the efforts children make, d) it encourages the children, e) invests in children's dreams and talents, and f) accepts children for who they are so that the children do not need to seek approval (see Table 17).

Kept Promises. Participants were asked to indicate whether their parents were reliable in fulfilling promises they made. Then a correlation was drawn with all the suicidal behaviours. The results showed that keeping to the promises one made to the children was positively correlated to suicidal thinking (r= .095, R2 =.093), suicidal planning (r=.005, R2 =.065) and suicidal attempt (r=.049, R2=.072), However, growing up in a family where parents were reliable in fulfilling the promises they made was negatively linked to self-harm (r=-.004, R2 = 05). This means that being reliable in keeping promises made was a risk factor for suicidal thinking, planning and attempt but a protective factor against self-harm. Secure parents focus on being available, caring and supportive of their children (Cassidy et al., 2014; Marrone, 2014) rather than fulfilling promises. Therefore, fulfilling promises in the absence of a secure attachment with children is a risk for suicidal thinking, suicidal planning and suicidal attempt, although they may not self-harm.

Encouraged to communicate. This study sought to understand the relationship between being encouraged to communicate one's wishes and suicidal behaviour openly. The results in Table 17 showed both a positive and negative relationship between the variables. Being encouraged to communicate one's wishes openly was positively linked to suicidal thinking (r=.058, R2 =.094) and self-harm (r=.016, R2 = .059). On the other hand, being encouraged to communicate what one wished for openly was negatively linked to suicidal planning (r=-.014,

R2 =.065) and suicidal attempt (r=-.039, R2 = .073). This means parents who encouraged their children to communicate their wishes openly were at risk of suicidal thinking and self-harm. Nonetheless, they were less likely to engage in suicidal planning and suicidal attempt.

These findings agreed with the Satir model theory, which revealed that primary caregivers who supported children to communicate their wishes honestly taught them to be congruent communicators (Baldwin, 2013). Such communicators were less likely to engage in suicidal planning and suicidal attempt. McLendon and Miller (2010) confirmed these findings. They contended that incongruence communication is associated with mental health problems. However, being a congruent communicator did not protect emerging adults from suicidal thinking and self-harm.

Maintained Connection. The study observed the relationship between maintaining connection and communication in crisis and suicidal behaviours. The results revealed a negative relationship in all suicidal behaviours; where suicidal thinking (r=-.100, R2 = .099), suicidal planning (r=-.043, R2 =.069), suicidal attempt (r=-.136, R2 =.077) and self-harm (r=-.085, R2 =.062) (See Table 17).

These findings were convergent to those recorded in the focus group discussions. Participants stated that families that remained connected and communicative during distress were supportive and helped them cope. At the same time, those unresponsive and disconnected in crisis made them pull away as they felt unsupported and uncared for. “Salome”, a 24-year-old third-year-old, shared her distress about how her family dealt with the children’s challenges.

> “I wish my family could have improved in the way that they handled our challenges. Our parents ignore and disconnect from us when we are in distress. My sister is going through so many things right now, but for some reason, she's

not getting the support from my parents, the people she should be getting their support from. It's shocking because my parents are supporting other people who are not even their son or daughters. Yeah, so yeah, that is really painful. But there is still room for improvement, yeah? That improvement should be both in form of communication and support."

The interpretation of these findings were that families that remained connected and communicated in crisis nurtured emotionally stable emerging adult who did not engage in suicidal behaviours. These findings are supported by the attachment theory, which states that a secure attachment with primary figures who stay close to the children and resist separation distressful nurtured secure emerging adults (Kruglanski et al., 2007; Miniati et al., 2017). These emerging adults are confident and equipped to explore healthy ways of solving problems rather than engaging in suicidal behaviours.

Responsiveness. The participants were asked to indicate how responsive their families were in seeking external help in times of need and the family's flexibility in coping with change. Based on the focus group discussion responses, sometimes families respond positively to family or children's distress by taking them to see a counsellor or finding someone they can take to. On the other hand, families sometimes respond negatively when in distress by withdrawing, leaving the children on their own (neglect), breaking up the family or being unsupportive (see Table 17).

Sought External Help. Turning on the results analyzing the relationship between seeking external help in times of need and suicidal behaviours, the findings revealed a negative relationship in all suicidal behaviours. The correlations results of seeking external help when in need were: suicidal thinking (r=-.150, R2 = .067, $p < .05$), suicidal planning (r=-.037, R^2 = .046), suicidal attempt (r=-.042, R^2 =.052) and self-harm (r=-.057, R^2 = .042).

Although seeking external help in times of need is revealed as important, not all families embraced this problem-solving method, according to the focus group discussions. The participants' decision on whether to seek external support in times of need was modelled by the family of origin. The participants confirmed that their current behaviours, to seek external help or not, were informed by what they observed growing up. “Atieno”, a 23-year-old female student in second year, stated that “If when you were growing up, you saw your parents and family members seek help for problems from other people. As a child, you will learn to seek help from others.” Another respondent, “Amina” a 26-year-old female student in her fourth year, coincided with Atieno by saying;

> “I think what I observed growing up very much has shaped me as an adult. It has shaped me to be the kind of person who when I'm going through something, I tend to just solve problems on my own because that's how I've been raised. That's how the environment of my family was. I even questioned my mother about it and she said that’s how she was raised as well. So it's something that was running through generations. She was raised, as you know, if you have issues sort them out on your own so that is how she raised us. Not to seek external help when in need but to solve our own problems.”

Another participant, “Ochola”, a 25-year-old male student in his fourth year, added that it is important to teach children to seek help so they can deal with life challenges differently as emerging adults. He added;

> “If I grew up in an environment where we were allowed to share things when in need, I could have grown up as someone who knows how to share things. For me, that sharing problems with others doesn't just come naturally it's

> something that I'm growing to learn now. Having gone through depression and gotten out of it and seeing how keeping things to myself really made me go into depression because I was not being able to share out. So it is something that I'm now learning as an adult, but I feel if it was drilled into me in my childhood, it would have made me grow up solving problems better with a variety of alternatives."

These findings aligned with the attachment theory that argues that children whose primary attachment figures were available and responsive developed a secure attachment style (Marrone, 2014; Miniati et al., 2017). Based on the interaction they had and whether the child was helped and encouraged to seek help when in need. The child might have also observed the caregiver seeking external assistance when the family was in need. Thus, emerging adulthood felt safe to seek external assistance in times of need instead of engaging in suicidal behaviours (Cassidy et al., 2014; Marrone, 2014).

Flexibility and Coping. The final aspect of the family relations this study explored the relationship between being flexible and coping well with change and suicidal behaviours. The results revealed that families that were flexible and that coped well with change were negatively correlated to suicidal thinking, suicidal planning and suicidal attempt. The correlation analysis recorded that: suicidal thinking ($r=-.158$, $R^2=.086$), suicidal planning ($r=-.026$, $R^2=.059$) and suicidal attempt ($r=-.014$, $R^2=.066$). The study further noted that self-harm was positively correlated ($r=.011$, $R^2=.054$) to being flexible and coping well with change (see Table 17).

The findings converged with the focus group discussions, which established that families taught children how to cope with change by how they interacted with the children and other family members. How family members deal with change becomes how they might deal with

change as emerging adults. “Doris”, a 27-year-old female fifth-year student, shared her experience:

> “Many decisions I made in campus were majorly based on how I was raised. As a kid, I grew up emulating people in my family environment. Yeah, so like when I got to campus it's like I was just mirroring the things that I saw back home and to some extent it was a bit stressful because nobody is perfect, and the things that I picked from home led me to get myself in situations that were bit stressful. I grew up to become a people pleaser. I just want everybody to be happy with me, everybody to be okay with me. That was what I saw people in my family doing. So having to be honest was really stressful for me. I'd find myself running away from people and situations because it's easier to avoid than to confront or face people and situations head on.”

“Mary”, a 20-year-old female first-year student, added that her family was not flexible with change,

> “I remember how growing up my father was abusive to my mother but even with my dad was abusive. My mother was a really nice person. They kept like breaking up with my dad. I have noticed that when these things happened, my mom would withdraw from people. She wouldn't talk about it. And for some reason I find myself also doing that. Thought I would to deal the best way with issues, when they happen; like seeking help or even accept that things are not okay, I withdraw.”

Emerging adults that observed healthier, flexible and positive problem-solving skills at work in their early families learnt to apply them just like those who learnt negative problem-

solving skills. According to the life course development theory, the early family teaches children to be resilient by being flexible and adjusting to expected and unexpected changes (McGoldrick et al., 2014; Valdez et al., 2013). This means that emerging adulthood who learnt to adjust and deal with change and transitions are less likely to engage in suicidal thinking, suicidal planning and suicidal attempt. This was because they had developed a healthy self-view and interpersonal skills to explore, solve problems or manage situations in a congruent way (Allen et al., 2022). They are resilient in that change does not hinder them from pursuing their goals.

Personal Growth

The second early family environment feature examined in this study was personal growth. The study sought to determine how families supported children towards personal growth in obtaining: positive self-esteem, self-regulation, problem-solving and spiritual values. The results are presented in Table 17.

Positive Self-Esteem. This study sought to capture the correlation between support for positive self-esteem and suicidal behaviours. The result revealed a negative relationship between support for positive self-esteem and suicidal thinking (r=-.022, R^2=.101), suicidal planning (r=-.058, R^2=.070) and suicidal attempt (r=-.096, R^2=.078). There was a positive correlation between support for positive self-esteem and self-harm (r=.005, R^2=064). The strength of the relationship was poor, with no statistical significance between the variables.

These findings are convergent with those of the focus group discussion. The participants confirmed that support for positive self-esteem was an important and protective factor for suicidal behaviours. “Dickson”, a 21-year-old first-year male student, said, “support for positive self-esteem always helps a lot. Because positive self-esteem will prevent suicidal behaviours on a scale of 8, from a scale of 1 to 10.” Another first-year male student “Larry”, 18-years-old added,

“Being supported to have positive self-esteem contributes largely to having a positive attitude towards life, yeah? Such that when you are in a bad situation, you will know it's not permanent. You know that eventually, it will pass. And things will get better.” So families that are keen on developing positive self-esteem in their children are equipping them to deal with challenges better emerging adulthood. “Zena”, a 25-year-old female student in her fourth year of university, gives an example of ways families can support the development of children’s positive self-esteem.

> “I would say there are many things that the family can do to help someone to have a positive self-view. For example, we used to consider what our parents used to tell us and believed everything so if a parent said that, I'm not beautiful then I believed it' because they cannot lie. In my family, my dad is a pastor and he used to tell us, his children every morning you are beautiful, I love you, you are wonderful, you are amazing so those words affected us. And when we are faced with something outside, we used to remember that no, no, you are not my parents. You are not like an important person in my life so I have to consider what my parents used to tell me every morning.”

However, the Delphi consensus was divergent from the survey and focus group discussion finding in that the counsellors agreed that support for positive self-esteem was not a strong protective factor for suicidal behaviours. Only one out of six counsellors thought positive support for positive self-esteem would sustain emerging adults towards healthy decisions.

These findings revealed that developing positive self-esteem was a protective factor to suicidal thinking, planning and attempt. This was parallel to the views in Satir Model according to Sommer-Flanagan and Sommer –Flanagan (2015), who noted that high self-esteem helps with

personal inner judgment, interaction with situations and others. Thus people with positive self-esteem will be compassionate to self, accept their strengths and weaknesses as they find creative ways to deal with challenges (Gehart, 2010; Satir et al., 1991). Therefore, developing children's positive self-esteem is a protective measure for suicidal behaviour but not self-harm.

Self-Regulation. The study sought to determine the correlation between support for personal growth in self-regulation and suicidal behaviour. Three statements captured this: I was allowed to decide what to do, like what to wear. I was encouraged to form close relationships outside the family, and I was encouraged to manage negative emotions when angry, sad or disappointed.

Allowed to Decide. The results revealed that being allowed to decide to do what one wanted early in life was positively correlated to all suicidal behaviours. Meaning that being allowed to decide what one wants was a risk for all suicidal behaviours. The analysis was that suicidal thinking ($r = .031$, $R^2=.066$), suicidal planning ($r = .048$, $R^2=.048$), suicidal attempt ($r = .062$, $R^2=.051$) and self- harm ($r = .005$, $R^2=.041$). The relationship was weak and had statistical insignificance.

These findings were divergent from the focus group discussions. The respondents felt that being allowed to decide what they wanted in childhood was good and bad. It was good because it helped them learn to make small and, eventually, big decisions. Bad because they are not mature enough to make the right decisions and might need to learn through painful experiences. According to "Judith" a 22-year-old female student in his second year of university said,

> "I can say that is good to some extent, and it was also not so good because I've always lived in that bubble of where my parents helped me to discern who is good for me

> and who is not. Now when I got to campus, it was like I had to decide for myself. Having grown up like being taught you need to be nice to people; you need to be welcoming has put me in situations where I've put myself in danger just by the mere fact that I am supposed to be nice to people."

These findings confirmed the view in attachment theory where avoidant attached parents allowed children too much freedom to make decisions (Miniati et al., 2017). Emerging adults develop avoidant attachment style, which causes them to be uncomfortable with close relationships and very independent (Davaji et al., 2010). Mandal and Zalewska (2012) note that people with avoidant attachment style were at risk of suicidal thinking and suicidal attempt when faced with stressful situations. Allowing children to do what they want is a risk factor for personal growth due to limited skills to deal with challenges, thus leading to suicidal behaviour.

***Encouraged to Form Relationships Outside*.** The study captured the relationship between being encouraged to form close relationships outside the family and suicidal behaviour. The findings showed that being encouraged to form relationships outside the family was positively correlated with suicidal thinking ($r = .039$, $R^2 = .075$). On the contrary, being encouraged to form relationships outside of the family was negatively correlated to suicidal planning ($r = -.047$, $R^2 = .052$), suicidal attempt ($r = -.016$, $R2 = .058$) and self-harm ($r = -.010$, $R^2 = .048$). However, the strength of the relationship was poor and statistically unimportant. It means that families that encouraged children to form close relationships outside the family were less likely to engage in suicidal planning, suicidal attempt and self-harm in emerging adulthood.

These findings were similar to the focus group discussion that showed that students who were not encouraged to form close relationships outside of the family struggled to deal with

challenges when they joined the university. As indicated by “Mueni” a 23-year old, female student in her second year of university,

> “forming close relationships outside of the family was not encouraged at home. I think before coming to campus, I was living in a bubble. Well, I would only relate with my brother, some of his friends and no one else. I never thought I would ever think about it. Then I came to campus and realized I needed others to help me because my family was not there with me. I learnt the hard way that forming close relationships outside of the family was very important.”

Some students got to form relationships outside the family due to campus demands because the family did not encourage them to form such relationships. “Karimi”, a 24-year-old female student in her third year, agreed with Mueni,

> “I was not encouraged to form close relationships outside of the family. I got to some place where I needed to form relationships with classmates. I had never been in a class with mixed-gender with boys who want to take me out and talk to me in group discussions. For me, it was too confusing. So here I think is where I have related with so many people. I was also in a bubble that had to be popped when I came to campus and this was one hard thing to adjust to when I joined university.”

There was a consensus among all the university counsellors that forming relationships outside of the family; was a strong protective factor for suicidal behaviours in emerging adulthood. Encouraging children to form close relationships outside the family is a protective factor for their personal growth and mental well-being.

Manage Negative Emotions. The study examined whether emerging adults were encouraged in their childhood to manage their negative emotions and their relationship to

suicidal behaviours. The results recorded negative and positive correlations between being encouraged to manage negative emotions and suicidal behaviour. There was a positive correlation between managing one's negative emotions with suicidal planning ($r = .049$, $R^2 = .056$) and with suicidal attempt ($r=.050$, $R^2 = .062$). On the contrary, there was a negative correlation between being encouraged to manage negative emotions with suicidal thinking ($r = -.043$, $R^2 =.081$) and self-harm ($r = -.003$, $R^2 = .051$). The strength of the relationship between the variables was poor and statistically insignificant.

This means that being taught to manage negative emotions when angry, sad or disappointed was a risk factor for suicidal planning and suicidal attempt. However, learning to manage one's negative emotions was a protective factor against suicidal thinking and self-harm. Based on these findings, managing negative emotions was not enough to protect emerging adults from engaging in suicidal behaviours. Furthermore, how negative emotions are processed can be positive and contractive or negative and destructive. Therefore, based on the Satir Model, these findings are similar. When negative emotions are managed with limited inner insight, denial and partial processing, there is a risk of engaging in suicidal behaviour (Goldenberg et al., 2017; Corey, 2017). This is because the emerging adult has not explored the content below the iceberg. Whereas managing negative emotions by engaging in self-awareness, acceptance and processing thoughts and feelings are protective factors against suicidal behaviour (Corey, 2017; Goldenberg et al., 2017). Therefore, the extent to which emotions are managed will determine whether learning to manage negative emotions is a protective or a risk factor against suicidal behaviours in emerging adults.

Problem- Solving. The study explored the relationship between support for personal growth in problem-solving and suicidal behaviours. There were three statements used to capture

problem-solving. The three statements were: conflicts were managed without blaming anyone in the family, there was an encouragement to constructively solve problems and encouragement to seek help when in need or trouble. The results of each problem-solving skill set discussed were recorded in Table 17.

Managing Conflict without Blaming. This study examined the correlation between being taught to solve conflict without blaming and suicidal behaviours. The results revealed a negative correlation between learning to manage conflict without blaming and all suicidal behaviours. The analysis showed that managing conflict without blaming negatively correlates with suicidal thinking (r = - .086, R^2 =.083), suicidal planning (r = - .061, R^2 = .058), suicidal attempt (r = - .086, R^2=.086) and self-harm (r = - .065, R2 = .052).

These results are convergent to Satir's Model, which views blaming, and an incongruent survival stance associated with people use to deal with intrapsychic distress (Goldenberg et al., 2017). People who blame place the responsibility of a situation on another person while ignoring their personal and contextual contribution to the prevailing distress. Such incongruent stances were learnt in a child through interaction with one's primary-triad, and it is associated with mental health problems, including suicidal behaviours (Capuzzi & Stauffer, 2021; Mclendon & Millar, 2010).

Therefore, emerging adults who were taught to deal with conflict without blaming have a chance to learn a key problem-solving skill of congruence stances to help them deal with distressing situations. Such an emerging adult is less likely to engage in suicidal behaviours.

Constructively Solve Problems. Another relationship explored in this study was being encouraged to solve problems and suicidal behaviours constructively. The results revealed a positive correlation between being encouraged to constructively solve problems and suicidal

thinking (r = .057, R^2 =.088). Whereas there was a negative relationship between being encouraged to constructively solve problems with suicidal planning (r = - .075, R^2 =.061), suicidal attempt (r= - .020, R^2 = .068) and self-harm (r = - .062, R^2 = .056) (see Table 17).

These findings are convergent to the life course development theory and Satir Model. Both theories see the family, specifically the parental figure, as responsible for teaching children to be resilient and congruently handle challenges. The life course development theory teaches children through life experiences to be flexible, cope, maintain strong interpersonal relationships, seek help and remain functional even in the face of adversity (Walsh, 2016; Goldenberg et al., 2017). At the same time, Satir's Model encourages the primary-triad to teach congruent survival stances that balance the needs represented by self, others and the context when experiencing challenging situations (Goldenberg et al., 2017; Satir et al., 1991). Building resilience and congruent survival stances equips children to solve problems constructively and thus not engage in suicidal planning, suicidal attempt and self-harm.

Seek Help When in Trouble. The final problem-solving skill explored in this study was seeking help when in trouble or in need. This study sought the link between being encouraged to seek help when in need in childhood and suicidal behaviours in emerging adulthood. The findings showed that learning to seek help when in trouble or in need was negatively correlated with all the dependent variables. The statistical recorded that: suicidal thinking (r = - .128, R^2 =.092), suicidal planning (r = - .039, R^2 = .074), suicidal attempt (r = -.023, R2 =.071) and self-harm (r = - .032, R2 = .058) (see Table 17).

The focus group discussion agreed that emerging adults learnt to seek help or not to seek help when in need from their families of origin. "Fred," a 22-year-old second-year male student, observed that.

> "the way your parents responded to situations growing up is the same as the way you respond to situations. As a mother, you will leave your child with the same value you personally live by. Then your children will have the same mentality you have. You will bring up your child like your mother and then pass on."

In addition, "Doris" added that,

> "If you were brought up seeing your parents seeking help for problems from other people, then as a child, you learn to seek help from others. The child may not tell their problems as a parent because they will solve it out there with someone else, like their peer. They might become confident and find permanent solutions from their age mates rather than the parents. So, there is a very strong relationship between how our parents handled their problems or solved their problems and how, us as their children, solve them."

These findings from the Delphi consensus converged with the survey findings that showed that developing problem-solving skills in children early in life might help them deal with challenges better as emerging adults. Three counsellors indicated that developing children to solve problems was a strong skill to support personal growth, whereas another three counsellors concluded that this was a very strong skill to support healthy decisions later on when they are in university.

These findings are parallel to those discussed in the Attachment Theory. Miniati et al. (2017) argue that when a caregiver is securely attached, they seek to establish a close, caring, reliable and responsive relationship with the child. In response to this secure base, the child can engage in other activities and turns to the caregiver when in distress. If the caregiver can respond

in ways that reassure love and support, the child learns to trust that others are supportive. Therefore, if they are distressed during emerging adulthood, they can seek help rather than hold back. The statistics on spiritual values will be discussed in objective four later.

Table 18

Stressful Life Events in Childhood

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-Harm
Mental illness in the family	0.002	0.309*	0.392**	0.159
	(0.227)	(0.159)	(0.173)	(0.147)
Sexual abuse (incest/rape/assault)	0.994***	0.212	0.270	0.041
	(0.279)	(0.196)	(0.213)	(0.180)
Ill-treatment	0.685***	0.155	0.110	0.066
	(0.202)	(0.141)	(0.154)	(0.130)
Rejection by a parent	0.326	-0.015	0.328*	0.036
	(0.227)	(0.159)	(0.173)	(0.147)
Death of a parent	0.080	-0.061	0.004	-0.132
	(0.225)	(0.158)	(0.172)	(0.146)
Death of a family member	0.192	0.023	-0.018	0.083
	(0.156)	(0.110)	(0.119)	(0.101)
Chronic illness	0.301*	0.237*	0.382***	0.103
	(0.180)	(0.126)	(0.137)	(0.116)
Parents separation	0.168	0.255	0.021	0.200
	(0.221)	(0.155)	(0.168)	(0.143)
Parents divorced	0.054	0.183	0.460**	0.140
	(0.265)	(0.186)	(0.202)	(0.171)
Domestic violence	-0.011	-0.288*	-0.122	-0.153
	(0.214)	(0.150)	(0.163)	(0.139)
Suicide death in the family	-0.187	-0.238	-0.076	0.233
	(0.340)	(0.238)	(0.259)	(0.220)
Increased arguments with parents	0.064	0.043	-0.051	0.022
	(0.173)	(0.121)	(0.132)	(0.112)

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-Harm
Alcohol and drug abuse	0.301	0.055	0.054	0.239*
	(0.194)	(0.136)	(0.148)	(0.125)
A troubled sibling	0.214	0.125	0.230	0.026
	(0.194)	(0.136)	(0.148)	(0.125)
Observations	397	397	397	397
R-squared	0.280	0.179	0.237	0.155

Note. The analysis of childhood stressful events against suicidal behaviours. The asterisk represents the level of significance *** p<.01, ** p<.05, * p<.1. The acceptable level is ** p<.05.

Childhood Stressful Life Events

Moreover, the study investigated the correlation between stressful life events experienced before 12 years and suicidal behaviours. The analysis of the correlation between each of the fourteen events and suicidal behaviours is evident in Table 18. The university counsellors identified what they thought were the worst childhood experiences emerging adults encountered. These were: rejection by parents (5 very strong, 1 strong), child neglect (3 very strong, 3 strong), maltreatment (physical, verbal and psychological abuse) (3 very strong, 3 strong), sexual abuse (2 very strong, 4 strong), separation/divorce (2 very strong, 4 strong) and comparison and favouritism (1 very strong, 5 strong).

Participants in the focus group discussions put up a list of childhood life experiences. They included: physical and emotional abuse, rejection, frequent re-locations, family/parental financial problems, sexual abuse, domestic violence, high expectations from parents, loss of a parent or a family member, parent abusing drugs, divorce and separation, parents' conflicts and poverty.

Suicidal Thinking. The results revealed that emerging adults who have experienced sexual abuse, ill-treatment or maltreatment and a chronic illness in the family before 12 years are at risk of suicidal thinking. The data analyzed recorded the correlation of suicidal thinking for the three events as sexual abuse ($r = .994$, $R^2 = .279$, $p < 0.01$), ill-treatment ($r = .685$, $R^2 = .202$, $p < 0.01$) and chronic illness ($r=.301$, $R^2 = .180$, $p<$ in the family. The relationship strength for sexual abuse was excellent, while that of ill-treatment was good, and that of chronic illness was poor.

These findings were similar to those by Pournaghash-Tehrani et al. (2019), who observed that sexual abuse and caregiver maltreatment were the most impactful childhood stressful life events. Sexual abuse and maltreatment are linked to suicidal behaviours. In addition, Pournaghash-Tehrani et al. argued that these stressful events were associated with suicidal behaviours. Specifically, a study by Duprey et al. (2019) contended that child maltreatment was linked with emerging adult suicidal thinking. The university counsellors ranked sexual abuse after childhood maltreatment. Participants in the focus group discussion ranked sexual abuse and maltreatment as highly associated with suicidal behaviours. Several participants highlighted that sexual abuse, physical abuse or harsh punishments at a very young age are a risk to suicidal behaviours in emerging adulthood. “Mary” said that “sexual abuse can really affect later relationships, how your view yourself and your body. It causes them not to form secure attachment, so they become independent and struggle to trust others enough to seek help.” “Zena”, added,

> “Being a sexual abuse victim under the age of 10 is the worst childhood stressful event. Mostly because it is perpetrated by people around them, people you know, either a parent or an uncle and auntie a cousin. It is always mostly the people close to them,

people they know, that also make them grow up with distrust. They don't trust people they know. These feelings of being unsafety, like you don't know whom to trust, if the people who say they love you do these things to you, how about people you don't know, people you're not even related to with by blood?"

These findings confirmed conclusions from numerous studies that identified childhood sexual abuse and maltreatment are a risk to emerging adult suicidal thinking (Pe'rez-Balaguer et al., 2022; Sekowski et al., 2020; Yoon et al., 2018; Canton-Cortes et al., 2020).

Suicidal Planning. The results further revealed that emerging adults at risk of suicidal planning were those who grew up in families where there was mental illness ($r=.309$, $R^2 = .159$, $p < .1$), chronic illness ($r=.237$, $R^2 = .126$, $p < .1$) and domestic violence ($r=-.288$, $R^2 = .150$, $p < .1$). Both mental illness and chronic illness in the family were positively correlated to suicidal planning. Meaning these are risk factors for suicidal planning in emerging adults. However, there was surprisingly a negative relationship between experiencing domestic violence in the family before age 12 and suicidal planning. This means that growing up in a family where there was domestic violence was not a risk for any suicidal behaviour. On the contrary, according to this study, it is a protective factor against suicidal thinking, suicidal planning, suicidal attempt and self-harm. The relationship strengths in the three experiences were poor and statistically insignificant.

These findings were dissimilar to other studies as they indirectly link parent mental illness to suicidal ideation and attempts rather than suicidal planning. These studies acknowledged that parents' mental illnesses were associated with several negative outcomes in emerging adults; they include anxiety, depression, behaviour problems, child abuse and other mental illnesses (Reupert et al., 2013; Rasic et al., 2014; Leijdesdorff et al., 2020). It is these

mental illnesses like depression and anxiety that has suicidal thoughts and probably engage in suicidal planning. These conclusions are supported by Afifi et al. (2014), who observed that these mental health conditions developing from abusive or neglectful families include suicidal ideation and attempts. Another divergent finding that is different from Afifi's study was that domestic violence is negatively correlated to all suicidal behaviours, whereas their study revealed that domestic violence (intimate partner violence) was associated the suicidal ideation and attempts.

Suicidal Attempt. In addition, growing up in a family where parents divorced ($r = .460$, $R^2 = .202$, $p<.05$), a family member was mentally ill ($r = .392$, $R^2 = .173$, $p<.05$) and chronically ill ($r = .382$, $R^2 = .137$, $p <.01$) (see Table 18). These relationships were positive and statistically significant to suicidal attempt. The strength of the relationship between chronic illness and mental illness was poor, while that of the parents' divorce was moderate. Rejection by a parent ($r=.328$, $R^2 = .173$, $p <.1$) was also a risk for suicidal attempt. The relationship was weak and statistically insignificant. These findings converged with the university counsellors who identified rejection by a parent or guardian as the worse stressful childhood experience associated with emerging adults' suicidal behaviour.

You et al. (2014) agreed that parental divorce increased the risk of suicidal behaviours among emerging adults. These findings differed from two other studies that concluded that parental divorce was associated with suicidal ideation and not suicidal attempt (Standfeld et al., 2016; Fuller-Thomson & Dalton, 2011). In addition, Stansfeld et al. noted that illness in the family during childhood was associated with suicidal ideation in midlife.

Self-Harm. The analysis of the fourteen childhood stressful events related to self-harm was also obtained. The results revealed that abuse of alcohol and drugs in the family before the

age of 12 years was positively related to self-harm (r=.239, R2=.125, p<.1). These findings agreed with Carr et al. (2020) and Steeg et al., (2023) who contended that substance misuse was a childhood stressful life event or Adverse Childhood Experience associated with self-harm among emerging adults.

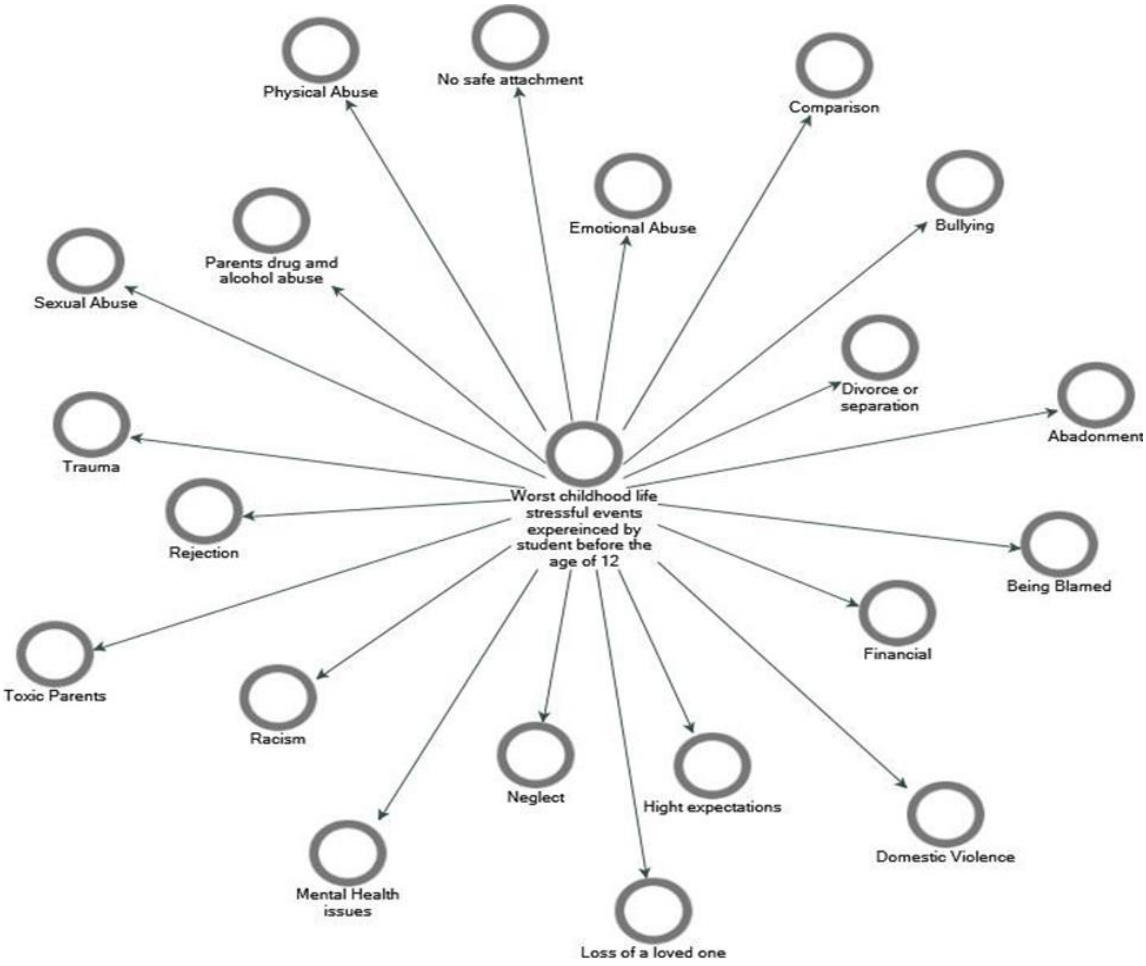
Other Stressful Life Events and Suicidal Behaviours. The results highlighted six stressful life events negatively associated with suicidal behaviours. This meant that the increase in this stressful life event resulted in a decrease in one or more suicidal behaviours. These life events are rejection by a parent, death of a parent, death of a family member, domestic violence, suicide death in the family and increased arguments with parents. Rejection by a parent was negatively correlated to suicidal planning ($r = -.015$, $R^2 = .159$), although it was positively correlated to suicidal thinking, suicidal attempt and self-harm. The death of a parent was expected to be positively correlated to all suicidal behaviours. However, the results revealed that a parent's death was negatively correlated to suicidal planning ($r = -.061$, $R^2 = .158$) and self-harm ($r = -.132$, $R^2 = .146$). Furthermore, the more emerging adults experienced the death of a family member, the less likely they were to engage in suicidal attempt ($r = -.018$, $R^2 = .119$). Although domestic violence in the family was expected to increase suicidal behaviours in emerging adults, it was negatively correlated to all suicidal behaviours: suicidal thinking ($r = -.011$, $R^2 = .214$), suicidal planning ($r = -.288$, $R^2 = .150$), suicidal attempt ($r = -.122$, $R^2 = .163$) and self-harm ($r = -.153$, $R^2 = .139$).

Logically, it seems accurate to imagine that suicidal death in the family might have increased the likelihood of suicidal behaviours among emerging adults. On the contrary, the results revealed that suicide death in the family have a negative correlation to suicidal thinking ($r = -.187$, $R^2 = .340$), suicidal planning ($r = -.238$, $R^2 = .238$) and suicidal attempt ($r = -.076$, R^2

=.259) but was positively correlated to self-harming behaviours. Moreover, increased arguments between parents were negatively correlated to suicidal attempt (r = -.051, R^2 =.132) and positively correlated to suicidal thinking, suicidal planning and self-harm.

Figure 12

Stressful Life Events before the Age of 12 Years



Note. The 20 themes identified as stressful life events from the focus group discussions.

The results from the focus group discussion, evident in Figure 12, revealed that sexual abuse was mentioned as the worst stressful life event in emerging adults in selected universities. The ranking of the worst stressful life events included: sexual abuse was mentioned by (6) 18.8%

of the participants, domestic violence (5) 15.6%, physical abuse (4) 12.5%. Parent's drug/alcohol abuse (3) 9.4%, no safe attachment (3) 9.4% and loss of a loved one (3) 9.4%. Furthermore, the Delphi interview explored the consensus from university counsellors on the worst childhood life events associated with emerging adults' suicidal behaviours. The consensus revealed that rejection by a parent/guardian (5) 83.3%, child neglect (3) 50%, maltreatment that was physical, verbal and psychological abuse (3) 50%, sexual abuse (2) 33.3%, and separation/divorce (2) 33.3%.

There was a convergent view in the survey and the focus group discussion that sexual abuse in childhood was a high risk of suicidal behaviours. This was divergent from the counsellors' consensus, where only two counsellors thought sexual abuse was a risk to suicidal behaviours. Instead, rejection by a parent/guardian was considered a very strong risk to suicidal behaviours by five counsellors. Based on the survey results, rejection by a parent/guardian was a risk to suicidal thinking, suicidal attempt and self-harm. However, it was mentioned once in the focus group discussions. Domestic violence was considered a high risk for suicidal behaviour in the focus group discussion, but it was negatively linked to suicidal behaviour in the survey and unidentified by the counsellors as a risk to suicidal behaviours.

Based on this study, it is evident that emerging adults are exposed to multiple stressful life events in childhood. The implication is that clinicians dealing with the mental health care of university students need to assess and treat students with childhood stressful life events. This will help in the prevention and intervention of suicidal behaviours among university students. Those with more than five childhood stressful events are at risk of suicidal ideation and planning (see. Cluver et al., 2015) and will need immediate intervention.

Psychological Stressors and Suicidal Behaviours

A third objective examined in this study was the psychological stressors compelling emerging adults to engage in suicidal behaviours in the selected universities. The study presented a list of psychological stressors and asked students to identify those that led or could have led them to engage in; suicidal thinking, suicidal planning, suicidal attempt and self-harm. In addition, the analysis captured the responses to psychological stressors as an added source of stressor associated with suicidal behaviours. Therefore, the two formed the findings and interpretations of psychological stressors and suicidal behaviours.

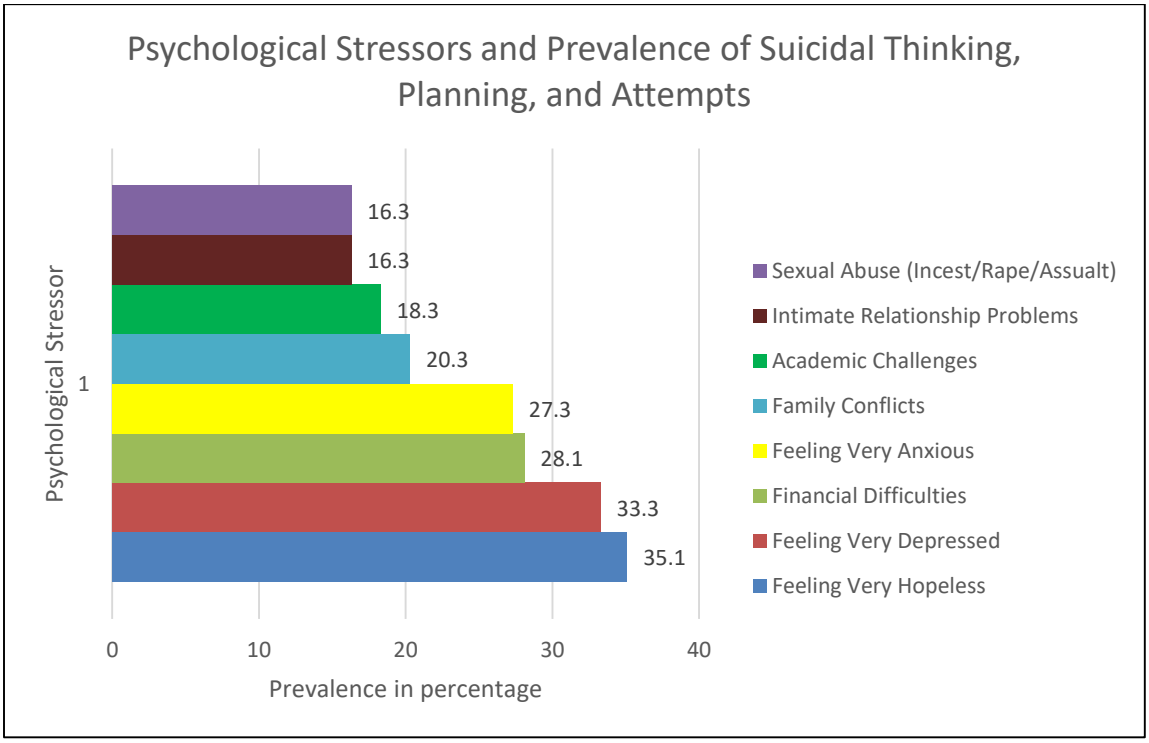
Psychological Stressors Related to Suicidal Behaviours

The study presented the students with a list of psychological stressors and requested them to indicate all the stressors that led them or could have compelled them to engage in suicidal behaviours. The results revealed the students' opinions which are described in Table 19. The results compared the differences in gender and university type in relation to psychological stressors and suicidal behaviours. These differences were recorded in percentages and the p-values ($p< 0.05$) to measure the significance of the difference.

The study revealed that feeling very hopeless, feeling very depressed, having financial difficulties, feeling very anxious, having family conflicts, having academic challenges, having intimate relationship problems, and sexual abuse were reasons emerging adults engaged in suicidal thinking, planning, and attempts. It was significantly noted that mental disorder symptoms, hopelessness, depression and anxiety were key reasons indicated in Figure 13 for suicidal thinking, planning, and attempts. After mediating for mental disorder symptoms, family conflicts, academic challenges, intimate relationship problems, and sexual abuse were the psychological stressors linked to suicidal thinking, planning, and attempts.

Figure 13

Psychological Stressors Linked to Suicidal Thinking, Planning, and Attempts

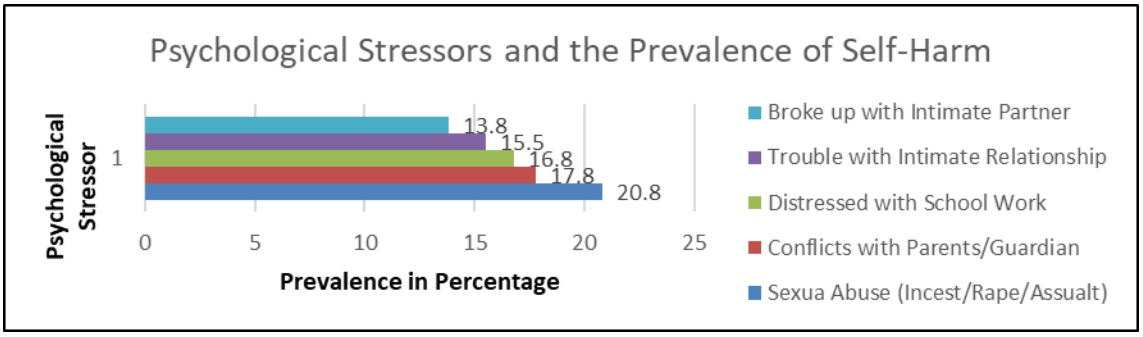


Note: Reasons compelling emerging adults to engage in suicidal thinking, planning, and attempts.

Moreover, this study revealed that sexual abuse, having conflicts with parents/guardians, distress with school work, trouble with intimate relationships, and relationship breakups were reasons students engaged in self-harm (see Figure 14).

Figure 14

Psychological Stressors Linked to Self-Harm.



Note: Reasons compelling emerging adults to engage in self-harm.

The qualitative results were convergent with the qualitative findings. In the focus group discussions, the students were asked to identify reasons students in their university were engaging in suicidal behaviours.

Mental Disorder Symptoms as Psychological Stressors. *By Gender*. Based on this study, psychological distresses represented by mental disorders symptoms ranked high among the psychological stressors causing suicidal behaviours (see Table 19). The results from the female students indicated that feeling very hopeless (43.2%), feeling very depressed (39.9%) and feeling very anxious (34.4%). At the same time, the results revealed that the main psychological stressor for male students is financial difficulties (28.6%). The mental disorder per percentages followed closely: feeling very hopeless (26.0%), feeling very depressed (25.4%) and feeling very anxious (20.1%). Further analysis of the male and female differences was obtained using the t-test. The findings showed that female students experienced significantly more hopelessness, depression, and anxiety than male students. The statistical differences were: hopelessness $t(43) = 0.17$, $p<.001$; depression $t(40) = 0.15$, $p<.002$ and anxiety $t(34) = 0.14$, $p<.002$ (see Table 19).

Table 19

Psychological Stressors and Suicidal Behaviours

	Overall		By Gender				By University Type			
Variable	n	Mean	Male %	Female %	df	p value	Priv Uni %	Pub Uni %	df	p value
Suicidal thinking, planning and attempt										
Academic challenges	399	0.183	0.148	0.216	-0.068	0.08	0.186	0.18	0.006	0.879
Financial difficulties	399	0.281	0.286	0.274	0.011	0.796	0.257	0.305	-0.049	0.28
Family conflicts	399	0.208	0.148	0.26	-0.112	0.006	0.221	0.195	0.026	0.522
Intimate relationship problems	399	0.163	0.138	0.188	-0.05	0.18	0.145	0.18	-0.035	0.355
Contracted HIV/AIDS	399	0.123	0.138	0.111	0.027	0.416	0.12	0.125	-0.005	0.894
Sexually abused (incest/rape/assault)	399	0.163	0.111	0.211	-0.101	0.007	0.206	0.12	0.086	0.02
Diagnosed with a mental disorder	399	0.123	0.106	0.14	-0.034	0.31	0.131	0.115	0.015	0.635
Feeling very depressed	399	0.333	0.254	0.399	-0.145	0.002	0.397	0.27	0.127	0.007
Feeling very anxious	399	0.273	0.201	0.342	-0.141	0.002	0.287	0.26	0.026	0.554
Feeling very hopeless	399	0.351	0.26	0.432	-0.174	0.001	0.357	0.345	0.012	0.806
Self-Harming										
Sexually abused (incest/rape/assault)	399	0.208	0.143	0.265	-0.121	0.003	0.252	0.165	0.087	0.034
Trouble with intimate relations	399	0.155	0.148	0.164	-0.015	0.675	0.136	0.175	-0.04	0.28
Broke up with intimate partner	399	0.138	0.133	0.144	-0.012	0.732	0.141	0.135	0.005	0.869
Distressed with schoolwork	399	0.168	0.153	0.178	-0.025	0.514	0.161	0.175	-0.014	0.706
Conflict with parent/guardian(s)	399	0.178	0.127	0.226	-0.099	0.01	0.206	0.15	0.056	0.144

Note. A comparison between psychological stressors compelling emerging adults to suicidal behaviours, gender and university type.

By University Type. This study revealed that students in the private university experienced more feelings of depression (39.7%), feeling hopeless (35.7%) and feeling anxious (28.7%) (see Table 19). In advanced statistical analysis, this study showed that students in private universities were significantly more depressed and sexually abused. The statistical differences recorded were: hopelessness $t(39.7) = 0.13$, $p<.007$ and sexual abuse $t(20.6) = 0.09$, $p<.02$.

The Delphi questionnaires further examined strong indicators associated with students engaging in suicidal behaviours. The results revealed convergent views to those of the survey and the focus group discussions. Five counsellors out of six stated feeling that the world was better without them, having depressive mood symptoms such as hopelessness, helplessness, poor appetite and sleep problems. Another four out of six counsellors indicated feeling like a burden, four out of six withdrawing from peers, three out of six posted messages on social media about the loss of hope and three out of six indicated an increase in drugs and alcohol use as indicators of a student engaging in suicidal behaviours. These findings were parallel to the quantitative results that identified that feeling very depressed, feeling very anxious and feeling very hopeless were psychological stresses that compelled emerging adults to engage in suicidal behaviours.

These findings correspond to several studies revealing that emerging adults presented with mental disorder symptoms such as feelings of hopelessness, depression and anxiety (Mortier et al., 2017; Othieno et al., 2014). Moreover, the three mental disorder symptoms were associated with suicidal behaviour in students pursuing education at the university (Bruffaerts et al., 2018; Krasnova et al., 2015; Auerbach et al., 2016). In addition, anxiety, hopelessness and

low self-esteem were mental illness symptoms common in university students associated with suicidal behaviours (McLaughlin & Gunnell, 2020; Oketch-Oboth & Okunya, 2018). As observed in this study, female students were more prone to experiencing depressive symptoms than male students (Polanco-Roman et al., 2019).

This means symptoms of mental illness, such as feelings of depression, anxiety and hopelessness, need to be assessed and intervened by university counsellors. This will help to prevent and treat students who might be engaging or about to engage in suicidal behaviours.

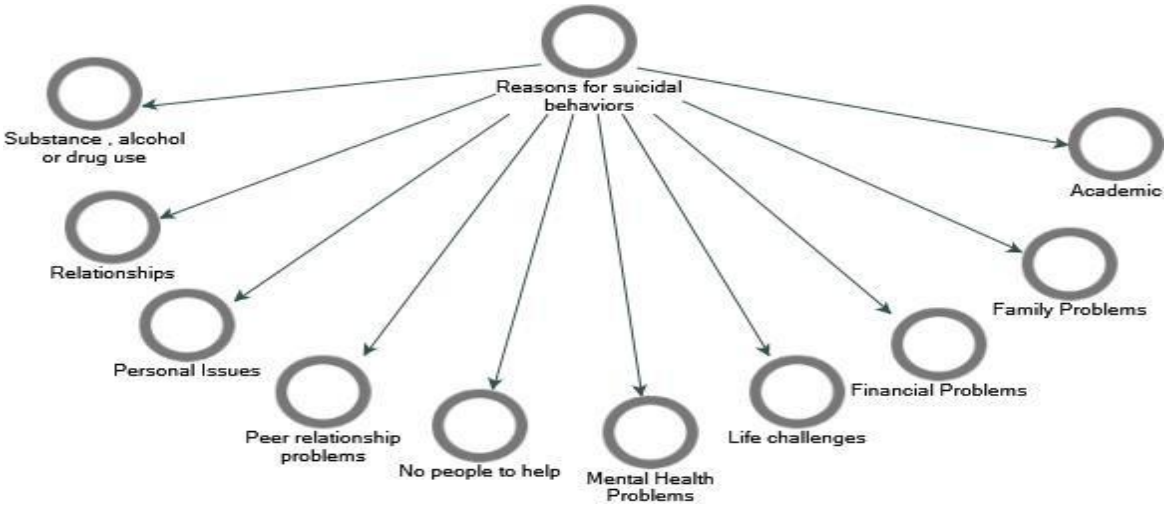
Psychological Stressors by Gender and University Type. Gender. After mediating for mental disorder symptoms, this study revealed five psychological stressors associated with suicidal behaviours among male and female students. The psychological stressors associated with male students were: financial difficulties (28.6%), family conflicts (14.8%), academic challenges (14.8%), intimate relationship problems (13.8%) and contracting HIV/AIDS (13.8%). The female students identified psychological stressors compelling them towards suicidal behaviours as financial difficulties (27.4%), family conflicts (26%), academic challenges (21.6%), sexual abuse (21.1%) and intimate relationship problems (18.8%. The statistical analysis revealed that female students were significantly compelled by family conflicts $t(26) = 0.11$, $p<.006$ and sexual abuse $t(21) = 0.10$, $p<.007$.

University Type. This study exposed three psychological stressors associated with suicidal behaviours among emerging adults in the university, as evident in Table 13. This was after mediating for mental disorder symptoms and academic problems. The results established that financial difficulties (25.7%), family conflicts (22.1%) and sexual abuse (20.6%) were the psychological stressors linked to suicidal behaviours in private university students. At the same time, financial difficulties (30.5%), family conflict (19.1%) and intimate relationship problems

(18.0%) were the psychological stressors associated with suicidal behaviours in the public university. Academic-related challenges were the fourth psychological stressor compelling emerging adults to engage in suicidal behaviours. The results showed that (18.6%) of the private university confirmed this, and (18%) of the public university. In addition, the statistical analysis showed that students from private universities students significantly forced sexually abused students into suicidal behaviours. Concerning self-harm, the study revealed that sexual abuse statistically drove both female and private university students to self-harm.

Figure 15

Psychological Stressors Compelling Students to Suicidal Behaviours



Note. Psychological stressors according to students' opinions from the focus group discussions.

The analysis from the focus group discussions generated eleven themes identified as psychological stressors compelling university students to engage in suicidal behaviours. As evident in Figure 15, the psychological factors identified were: family problems (40.6%), academic problems (37.5%), life challenges (34.4%), personal issues (34.4%), intimate

relationships problems (28.1%), mental health problems (21.9%), no one to help (18.8%), financial problems (15.6%), peer relationship problems (12.5%), substance use – alcohol and drugs (12.5%), and abuse (6.3%). These findings were convergent with the survey findings, thus confirming that confirmed family problems, financial problems, intimate relationship problems and abuse were psychological stressors that compelled university students to engage in suicidal behaviours.

The Delphi results were both divergent and convergent from those of the survey and focus group discussions. These findings underestimated what students considered psychological stressors compelling them to suicidal behaviours. At the same time, they highlighted issues students considered low-risk factors for suicidal behaviours. The main psychological stressors associated with emerging adults' suicidal behaviours, according to the university counsellors, were; parental rejection, mental health symptoms and or illness, drug and alcohol use, financial problems, and relationship break up. The Delphi results were convergent with the survey interviews that recognized ongoing family conflicts and mental health symptoms or/and illness as reasons for suicidal behaviours. Three of six university counsellors identified ongoing family conflict as a key psychological stressor linked to suicidal behaviours.

In addition, the Delphi consensus rated parental rejection as a key psychological stressor compelling emerging adults towards suicidal behaviours. The analysis showed that four out of six counsellors identified rejection by parents as the main psychological stressor associated with emerging adults to suicidal behaviours. This was divergent from the survey, which showed that rejection by parents had a weak and insignificant association with suicidal behaviours. Based on the survey interview, rejection by parents was positively associated with suicidal thinking, suicidal attempt and self-harm, although the relationship was statistically insignificant. The

Delphi consensus ranked financial problems and problems with a romantic partner as weak reasons for engaging in suicidal behaviours. Only two of six university counsellors considered financial problems a key reason students were engaging in suicidal behaviours. Besides, another two of the six counsellors felt that financial problems were a weak driver for suicidal behaviours. On the other hand, one of six counsellors thought having problems in romantic relationships was associated with suicidal behaviours. While five of six university counsellors thought having problems in an intimate relationship was not as strongly associated with suicidal behaviours.

These findings were similar to that of McLaughlin and Gunnell (2020), who identified financial difficulties and academic difficulties as stressors compelling university students to suicidal behaviours. Other studies identified financial problems, academic stressors, parent-child conflicts, family conflicts, problems in romantic relationships as reasons emerging adults were engaging in suicidal behaviours (Ajibola & Agunbiade, 2022; Wang & Wu, 2021; Halliburton et al., 2021; Oketch-Oboth & Okunya, 2018; Owiti, 2019; Nyamori, 2015;)

The quantitative results revealed that emerging adults are compelled to suicidal behaviours, financial difficulties, family conflicts, academic challenges, sexual abuse and intimate relationship problems. This was after mediating for mental disorder symptoms such as feelings of anxiety, depression and hopelessness. The qualitative results from the focus group discussions revealed that academic stress, family problems, financial problems, life challenges, having no one to help, peer relationship problems, personal issues, intimate relationship problems and substance abuse as reasons for engaging in suicidal behaviours. While the qualitative Delphi consensus revealed parental rejection, family conflicts, financial problems, intimate relationship problems and use of drugs and alcohol. After mediating for academic-

related problems, this study concludes that students experiencing financial difficulties, family conflict, and intimate relationship problems are most at risk for suicidal behaviours.

This calls for university counsellors to screen and intervene for students with financial problems, family conflicts and intimate relationship problems to reduce risks for suicidal behaviours. Moreover, lecturers need to be encouraged to send students exhibiting signs of depression, anxiety, hopelessness and academic challenges for counselling to support them against engaging in suicidal behaviours.

Responses to psychological stressors. This study examined how emerging adults handled psychological stressors and correlated them to suicidal behaviours. The view was borrowed from the Life Course Development Theory, which holds that part of the problem in the family was the way people were handling the problem (McGlorick et al., 2014). To capture ways students at the university handled their psychological stressors, the study asked participants to indicate their attachment responses, communication stances, beliefs, feelings, behaviours, expectations and yearnings towards self, others and situations when distressed.

Attachment Responses. To find out the students' attachment responses in stressful situations, this study asked students to indicate if they would tell their parent/guardian about their stress. The responses captured students' responses to identify one of four alternatives adopted from the attachment theories; safe (secure), anxious (anxious), fearful (avoidant) and unsure (ambivalent), as evident in Table 21. The findings revealed that a majority (39.3%) of the students felt secure about sharing their stressors with their parents/guardians, (16 %) felt unsure, (10.1%) felt anxious, and (35.1 %) felt fearful of telling parents/guardians about their prevailing stressors.

Table 20

Responses to Psychological Stressors and Suicidal Behaviors

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-Harm
Feeling about telling parent/guardian of current				
Challenges: Attachment responses				
Feel safe (secure)	-0.500**	0.195	-0.178	0.080
	(0.223)	(0.151)	(0.173)	(0.142)
Feel anxious (anxious)		Omitted due to collinearity		
Feel fearful (avoidant)	0.109	0.578***	0.186	0.116
	(0.292)	(0.198)	(0.226)	(0.186)
Feel unsure (ambivalent)	-0.281	0.251*	-0.160	0.068
	(0.223)	(0.151)	(0.172)	(0.141)
Response when in distress or in trouble:				
Communication stances				
I blaming others (blaming)	-0.229	-0.143	-0.478*	0.404*
	(0.338)	(0.229)	(0.262)	(0.215)
I blaming myself (placating)	0.704***	0.261*	0.266	0.233*
	(0.214)	(0.145)	(0.166)	(0.136)
I analyzing the situation (super reasonable)	0.237	0.087	0.101	0.079
	(0.192)	(0.130)	(0.149)	(0.122)
I ignoring everything and everyone (irrelevant)				
When in distress feel, belief and expect: The Satir				
Iceberg				
Feelings				
Feel it serves me right to be in a distressing situation	0.276*	-0.048	-0.125	0.023
	(0.165)	(0.112)	(0.128)	(0.105)
Feel others are responsible for my distress	0.553***	0.296**	0.240*	0.132
	(0.169)	(0.114)	(0.131)	(0.107)
Feel the context is fully responsible for the distress	0.284*	0.210**	0.199*	0.186*
	(0.151)	(0.103)	(0.117)	(0.096)

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-Harm
Beliefs				
Belief you can solve the challenges you are experiencing	-0.092	0.069	-0.122	-0.155
	(0.211)	(0.143)	(0.163)	(0.134)
Belief someone else holds the solution of your current situation	0.173	0.178	0.148	0.174
	(0.167)	(0.113)	(0.129)	(0.106)
Belief the current situation will change for the better	-0.073	-0.110	-0.105	0.135
	(0.251)	(0.170)	(0.195)	(0.159)
Expectations				
Expect good from life's challenges	-0.423*	-0.171	-0.172	-0.122
	(0.236)	(0.160)	(0.183)	(0.150)
Expect understanding and support from others in times of need	-0.153	0.067	-0.144	0.027
	(0.178)	(0.120)	(0.138)	(0.113)
Expect things to change for the better in the future	0.871***	0.139	0.491**	0.105
	(0.298)	(0.202)	(0.231)	(0.189)
Yearning : I am yearning for:				
Love	0.198	0.266*	0.094	-0.043
	(0.206)	(0.139)	(0.159)	(0.131)
Acceptance	0.308	0.013	0.155	-0.049
	(0.219)	(0.149)	(0.170)	(0.139)
Validation	-0.352*	-0.058	0.025	0.025
	(0.195)	(0.132)	(0.151)	(0.124)
A purposeful life	-0.153	-0.227	-0.356	0.257
	(0.301)	(0.204)	(0.233)	(0.191)
Meaningful living	0.103	0.192	0.451*	0.287
	(0.345)	(0.234)	(0.268)	(0.219)
Freedom to make my own choices	-0.128	-0.115	-0.182	-0.300**
	(0.230)	(0.156)	(0.179)	(0.146)
Self : I am …				
A spiritual being	-0.019	-0.537***	-0.215	-0.092
	(0.253)	(0.171)	(0.196)	(0.160)
A lovable person	-0.162	0.241	-0.107	-0.053
	(0.354)	(0.240)	(0.274)	(0.225)

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-Harm
Hopeful of a bright future	-1.179***	-0.462	-0.654**	-0.256
	(0.428)	(0.290)	(0.332)	(0.272)
Important in the universe	-0.355	-0.705***	-0.598**	-0.653***
	(0.305)	(0.207)	(0.237)	(0.194)
Observations	397	397	397	397
R-squared	0.324	0.281	0.262	0.236

Note. The results of the analysis of the student's responses to psychological stressors and suicidal behaviours. The standard error is in parentheses, and the asterisk represents the degree of significance where *** p<.01, ** p<.05 and * p<.1. The accepted degree of significance is p<.05.

The study further recorded the statistical relationship between attachment responses towards parents/guardians in distress and suicidal behaviours. As evidenced in Table 20, feeling safe with a parent/guardian was positively correlated to suicidal planning (r = .195, R^2 = .151) and self-harm (r = .080, R^2 = .142) and negatively correlated to suicidal thinking (r =-.50, R^2 = .223, p.05<) and suicidal attempt (r =-.178, R^2 = .173). Meaning that those who felt secure to tell their parent/guardian about their distress were less likely to engage in suicidal thinking and suicidal attempt. The relationship between feeling safe and suicidal thinking was statistically significant at p<0.05. The statistical correlation analysis for the attachment response of being fearful was positively associated with all suicidal behaviours. The results showed that suicidal thinking was (r = .109, R^2 = 292), suicidal planning (r = .578, R^2 =.198, p< .01), suicidal attempt (r=.182, R^2 =.226) and self-harm (r =.116, R^2 =.186). There was a statistically significant correlation between feeling fearful and suicidal planning p< .01. Meaning that those who were fearful of telling their parents/guardians about their stress were more likely to engage in all

suicidal behaviours; suicidal thinking (r=.109, R^2 =.292), suicidal attempt (r =.182, R^2 = 226) and self-harm (r =.116, R^2 =.186). This was true, especially for suicidal planning (r =.578, R^2 =.198). The study showed that feeling unsure of telling parents/guardians about ongoing stress was negatively correlated to suicidal thinking (r=-.281, R^2 =.223) and suicidal attempt (r=-.160, R^2 =.172). While feeling unsure of disclosing to parents/guardians about one's stresses was positively correlated to suicidal planning (r=.251, R^2 =.151) and self-harm (r=.068, R^2 =.141). This means that being unsure about sharing personal stress was a protective factor for suicidal thinking and attempt but a risk factor for suicidal planning and self-harm.

Further analysis was done to capture the differences by gender and university type (see Table 21). The analysis by gender revealed that more male students (51.3%) felt safe sharing their stressors with parents/guardians compared to (28.8%) female students. The difference was statistically significant at t (51.3) = .225, p< .001. Moreover, students from public universities (46%) felt safe sharing challenges with parents/guardians. This difference was statistically significant at t (46) =.134, p< .007. More female students (20.2%) compared to (10.6%) male students felt anxious about sharing their distress with parents/guardians. The difference was statistically significant at t (20.2) = .096, p< 0.009. In addition, more students from the private university (42.2%) compared to (22.8%) of the students in the public university felt unsure about sharing their challenges with parents/guardians. This difference was statistically significant t (42.2) = .142, p< 0.003.

Table 21

Responses to Psychological Stressors by gender and university type

Variable	Overall	By Gender				By University type			
	n	Male %	Female %	df	p value	Private uni %	Public uni %	df	p value
Feeling about telling Attachment responses									
Feel safe (secure)	399	0.513	0.288	0.225	0.001	0.327	0.46	-0.134	0.007
Feel anxious (anxious)	399	0.106	0.202	-0.096	0.009	0.171	0.14	0.031	0.397
Feel fearful (avoidant)	399	0.085	0.116	-0.03	0.311	0.081	0.12	-0.04	0.189
Feel unsure (ambivalent)	399	0.296	0.394	-0.098	0.041	0.422	0.28	0.142	0.003
Response to distress: Satir Communication Stances									
I blaming others (blaming)	399	0.048	0.068	-0.019	0.403	0.056	0.06	-0.005	0.84
I blaming myself (placating)	399	0.248	0.313	-0.064	0.159	0.306	0.26	0.046	0.303
I analyzing the situation (super reasonable)	399	0.545	0.409	0.137	0.007	0.432	0.51	-0.078	0.12
I ignoring everything (irrelevant)	399	0.159	0.211	-0.053	0.178	0.206	0.17	0.036	0.358
When in distress would feel, belief and expect: Satir's Iceberg									
Feelings									
Feel it serves me right to be in a	399	0.254	0.279	-0.025	0.577	0.291	0.245	0.046	0.296
Feel others are responsible for	399	0.275	0.293	-0.018	0.69	0.287	0.28	0.007	0.887
Feel the context is fully responsible	399	0.445	0.476	-0.032	0.53	0.522	0.405	0.118	0.018
Beliefs									
Belief you can solve the challenge	399	0.815	0.769	0.045	0.266	0.769	0.815	-0.046	0.257
Belief someone else holds the solution	399	0.281	0.265	0.016	0.722	0.216	0.325	-0.109	0.015
Belief the current situation will change	399	0.82	0.818	0.003	0.943	0.774	0.865	-0.091	0.018
Expectations									
Expect good from life's challenge	399	0.793	0.741	0.053	0.211	0.729	0.805	-0.076	0.072
Expect understanding and support	399	0.661	0.668	-0.007	0.885	0.598	0.725	-0.127	0.007
Expect things to change for the	399	0.826	0.851	-0.026	0.49	0.824	0.855	-0.031	0.402
I am yearning for:									
Love	399	0.715	0.721	-0.007	0.88	0.709	0.73	-0.022	0.635
Acceptance	399	0.645	0.668	-0.023	0.634	0.633	0.685	-0.052	0.276
Validation	399	0.588	0.577	0.011	0.835	0.558	0.605	-0.047	0.341
A purposeful life	399	0.889	0.875	0.014	0.669	0.88	0.885	-0.005	0.863
Meaningful living	399	0.879	0.908	-0.03	0.328	0.904	0.885	0.019	0.526
Freedom to make my own choices	399	0.836	0.832	0.004	0.91	0.819	0.85	-0.031	0.408

Variable	Overall	By Gender				By University type			
	n	Male %	Female %	df	p value	Private uni %	Public uni %	df	p value
SELF: I am …									
A spiritual being	399	0.905	0.899	0.005	0.849	0.875	0.93	-0.056	0.061
A lovable person	399	0.931	0.932	-0.002	0.954	0.934	0.93	0.005	0.853
Hopeful of a bright future	399	0.953	0.962	-0.009	0.653	0.94	0.975	-0.036	0.081
Important in the universe	399	0.947	0.908	0.038	0.143	0.904	0.95	-0.045	0.081

Note. The comparison of the responses to psychological stressors by gender and university type.

The study concluded that the use of secure attachment responses was a risk for suicidal planning and self-harm but a protective factor for suicidal thinking and suicidal attempt. The use of avoidant attachment responses was a risk factor for all suicidal behaviours: suicidal thinking, suicidal planning, suicidal attempt and self-harm. Therefore, the use of ambivalent attachment response was a risk factor for suicidal thinking and suicidal attempt. The results by gender and university type were also obtained. This study revealed that more male students employed secure attachment responses while more female students employed anxious attachment responses in stressful situations. Likewise, more public university students had secure attachment responses towards their parents, and more private university students had ambivalent attachment responses.

The conclusions from this study were in agreement with previous studies which noted that insecure attachment styles were a risk factor for suicidal behaviours while secure attachment was associated with lower levels of suicidal behaviours (Stepp et al., 2008; Davaji et al., 2010; Kasomo, 2013; Miniati et al., 2017; Green et al., 2021). Specifically, Green et al. (2021) observed that avoidant and anxious attachment responses increased the risk of suicidal thinking and self-harm. Although secure attachment responses are encouraged because they help support the search for a solution to a problem (Mathews et al., 2016), they do not eliminate the risk of

suicidal behaviour. Thus, this study revealed that secure attachment responses were a risk for suicidal planning and self-harm.

These findings imply that having secure attachment response reduces the risk of suicidal thinking and attempt, but it does not eliminate the risk completely. Emerging adults need additional problem-solving skills to help them deal with the stressors they are facing in life and in the university.

Communication Stances. To further investigate the students' responses to psychological stressors, this study examined their communication patterns in distress. The participants were asked to indicate the responses they employ in distress by picking one of four alternatives adopted from Satir's communication stances. These alternatives were; blaming others (blaming), blaming myself (placating), analyzing the situation (super reasonable), and ignoring everything and everyone (irrelevant). The results as shown in Table 20, the regression analysis revealed that the blaming response was negatively linked to; suicidal thinking ($r = -.229$, $R^2 = .338$), suicidal planning ($r = -.143$, $R2 = .229$), suicidal attempt ($r = -.478$, $R^2 = .262$) and positively correlated to self-harm ($r = .404$, $R^2 = .215$). Thus the blaming response was a protective factor for suicidal thinking, suicidal planning and suicidal attempt but a risk factor for self-harm.

The results further showed that blaming self in distress was positively correlated to all suicidal behaviours. The findings recorded; suicidal thinking ($r = .704$, $R^2 = .214$, $p < .01$), suicidal planning ($r = .261$, $R^2 = .145$), suicidal attempt ($r = .266$, $R^2 = .166$) and self-harm ($r = .233$, $R2 = .136$). Blaming self was a risk for all suicidal behaviours, especially suicidal thinking. Self-blame in distress was significantly correlated to suicidal thinking with $p < 0.01$. Participants who responded to stress in a super reasonable manner were at risk of all suicidal behaviour. Analyzing showed a positive association to suicidal thinking ($r = .237$, $R^2 = .192$), suicidal

planning (r=.087, R^2 = .130), suicidal attempt (r=.101, R^2 =.149) and self-harm (r=.079, R^2 = .122). The relationship between being super reasonable and all the suicidal behaviours was weak and statistically insignificant.

Gender. The study further examined the relationship between the communication stances by gender and university type. The findings revealed that slightly more female students t (6.8) = .019 blamed others for their distress than the male students (see Table 21). At the same time, more female students (31.3) = .064 than male students blamed themselves for the stressors they were experiencing. The study revealed that the most common response in distress for male students was to super reasonable t (54.5) =. 137, p< .007 was analyzing the situation compared to female students. This difference was statistically significant.

***University Type*.** The results on differences revealed that more public university students t (6) =. 005, compared to those in the private university, blamed others for their distress. On the placating stance, more students in the private university employed self-blame responses t (30.6) = .046 than those in the public university. At the same time, more public university students used super reasonable stances when stressed t (51) =. 078 compared the private university students to analyzes the situation (see Table 21). More students in the private university employed the irrelevant stance t (20.6) =.036 compared to those in public university when in distress.

The Satir Model views these communication stances; blaming, placating, super reasonable and irrelevant as dysfunctional (Goldenberg et al., 2017). This was evident in this study as the four incongruent communication stances are associated with suicidal behaviours. Emerging adults who responded to their psychological stressors by placating and super reasonable stances were at risk of all suicidal behaviour. The results on the placating and super reasonable stances were similar to previous studies which associated these stances with

destructive behaviours (Satir et al., 1991; Gehart, 2017; Sommer-Flanagan & Sommer-Flanagan, 2015). Furthermore, these findings are parallel to the work by Lum et al. (2002), who observed that youth who employed the placating stance experienced a deep sense of unimportance, hopelessness and powerlessness, emotions strongly associated with suicidal behaviours. In addition, they had low self-esteem, a key characteristic showing that one is placating when in distress. Surprisingly, the blaming stance is a risk factor for self-harm but a protective factor for suicidal thinking, suicidal planning and suicide. This study concurs with Lum et al. (2002) observations that blaming emerging adults had a deep sense of inner isolation and loneliness aspects that placed them at risk of self-harming behaviours.

Emerging adults that engaged the super reasonable stance were at risk of all suicidal behaviours. This study resounds Lum et al. (2002) that emerging adults that use super reasonable stances were isolated from self and others, putting them at risk of suicidal behaviours. The multivariate statistical analysis for irrelevant stance was omitted due to collinearity. This study finding resounds Lum et al. (2002), who noted that youth who use the irrelevant communication stance in distress had no sense of belonging and were disconnected from self, thus putting them at risk of poor choices and impulsive behaviour, especially suicidal behaviours to cover up the deep turmoil and chaos hidden in their humour or jokes. Meaning emerging adults who took up full responsibility by placating and those who focused on the context by being super reasonable when facing stress were at risk of engaging in suicidal behaviours. Similarly, those who employed the irrelevant stance avoided the distress, thus putting themselves at risk of engaging in suicidal behaviour.

Emotional Responses. Another response examined against suicidal behaviours was emotional response. This study provided three alternative emotional responses to identify which

response was representative of their personal response when in distress. Each response reflected on their feelings about self, others and the context of the stressor. As shown in Table 21, The regression analysis showed that a) feeling that it serves me right to be in the distressing situation was positively associated with suicidal thinking (r=. 276, R^2 =.165) and self-harm (r=.023, R^2 =.105). On the contrary, it was negatively correlated to suicidal planning (r=-.048, R^2 = .112) and suicidal attempt (r=-.125, R^2 =.128). Meaning this feeling is a protective factor for suicidal planning and attempt but a risk factor for suicidal thinking and self-harm.

The analysis of the second statement showed that feeling that others are responsible for my distress in stressful situations was positively correlated to all suicidal behaviours. The analysis revealed a strong and statistically significant relationship between feeling that others were responsible for their distress and suicidal thinking (r=.553, R^2 =.169, $p<.01$) and suicidal planning (r=.296, R^2 =.114, $p<.05$). Whereas the other two suicidal behaviours were positively correlated although the relationship was statistically insignificant; where suicidal attempt (r=.240, R^2 =.131) and self-harm (r=.132, R^2 =.105). This means that holding others responsible for one's distress was a risk for suicidal behaviours among emerging adults in the selected universities.

The third statement linked to suicidal behaviours was c) feeling that the context is fully responsible for my distress. The regression analysis showed a positive relationship across all suicidal behaviours, with suicidal planning having a statistically significant association with this statement. The analysis showed: suicidal thinking (r=.284, R2 =.151), suicidal planning (r= .210, R2 =.103, $p<.05$), suicidal attempt (r= .199, R2 = .117) and self-harm (r=.186, R2= .096).

The comparative results on emotional responses by gender and university type showed that female students and private university students use these emotional responses slightly more

than male and public university students. More female students said it served them right to be in distress t (27.9) = .025 than the male students. At the same time, more private university students felt it served them right to be in the distress t (29.1) = .046 than public university students. The second feeling captured as those who felt others were responsible for their distress. The result revealed that more female students' t (29.3) = .018 compared to the male students felt that others were responsible for their distress. While more students in the private university t (28.7) = .007 felt that others were responsible for their distress than students from the public university. The third feeling recorded was of those who felt that the context was fully responsible for their distress. Findings showed more female students (47.6) =. 032 feel the context is fully responsible for their distress than the male students. Furthermore, more private university students' t (52.2) =.118 felt that the context was fully responsible for their distress than students in public university.

This study shows that feeling that others and the context are responsible for one's distress are risk factors for suicidal behaviours. While taking up some level of personal responsibility for being in a stressful situation is a protective factor against suicidal planning and attempt. These findings are similar to Satir's theory, which holds that a lack of acceptance regarding prevailing situations was associated with suicidal behaviours (Mclendon & Miller, 2010; Lum et al., 2002, Yang et al., 2022).

Cognitive Responses. Another response explored among emerging adults was their beliefs during distress (see Table 20). Each participant was asked to indicate one of three beliefs; that they can solve the distress, someone else holds the solutions to the distress, and the situation will change for the better. The regression analysis correlated each of the statements to all suicidal behaviours. Believing that one can solve the prevailing challenges was positively linked to

suicidal planning (t=.069, R^2 =.163). The other suicidal behaviours were all negatively correlated to the belief that one can solve the stressor; suicidal thinking (r = -.092, R^2 = .143), suicidal attempt (r= -.122, R^2 = .163) and self-harm (r= -.155, R^2 =.134). Thus believing that one can solve their own problem is a protective factor against suicidal thinking, suicidal attempt and self-harm. However, it was a risk factor for suicidal planning.

The second belief examined was that someone else holds the solution to one's prevailing challenges. The results revealed that such a belief was positively correlated to all suicidal behaviours, although the relationship was statistically insignificant. The correlation was; suicidal thinking (r=.173, R^2 = .167), suicidal planning (r=.178, R^2 = .113), suicidal attempt (r=.148, R^2 =.129) and self-harm (r = .174, R^2 =.106). The third statement correlated to suicidal behaviours was the belief that one's prevailing distress would change for the better. The results revealed that such a belief was negatively correlated to suicidal thinking (r = -.073, R^2 = .251), suicidal planning (r =-.110, R^2 = .170), suicidal attempt (r =-.105, R^2 = .195). On the contrary, believing that the prevailing distress would change for the good was negatively correlated to self-harm (r=.135, R^2 = .159).

The study compared the three cognitive responses by gender and university type (see Table 21). More male students' t (81.5) = .045 believed they could solve the challenge they were experiencing compared to the female students. Equally, more public university students' t (81.5) =.046 against private university students. Concerning the second statement of belief, this study revealed that more male students t (28.1) =. 016, as compared to female students, believed that someone else had the solution to their distress. At the same time, more students from the public university students' t (32.5) =.325, $p < .015$ believed that someone else had the solution to their problem than the private university students. The difference between the two university types

was significant. The analysis of the last statements examined was the belief that things would change for the better. As evident in Table 15, the male students recorded a slightly more likelihood t (82) =.003 of believing that their prevailing challenge will change for the better than their female counterparts. However, more students from the public university t (85.5) = .091, < .018 believed that their prevailing challenges would change for the better compared to students in the private university. This difference was statistically significant.

This means that believing that one can solve the challenges is a protective factor against suicidal thinking, suicidal attempt and self-harm. At the same time, this belief is a risk to suicidal planning. In addition, believing that the challenge one is facing will change for the better is a protective factor against suicidal thinking, suicidal planning and suicidal attempt. While believing that someone else holds the solution to one's prevailing challenge is a risk factor against suicidal thinking, suicidal planning, suicidal attempt and self-harm. Believing that one's prevailing situation will change for the better is a risk for self-harm.

These findings were similar to Satir et al. (1999) views about having high self-esteem as a protective factor against negative beliefs about self and situations. Baldwin (2013) and Sommer-Flanagan and Sommer-Flanagan (2015) noted that people with high self-esteem respond to challenges maturely and creatively because they see themselves as capable of solving problems. Thus they are less likely to engage in suicidal behaviours. On the contrary, emerging adults who believe that others hold the solution to their problems lack the self-confidence they need to face their challenges; thus, they are at risk of engaging in suicidal behaviours (Sommer-Flanagan & Sommer-Flanagan, 2015). In addition, believing others have the solution to one's problem is a rejects personal responsibility, thus a set up for disappointment and hurt, which risks engaging in suicidal behaviours. Mclendon and Miller (2010) and Yang et al. (2022)

concluded that accepting situations and acting on them was associated with healthier outcomes free of suicidal behaviours. Whereas the findings that believing that things will change for the good was parallel to Satir's concept of hope, known as a protective factor against suicidal behaviours. Satir et al. (1991) viewed hope as vital in helping people develop ways to change things for the better. These sentiments were supported by Gvion and Apter (2012), who contended that having hope that things would change for good provided optimism which in turn eliminated the need to engage in suicidal behaviours.

Expectations in Stressful Situations. The study explored students' responses based on their expectations during distressing situations. The participants were given three statements to identify which they tended to apply when facing challenging situations. A regression analysis was obtained for each statement against all the suicidal behaviours (see Table 20). The results revealed that expecting good from life's challenges was negatively linked to suicidal thinking (r =-.423, R^2 =. 236), suicidal planning (r = -.171, R^2 =.160), suicidal attempt (r =-.171, R^2 =.160) and self-harm (r=-.122, R^2 =.150), which means that expecting good from a challenging situation is a protective factor against all suicidal behaviours.

The second expectation explored was whether emerging adults expected understanding and support from others in stressful situations. The results revealed that this expectation was positively correlated to suicidal planning (r=.067, R^2=.120) and self-harm (r=.027, R^2=.113). In addition, expecting understanding and support in stressful situations was negatively linked to suicidal thinking (r=-.153, R^2 =.178) and suicidal attempt (r=-.144, R^2 =.138). Based on these findings, expecting others to understand and support an emerging adult during stressful situations is likely a risk factor if people fail to meet this expectation. Thus, putting the emerging adult at risk of suicidal planning and self-harm. Consequently, people around the emerging adult might

fail to meet their expectations for understanding and support, but the emerging adult is able to deal with the disappointment and cope well. Thus they resist engaging in suicidal thinking and suicidal attempt because of being resilient.

The third expectation studied was the students' expectation that things would change for the better in the future. The results revealed a positive correlation between this expectation and all suicidal behaviours. Expecting that things would change for the better in the future was positively linked to suicidal thinking ($r = .871$, $R^2 = .298$, $p < .01$), suicidal planning ($r = .139$, $R^2 = .202$), suicidal attempt ($r = .491$, $R^2 = .231$, $p < .05$) and self-harm ($r = .105$, $R^2 = .189$). The correlation is statistically significant between expecting things to change for the better in the future and suicidal thinking as well as suicidal attempt (see Table 20). The results propose that having expectations that things will for better in the future was a risk factor for all suicidal behaviours, especially suicidal thinking and suicidal attempt.

This study captured the comparison between the three expectations against gender and university. This study revealed that more male students' t (79.4) =. 053 than the female students expected good from life's challenges. It was noted that more students in the public university t (80.5) =.076 expected good from life's challenges than private university students. Turning to the expectation that others will understand and support the students in distress revealed that slightly more female students' t (66.8) =.007 compared to the male students had this expectation. The analysis by university type showed that the majority of the students in public university t (72. 5) =.127, p< 0.007 compared to students in the private university. The difference in this expectation between the universities was statistically significant. The finding noted that more female students (85.1) =.026 had higher expectations that things would change for the better in the future than

male students. Whereas slightly more students in the public university t (85.5) =.031 compared to those in the private university expected things to change for the better.

The results showed that expecting good from life challenges was negatively associated with all suicidal behaviours. These findings are similar to Walsh's (2016) views of resilient people who resist the power of stressful events and focus on aspects of their situation that support them to thrive, maintain functionality and keep steady in distress. Thus expecting good from challenging situations is the pillar of resilience. Based on the Life Development Cycle Theory, resilience is a protective factor against suicidal behaviours.

Whereas expecting understanding and support from others during distressful times was a negative association with suicidal thinking and suicidal attempt. Moreover, they recorded a positive correlation between suicidal planning and self-harm. These findings are similar to those of McGlorick et al. (2014) and Goldenberg et al. (2017), who discussed that resilient people maintain positive self-worth, are flexible in tough situations, develop ways to solve their problems and authentically communicate what they need. This means that resilient emerging adults whose expectation of understanding and support is denied can accept the unmet expectation and search for constructive alternatives to solve their problem without engaging in suicidal behaviours.

Finally, expecting things to change for the better in the future was positively correlated to all suicidal behaviours. These findings contradict the concept of hope based on the Satir model. Gvion and Apter (2012) define hope as the ability to positively and effectively cultivate a strong belief that the future will be better than the prevailing situations. Thus, an emerging adult would not need to engage in suicidal behaviour. However, these findings reveal that expecting a better future is a risk for all suicidal behaviours.

Spirituality and Suicidal Behaviours

The fourth study objective sought to examine the role of spirituality in emerging adults' suicidal behaviours. The study captured aspects of spirituality through various questions such as religious affiliations, practices, moral adherence, and beliefs about the value of life, meaning and purpose. The results analyzed the association between emerging adults' early family spiritual values and prevailing spiritual experiences.

Early Family Spiritual Values

The results of the interaction between students' early family spirituality and suicidal behaviours were captured in Table 22. The participants were required to answer four questions examining ways their families adhere to morality, faithfulness in religious meetings, integration of religious practice into the family culture and maintaining hope in stressful situations.

Table 22

Early Family Spirituality

	Suicidal thinking	Suicidal planning	Suicidal attempt	Self-harm
Spiritual Values				
Morality was valued and encouraged	-0.035	0.053	0.040	0.007
	(0.106)	(0.074)	(0.082)	(0.067)
Religious practices were part of the family culture	-0.021	-0.024	-0.001	-0.031
	(0.083)	(0.058)	(0.064)	(0.052)
Faithfully attended religious meetings	0.057	0.061	0.049	0.014
	(0.086)	(0.060)	(0.066)	(0.054)
Family was hopeful in stressful life events	0.132	0.006	0.039	0.078
	(0.102)	(0.071)	(0.079)	(0.064)

Note: Statistical analysis on early family spiritualiy and suicidal behaviours.

Morality. The study examined whether the emerging adults' family valued and encouraged morality. The results revealed that growing up in a family that valued and encouraged morality might protect emerging adults from suicidal thinking (r=-.035, R2=.106) (see Table 22). However, it was a risk factor for suicidal planning (r=.053, R2=.074), suicidal attempt (r=.040, R2.082) and self-harm (r=.007, R2=.067). Therefore, valuing and instilling morality in children was a protective factor against suicidal thinking and a risk factor for suicidal planning, attempt and self-harm.

These findings were divergent from those obtained from the focus group discussion. The participants noted that families where religion was prominently taught moral living, which has positively impacted many of them. "Salome" notes:

> "So if you were brought up maybe in a Christian family with biblical teachings and all that, I think the fact that maybe you were taught the sacred nature of life that it is wrong maybe to commit suicide because maybe your body is the temple of the Holy Spirit and all that. I think that plays a role into even the maybe as you might get to the point of thinking about suicide, you might not get the point of planning or maybe attempting because you know that inherently, you have this idea that it is wrong, and if you go ahead with it and maybe you succeed, you will not end up in some eternal damnation and all that. So I think that plays a lot into your decision making as far as you're thinking about maybe suicide and all that."

Morality was encouraged by religious families; that is, belief in God and regard for moral living as essential (Ward & King, 2018). These findings contradicted Osafo et al. (2013), who observed commitment to religious beliefs and practices such as the sanctity of life and rejected

suicidal behaviours. Similarly, Gearing and Alonzo (2018) argued that having a low moral objection to suicidal behaviours increased the risk for suicidal attempt. Gearing and Alonzo contended that having a high moral objection to suicide was associated with reduced suicidal behaviours due to an alleged motive to be alive.

Meaning that growing up in a family that encouraged morality, such as the sanctity of life, was a protective factor against suicidal thinking. However, that did not protect emerging adults from engaging in suicidal planning, suicidal attempt and self-harm. This study confirms Nkansah-Amankra, (2013) conclusion that although many religions uphold high moral objection to suicidal behaviours, their position has not eliminated the suicidal behaviour patterns among young people.

Religious Practices and Family Culture. The study explored how families with religious practices as part of their family culture were associated with suicidal behaviours. The findings showed a negative relationship between practising religious practices as part of the family culture and all suicidal behaviours (see Table 22). The analysis showed association as follows; suicidal thinking (r=-.021, R^2=.083), suicidal planning (r=-.053, R^2 =.074), suicidal attempt (r=.001, R^2=.064) and self-harm (r=-.031, R^2 = .052). This means that families whose family interactions and rituals were integrated with religious practices growing up are less likely to engage in suicidal behaviours.

These findings were convergent to the focus group discussions. “Dina” agreed that growing up in a family with faith was integrated into the family life has a positive impact on one values and as an emerging adult. She explained:

> “I have been raised by Christian parents, it was like natural for me. Let us say God was drilled into me, so I grew up knowing God as much as I can't say

> like I had a relationship with God per se, but I knew the reality of God for me, you know, a simple thing like praying for a meal before eating it I think the because of being raised as a Christian. It played a factor of me knowing and having the reality of God in my life, so it is in a lot of ways. Whether I was aware of it or not, it shaped the decisions I made, you know, growing up as a child and even as an adult. These values I have from home already form my foundation of the existence of God, even when I was not living for God. These beliefs or thoughts shaped me and just having that reality that God exists and, you know, yes. Being raised as a Christian and knowing that there is God has shaped the decisions I have made and how I lived growing up and as an emerging adult."

These findings are parallel to Bengtson et al. (2013), who observed the relationship between emerging adults' practices and childhood religious training. Bengtson et al. noted that emerging adults whose parents modelled faith in their parenting skills through teaching and living the religious principles of prayer, reading, serving and open communication were likely to engage in their same principles. Thus, families that integrated religious practices as part of the family culture reduced the risk of emerging adults from engaging in all forms of suicidal behaviours.

Attending Religious Meetings. This study examined the relationship between how emerging adults whose families attended religious meetings correlated to suicidal behaviours. The results revealed that growing up in a family that faithfully attended religious meetings was positively linked to emerging adults' suicidal behaviours. The findings revealed that faithfully attending religious meetings was positively associated with suicidal thinking ($r = .057$, $R^2 = .086$, suicidal planning ($r = .061$, $R^2 = .060$), suicidal attempt ($r = .049$, $R^2 = .066$) and self-harm ($r = .014$,

R^2=.054) (see Table 22), which means that emerging adults whose families faithfully attended religious meetings during childhood were at risk of engaging in all suicidal behaviours.

These findings were divergent from those obtained from the focus group discussions. The students confirmed that attending religious meetings was helpful in teaching, encouraging and forming social support that might help to reject suicidal planning, attempts and self-harm. According to "Okello" attending religious meetings was helpful because

> "It guides me for example, in my church that we have a youth like kind of a youth church we meet every week on Sunday we discuss what is happening for topics, different topics. Like Mental health, family, just different topics that any youth can go through. So this opens up space for people to express themselves and also issues that they might be going through."

"Mary" shared the same views that her engagement in religious meetings has proved valuable in how she lived her life as an emerging adult. Attending church meetings,

> "it had given me encouragement. Through my communication and interaction with the fellow youth and through God because; God is personal, God is my saviour. So he would lead me in even some things that people have not gone through and it has only happened in my life, thank God. It gives me confidence to know that my God is in control, even if I can't handle it. I will handle it with his help, so it gives me more peace. Yes, peace with my life situations."

"Hussain" also added that attending religious meetings has influenced his life. He said,

> "it influences a lot of my decisions. Yeah, like there are classes that happen in our religion as well where they teach us like how we need to even

> live. Like look out for the environment as well as animals and also like respect others and their time, so we are taught a lot. We are taught to respect our lives and not to commit suicide."

These findings differed from Toussaint et al. (2015), who argued that attending religious services had a lesser probability of suicidal thinking and suicidal attempt. A study by Gearing and Alonzo (2018) and Lawrence et al. (2016) proposed that attending religious meetings was a protective factor for suicidal attempt but not suicidal ideation or thinking. However, Cook (2018) contended that attending religious services at least twenty-four times a year was a protective factor for suicidal behaviours compared to those who attended religious services less often. However, Svob et al. (2018) observed that parents who took religion seriously nurtured children, especially girls, who were less likely to engage in suicidal behaviours. However, this was contrary to emerging adults whose parents did not take religion seriously because they were at risk of suicidal behaviours.

Although attending religious services was a protective factor for suicidal thinking and other suicidal behaviours, this study revealed it as a risk factor for all suicidal behaviours.

Hopeful in Stressful Events. Another aspect of spirituality explored in this study was being hopeful in stressful situations. The findings showed that growing up in a family that was hopeful in stressful life events was positively associated with all suicidal behaviours (see Table 22). The regression analysis showed the association as suicidal thinking (r=.132, R=.102), suicidal planning (r=.006, R2 = .071), suicidal attempt (r=.039, R2 = .079) and self-harm (r=.078, R2=.064). Nevertheless, the correlations were very weak.

Previous studies have revealed that having hope was a protective factor for suicidal behaviours. A study by Tucker et al. (2016) revealed that hope was a protective factor against

suicidal ideation. In addition, hopelessness was a risk factor for suicidal ideation (Lew et al., 2020). Both Tucker et al. (2016) and Lew et al. (2020) cite Snyder's (2002) Hope Theory, which defines hope as a futuristic push of a cognitive view that involves setting goals, planning to achieve them and keeping the motivation alive towards achieving the set goals. Gvion and Apter (2012) concluded that hope was a key factor inherent in mentally healthy individuals with the ability to see life beyond the challenges they are facing. Thus lack of hope is a state void of prospective objectives, strategies and reasons to deal with a challenge which is a risk for suicidal behaviours.

However, according to this study, having hope in stressful events was a risk factor for suicidal behaviours. Meaning being in stressful events made being hopeful seem incongruent, which is associated with suicidal behaviours. Moreover, hope is highly generating from spirituality (Talib & Abdullahi, 2017; Mo et al., 2022) which is connected to one's religious beliefs. For example, having hope when in distress, from a Christian perspective, is founded on the belief in God's ability to help, support and resolve the believer's issue. This was evident in other religious views. Talib and Abdullahi (2017) observed that spirituality was a protective factor against hopelessness and suicidal behaviours. Furthermore, Griggs (2017) reviewed articles on hope and mental health among emerging adults in college from 2011 – 2016. Two out of five themes summed up by Griggs were that hope was a protective factor against suicidal behaviours and it was associated with an increased ability to cope with difficult situations. Therefore, having hollow hope, that is, hope without an object or a strong supreme to deal with one's distress, was the risk factor for suicidal behaviours.

This means that emerging adults whose early families had hollow hope in stressful events were at risk of suicidal behaviour. This conclusion was observed by Talib and Abdullahi (2017),

who argued that a lack of spirituality or faith in a supreme being was the reason hope in stressful life events was a risk of suicidal behaviours.

Universal-Spiritual Dimension.

The study further explored the participants' universal-spiritual aspects and their correlation to suicidal behaviours. The universal-spiritual dimension in the Satir model represents the individual’s universal yearnings and the self. The self is also known as the core of human behaviour (see Table 23). This universal aspect is captured in six yearnings of emerging adults notorious for distress and the relationship to suicidal behaviours.

Table 23

Interpersonal and Intrapersonal Spirituality

	Suicidal Thinking	Suicidal Planning	Suicidal Attempt	Self-Harm
Yearning: I am yearning for . … (Interpersonal Spirituality)				
Love	0.198	0.266*	0.094	-0.043
	(0.206)	(0.139)	(0.159)	(0.131)
Acceptance	0.308	0.013	0.155	-0.049
	(0.219)	(0.149)	(0.170)	(0.139)
Validation	-0.352*	-0.058	0.025	0.025
	(0.195)	(0.132)	(0.151)	(0.124)
A purposeful life	-0.153	-0.227	-0.356	0.257
	(0.301)	(0.204)	(0.233)	(0.191)
Meaningful living	0.103	0.192	0.451*	0.287
	(0.345)	(0.234)	(0.268)	(0.219)
Freedom to make my own choices	-0.128	-0.115	-0.182	-0.300**
	(0.230)	(0.156)	(0.179)	(0.146)
Self : I am … (Intrapersonal Spirituality)				
A spiritual being	-0.019	-0.537***	-0.215	-0.092
	(0.253)	(0.171)	(0.196)	(0.160)
A lovable person	-0.162	0.241	-0.107	-0.053
	(0.354)	(0.240)	(0.274)	(0.225)
Hopeful of a bright future	-1.179***	-0.462	-0.654**	-0.256
	(0.428)	(0.290)	(0.332)	(0.272)
Important in the universe	-0.355	-0.705***	-0.598**	-0.653***
	(0.305)	(0.207)	(0.237)	(0.194)

Note: Statistical analysis on the correlation between interpersonal and interpersonal spiritual and suicidal behaviours.

Yearning for Love. As evidenced in Table 23, the results revealed that yearning for love was positively linked to suicidal thinking (r=.198, R^2 =.206), suicidal planning (r=.266, R^2

=.139) and suicidal attempt (r = .094, R^2=.159). But yearning for love was negatively associated with self-harm (r=-.043, R2 = .131). The results showed that yearning for love was a risk factor for suicidal thinking, suicidal planning and suicidal attempt. Whereas, yearning for love was a protective factor against self-harm. Comparatively, more female students longed for love t (72.1) =.007 and more public university students at t (73) =.022 when dealing with distressful situations. So, more female students and students in public university were are risk of engaging in suicidal thinking, suicidal planning and suicidal attempt.

Yearning for Acceptance. The second spiritual universal need examined was acceptance. This study examined the relationships between yearning for acceptance and suicidal behaviours. The results revealed a positive correlation between yearning for acceptance and suicidal thinking (r =.308, R^2 =.219), suicidal planning (r=.013, R^2 = .149) and suicidal attempt (r = .155, R^2 =.170) (see Table 23). However, yearning for acceptance was negatively associated with self-harm (r=-.049, R^2 = 025). This means that longing for acceptance is a protective factor for self-harm but a risk factor against suicidal thinking, suicidal planning and suicidal attempt. The results showed that more female students t (66.8) = .023 and more students in the public university t (68.5) =.052 yearned for acceptance when distressed. Meaning more female students and public university students were at risk of engaging in suicidal thinking, suicidal planning and suicidal attempt.

Feeling loved and accepted are marks of a securely attached emerging adult. While feeling unloved and unaccepted are qualities of an insecurely attached emerging adult at risk of engaging in suicidal behaviours (Cassidy et al., 2014; Marrone, 2014). It is evident that both yearning for love and acceptance are a risk for suicidal thinking, suicidal planning and suicidal

attempt. Thus, these findings are similar to Goodman et al. (2018) and Davaji et al. (2014), who concluded that insecure attachment styles are a risk for suicidal thinking and suicidal attempt.

Yearning for Validation. In addition, this study explored the relationship between yearning for validation and suicidal behaviours. The findings showed that yearning for validation was positively correlated to suicidal attempt (r=.025, R^2 =.151 and self-harm (r=.025, R^2=.124). On the contrary, yearning for validation was negatively correlated to suicidal thinking (r=-.352, R^2=.195) and suicidal planning (r=-.058, R^2 =.132). This study revealed that yearning for validation was a risk factor for suicidal attempt and self-harm but a protective factor for suicidal thinking and suicidal planning. Moreover, the study showed that more male students t (58.5) = .011 and students in the public university t (60.5) =.047 needed validation in times of distress (see Table 24). Therefore, male students and public university students were more likely to engage in suicidal attempt and self-harm but less likely to think and plan suicide.

Table 24

Interpersonal and Intrapersonal Spirituality by Gender and Univestiy Type

Variable	Overall	By Gender				By University type			
	n	Male %	Female %	df	p value	Private uni %	Public uni %	df	p value
I am yearning for:									
Love	399	0.715	0.721	-0.007	0.88	0.709	0.73	-0.022	0.635
Acceptance	399	0.645	0.668	-0.023	0.634	0.633	0.685	-0.052	0.276
Validation	399	0.588	0.577	0.011	0.835	0.558	0.605	-0.047	0.341
A purposeful life	399	0.889	0.875	0.014	0.669	0.88	0.885	-0.005	0.863
Meaningful living	399	0.879	0.908	-0.03	0.328	0.904	0.885	0.019	0.526
Freedom to make my own choices	399	0.836	0.832	0.004	0.91	0.819	0.85	-0.031	0.408
SELF: I am …									
A spiritual being	399	0.905	0.899	0.005	0.849	0.875	0.93	-0.056	0.061
A lovable person	399	0.931	0.932	-0.002	0.954	0.934	0.93	0.005	0.853
Hopeful of a bright future	399	0.953	0.962	-0.009	0.653	0.94	0.975	-0.036	0.081
Important in the universe	399	0.947	0.908	0.038	0.143	0.904	0.95	-0.045	0.081

Note: Comparing interpersonal and intrapersonal spirituality statistics by gender and university type.

These findings are somewhat similar to Iyer et al. (2023), who noted that supporting adolescents to form a healthy self-image and to keep socially connected was a protective factor against suicidal behaviours in emerging adulthood. Emerging adults yearning for validation will seek it out, thus reducing the risk of suicidal behaviours. This is unlike emerging adults who are not seeking support which might lead to internalizing behaviours linked with suicidal

behaviours. However, these findings reveal that yearning for validation or support was a protective factor against suicidal thinking and planning but a risk factor against suicidal attempt and self-harm.

Yearning for a Purposeful Life. This study further examined the relationship between yearning for a purposeful life and suicidal behaviours. The results revealed that yearning for a purposeful life was positively correlated to self-harm (r=. 257, R^2 =.191). Besides, yearning for purposeful life was negatively correlated to suicidal thinking (r=-.153, R^2=.301), suicidal planning (r=-.227, R^2= .204) and suicidal attempt (r=-.356, R^2=233). This means longing for a purposeful life is a risk for self-harm (see Table 23).

On the contrary, yearning for a purposeful life is a protective factor against suicidal thinking, suicidal planning and suicidal attempt. A comparison was drawn between gender and university type. The results showed that more male students t (88.9) = .014 and more public university students t (88.5) = .005 desired a purposeful life when in stressful situations (see Table 24). So, more male students and public university students are less likely to engage in all suicidal behaviours.

These findings agree with Koenig (2015), who concluded that religion is a source of purpose in life and mental health. The presence of purposeful life is associated with better mental health, which is void of suicidal behaviours. No wonder these findings reveal that yearning for purposeful life was a protective factor against suicidal thinking, suicidal planning and suicidal attempt.

Yearning for a Meaningful Living. The study examined another universal aspect involving yearning for meaningful living. The findings revealed that yearning for meaningful living was positively correlated to all suicidal behaviours. The regression analysis exposed that

longing for a meaningful living was positively correlated to suicidal thinking at (r=.103, R^2 =.345), suicidal planning (r=.192, R^2=.234), suicidal attempt (r=.451, R^2=.268) and self-harm (r=.287, R^2=.219) (see Table 23). The findings mean that yearning for meaningful living was a risk factor for all suicidal behaviours. This study compared the students' desire for a meaningful living by gender and university type. The findings revealed that more female students t (90.8) =.03 and more private university students t (90.8) = .019 desired a meaningful life when distressed (see Table 24). Thus, female students and private university students were more at risk of engaging in all suicidal behaviours.

These findings differ from Whitlock et al. (2013), who observed that having meaning in life was a protective factor against those already engaged in self-harm to progress to suicidal thinking and suicidal behaviours. Therefore, according to Whitlock et al., yearning for a meaningful life is a protective factor against suicidal behaviours. However, based on this study longing for meaningful living was a risk factor for all suicidal behaviours.

Yearning for Freedom to Make Personal Choices. The final universal yearning examined in this study was the desire for freedom to make personal choices. A linear regression against all four suicidal behaviours was obtained. The results revealed that the desire to make personal choices was negatively correlated to all suicidal behaviours. The regression analysis showed the following results suicidal thinking (r=-.128, R^2=.230), suicidal planning (r=-.115, R^2 =.156), suicidal attempt (r=-.182, R^2=179), and self-harm (r=-.300, R^2=.146, p< .05) (see Table 23). Besides, the association between yearning for freedom to make own choices was statistically significant for self-harm. This means that longing for the freedom to make personal choices was a protective factor against all suicidal behaviours. However, the correlation was more significant for self-harm. In addition, more male students and public university students longed for the

freedom to make personal choices when in distress. Thus, they were less likely to engage in all suicidal behaviours.

These findings confirmed that a lack of control over one's life and choices was associated with suicidal behaviours (Bruffaerts et al., 2018; Mortier et al., 2017; Tucker et al., 2015; Wanyoike, 2015). This means that yearning for freedom to make personal choices is a healthy pursuit that breaks away from feeling helpless. It is the opposite of lacking control which is having the willpower to be responsible and take charge of one's life, thus a protective factor against all suicidal behaviours.

Self "I Am".

The second aspect of the universal-spiritual dimension is the self. This study explored the findings of the self-characterized by self-identity, lovability, hope and purpose provided by spirituality. Table 14 revealed that spirituality is a strong protective factor for multiples.

A Spiritual Being. The study explores the relationship between emerging adults' core identity and suicidal behaviours. The results showed that believing that one was a spiritual being was negatively correlated to all suicidal behaviours. The analysis of the linear regression represented: suicidal thinking (r=-.019, R^2 = .253), suicidal planning (r=-.537, R^2=.171, p< .01), suicidal attempt (r=-.215, R2 = .196) and self-harm (r=-.092, R2 =.160) (see Table 23). There was a statistically significant relationship between believing one was a spiritual being and suicidal planning. This means that defining the self as a spiritual being was a protective factor against all suicidal behaviours. Moreover, this study compared the correlation between being a spiritual being and suicidal behaviours by gender and university type. The results revealed that more male students (90.5) =.005 and more public university students t (93) = .065 were likely to

define themselves as spiritual beings (see Table 24). So, the male students and the public university students were less likely to engage in all suicidal behaviours.

A Lovable Person. Whereas believing one was a lovable person was positively associated with suicidal planning (r=.241, R^2 =.240). On the other hand, believing that one is a lovable person was negatively associated with suicidal thinking (r=-.162, R^2 = .354), suicidal attempt (r=-.107, R^2 = .274) and self-harm (r = -.053, R^2 = .225) (see Table 23). The association was not statistically significant. Therefore, believing that one is a loveable person is a protective factor against suicidal thinking, suicidal attempt and self-harm. There were more female students t (93.2) =.002 and private university students t (93.4) =.005 who believed they were lovable people (see Table 24). So, more female students and private university students who believed they were lovable beings were likely to engage in self-harm.

Hopeful of a Bright Future. In addition, the study examined the participants' beliefs about a hopeful future concerning suicidal behaviours. The results showed a negative relationship between being hopeful of a bright future and all suicidal behaviours. The regression analysis showed that being hopeful for a bright future was related to suicidal thinking (r=-.1.179, R^2 = .428, p< .01)), suicidal planning (r=-.462, R^2=.290), suicidal attempt (r=-.654, R^2 =.332, p< .05).) and self-harm (r-=-.256, R^2=.272) (see Table 23). Besides, the correlation was statistically significant for suicidal thinking and suicidal attempt. This means that being hopeful for a bright future was a protective factor against all suicidal behaviours. Comparing the findings by gender and university type revealed that more female students t (96.2) =.009 and more public university students t (97.6) = .036 believed in hope for a bright future (see Table 24). Hence, these female students and public university students are likely not to engage in behaviours.

These findings were convergent with those of the Delphi interviews, where a majority of the university counsellors, four out of six, believed that having hope in life was very significant protector against suicidal behaviour, while two out of six believed it was significant.

Important in the Universe. Finally, the study explored the relationship between believing one is important in the universe and suicidal behaviours. The results were correlated to suicidal behaviours. The results showed that believing one was important in the universe negatively correlated to all suicidal behaviours. The analysis recorded the regression as follows: suicidal thinking ($r=-.355$, $R^2=.305$), suicidal planning ($r=-.705$, $R^2=.207$, $p<.01$), suicidal attempt ($r=-.598$, $R^2=.237$, $p<.05$) and self-harm ($r=-.653$, $R^2=.653$, $p<.01$) (see Table 23). Additionally, believing that one was important in the universe was statistically significant to suicidal planning, suicidal attempt and self-harm. That means believing one is important in the universe is a protective factor against all suicidal behaviours.

Furthermore, a comparison between regarding believing one is important in the universe by gender and university type was explored. The results revealed that more male students, $t(94.7)=.038$, and public university students, $t(95)=.045$ (see Table 24). This means that there is a lower likelihood of male students and public university students who believe they are important in the universe to engage in suicidal behaviours.

These findings are similar to Satir's Theory of self-esteem. Where having a positive view of self was a protective factor against suicidal behaviours (Baldwin, 2013; Satir et al., 1991). Believing that one is a spiritual being, a lovable person, being hopeful of a bright future and being important in the universe are markers of positive self-esteem. It shows that one has an optimistic judgment of their personal value which generated feelings of compassion and acceptance of one's strengths and weaknesses (Sommer-Flanagan & Sommer-Flanagan, 2015;

Gehart, 2010). Thus positive beliefs of self are a protective factor against suicidal behaviours, as observed in Baldwin (2013), citing Satir et al. (1991).

Data drawn from the focus group discussions and the Delphi interviews was convergent to each other on spirituality is both a risk and protective factor. The earlier findings revealed that religious affiliation was a protective factor for only suicidal thinking among Protestants and Muslim students. But a risk factor for suicidal planning, suicidal attempt and self-harm.

These views were convergent to the Delphi consensus and the focus group discussions. The Delphi interview showed that fewer university counsellors thought that devotion to spirituality was a very significant indicator of whether the students will be engaging in suicidal behaviours or not. Three out of six counsellors indicated that devotion to spirituality was very significant on whether a student was engaging in suicidal behaviours. Another two out of six indicated that spiritual devotion was significant, and one out of six counsellors indicated that spiritual devotion was somewhat significant. Moreover, some students in the focus group discussion were concerned that spirituality was not a protective factor against suicidal behaviours. “Koli”, said, “I did not ascribe to my parents' faith, although I was brought up in a strict religious family. I do not engage in spiritual activities as a means of solving problems.”

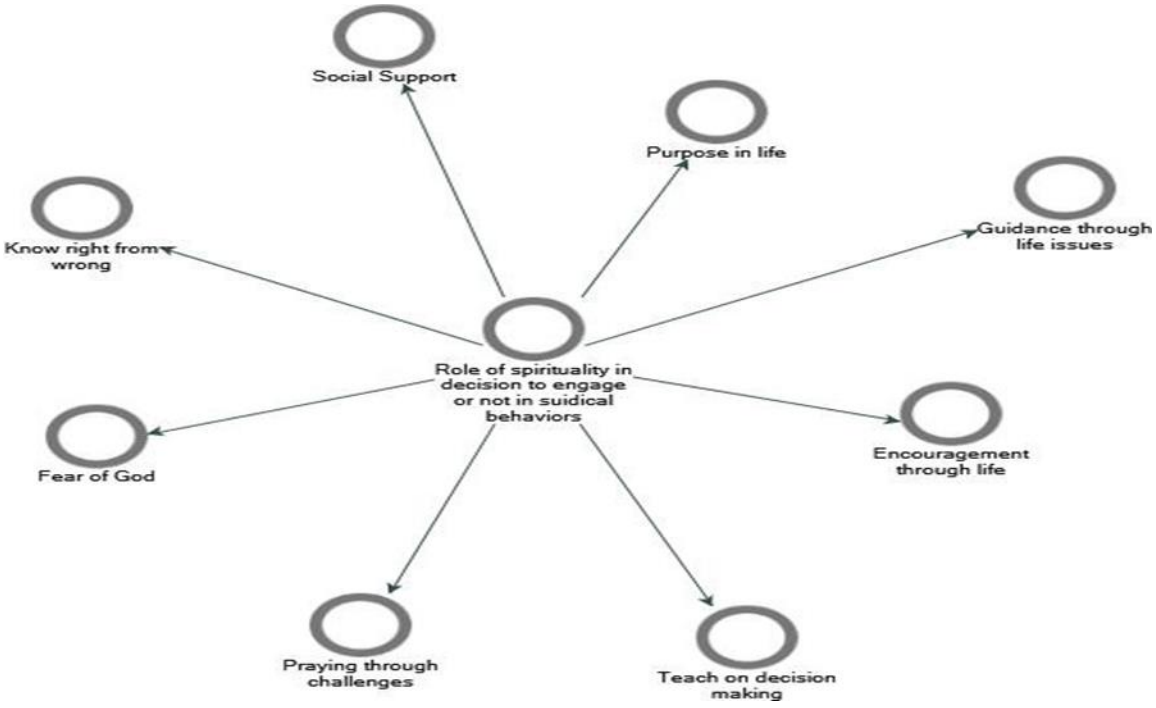
On the contrary, the students in the focus group discussions stated that spirituality played a very significant role in determining whether they engaged in suicidal behaviours or not. According to “Ndirangu”, devotion to spirituality can prevent suicidal behaviours compared to a person who is not committed to spirituality.

> “Comparing someone who grows up from the start with very strong faith in God and having a very elaborate understanding of who God is, what God is able to perform. Comparing that kind of a child to someone who was just brought

up in a family where God is even never talked about? Faith is never touched on. Comparing these two scenarios, there is a very great, very distinction. It creates some sort of conviction to help in your decision that something is not good for you or everyone else. They somehow remember the spirituality or values instilled in you while you are in church."

Figure 16

The Role of Spirituality in Deciding Whether to Engage in Suicidal Behaviours



Note. The reason spirituality was a protective factor for suicidal behaviours.

Furthermore, the participants in the focus group discussions identified eight valuable tools on spirituality and the benefits of belonging to a spiritual community provides that enabled them not to engage in suicidal behaviours, as shown in Figure 16. These are knowledge of right and wrong, social support, purpose in life, guidance through life issues, encouragement through life issues, teaching decision-making, praying through challenges, and the fear of God.

These findings confirmed Eskin et al. (2019 and Lawrence et al. (2016), who observed that strong spirituality was a protective factor against suicidal ideations among emerging adults. In the same breath, Eskin et al. (2019) and Lawrence et al. (2016) argued that spirituality can be a risk factor for suicidal attempt. This shows that spirituality can be a protective factor against suicidal behaviour under certain conditions.

This means spiritual affiliation alone was insufficient to protect emerging adults from suicidal behaviours. There is a need for an emerging adult to have a positive view of self, desire a purposeful life, long for the freedom to make their own choices and grow up in a family that integrated religious practices with the family culture. In addition, spirituality can be a protective factor if parents teach it with a positive parenting style who are secure and supportive to emerging adults.

Chapter Summary

This chapter presented the study's results, analysis and interpretation of the early family environment and suicidal behaviours among emerging adults. The results were presented based on the study objectives. The chapter discussed the prevalence of suicidal behaviours among emerging adults and the dimension of the early family environment associated with suicidal behaviours. Further findings on the psychological stressors linked with emerging adults' suicidal behaviours were discussed. Finally, the role of spirituality in emerging adults' suicidal behaviours was presented.

Chapter Five

Summary of the Findings, Recommendations, Further Research and Conclusion

This chapter summarizes the study's overall findings on early family environment and suicidal behaviours among emerging adults. It discussed the findings guided by these objectives will guide the discussion: the prevalence of suicidal behaviours among emerging adults in the university in Kenya, features of early family environment linked to suicidal behaviours, psychological stressors compelling emerging adults to engage in suicidal behaviours, and the role of spirituality in emerging adults' suicidal behaviours. It makes recommendations based on these findings and a discussion on the areas for further research drawn from the study. In addition, this chapter will look at the implications of the findings in light of the theoretical and conceptual framework and the literature reviewed in chapter two. A conclusion will be drawn explaining the extent to which the research objectives were answered and recommendations based on the findings.

Summary of the Findings

The study sought to examine the influence of early family environment on emerging adults' suicidal behaviours among university students. This study was guided by four study objectives, namely; to a) examine the prevalence of suicidal behaviours among emerging adults in university, b) investigate the features in the early family environment linked to their suicidal behaviours, c) determine the psychological stressors associated with emerging adults' suicidal behaviours, and d) establish the role spirituality plays in emerging adults' suicidal behaviours among university students. The study hypothesized that emerging adults are significantly engaging in suicidal behaviours at the university. The early family environment predisposes emerging adults towards suicidal behaviours due to poor family relations, inadequate personal

skills to handle life's challenges, and unresolved childhood stressful life events experienced in childhood.

This study established that emerging adults in universities are engaging in suicidal thinking, planning, attempts, and self-harm. The prevalence of these suicidal behaviours was: 17.1% for suicidal thinking, 5.9% for suicidal planning, 7.8% for suicidal attempts, and 5.5% for self-harm. This shows that suicidal thinking and attempts were the common suicidal behaviours, and several students were engaging in multiple suicidal behaviours. The dominant self-harming behaviours for female students were cutting or slitting the wrist and alcohol or drug overdose for male students. The study revealed being young, female, in fouth-year, attending a private university, living in the hostels, and alone were risk factors for suicidal behaviours. Parents who were authoritarian and neglectful, insecurely attached, college educated, and in blended or guardians families were at risk of having emerging adults engage in suicidal behaviours.

This study revealed that family relations and unresolved childhood stressful life events were strong predictors of suicidal behaviours in emerging adulthood. At the same time, support for personal development was a strong protective factor against suicidal behaviours. The family relations feature was a significant risk for suicidal behaviours where: there were strong parent-child bonds, parents kept promises, conflict was voiced openly, negative emotions were hidden, and children communicated their wishes openly. On the contrary, families where children felt loved and wanted, free to voice feelings and thoughts, and the family maintained communication in a crisis, sought help in times of need, family members were flexible and coped well with change, were protective of emerging adults' suicidal behaviours. The personal development feature was a strong protective factor against emerging adults' suicidal behaviours. Emerging adults who were supported form positive self-worth, manage conflict without blaming others,

seek help when in trouble, solve problems constructively, form close relationships outside the family, and integrate religious practices into the family culture were less likely to engage in suicidal behaviours. However, unresolved childhood stressful life events such as parental divorce, mental and chronic illness in the family, ill-treatment and sexual abuse were serious risk factors for suicidal behaviours among emerging adults.

The third objective of the study was to examine the psychological stressors compelling emerging adults to suicidal behaviours. The study revealed that mental disorder symptoms such as hopelessness, depression and anxiety were strongly linked to emerging adults' suicidal behaviours. Moreover, the study revealed that having financial difficulties, family conflicts, academic challenges, experiencing sexual abuse, and problems in intimate relationships were risks for suicidal thinking, planning, and attempts. In addition, experiencing sexual abuse, conflicts with parents, academic stress, intimate partner problems and breakups were psychological stressors associated with self-harm. These findings were similar to numerous studies associating family conflicts, financial difficulties, and academic challenges as common psychological stressors associated with suicidal behaviours. This study revealed that responding to psychological stressors by placating or super reasonable was a risk for suicidal behaviours. This study shows that having positive beliefs in one’s ability to solve problems and believing that situations will change for the better are strong preventative factors against suicidal behaviours. Furthermore, expecting good from life’s challenges was a protective factor against suicidal behaviours among emerging adults.

Finally, the study sought to determine spirituality's role in emerging adults’ suicidal behaviours. This study reveals that spirituality is both a risk factor and a protective factor against suicidal behaviours among university students. Based on this study, having a religious affiliation,

attending religious meetings, and growing up in a family that upheld morality were risk factors for suicidal behaviours. This study revealed that having unmet interpersonal yearnings for love and acceptance, validation, meaningful living, and a purposeful life were risk factors for suicidal behaviours. On the contrary, growing up in a family that integrated religious practices and family culture was protective against suicidal behaviours. In addition, yearning for freedom to make personal choices was a protective factor for suicidal behaviours among emerging adults. As observed in this study, having strong intrapersonal beliefs such as I am a spiritual being, l am lovable, I am hopeful of a bring future, and I am important in the universe were strong protective factors against suicidal behaviours.

Conclusion

The findings of the study answered all four study questions. The general aim of this study was to explore the influence of early family environment on emerging adults' suicidal behaviours among emerging adults in selected universities. Several conclusions were made from the data presented in this study. The findings have shown that emerging adults are engaging in all suicidal behaviours, especially suicidal thinking, at 17.1% and attempt at 7.8%. The second conclusion based on this study was that the family relations dimension was strongly associated with suicidal behaviours than the personal growth dimension. However, supporting children towards personal development is protective against suicidal behaviours because it helps them manage conflicts without blaming, solve problems constructively, seeking help when in trouble, form a positive self-view, and develop self-regulation. Additionally, this study revealed the top five stressful life events significantly associated with suicidal behaviours in emerging adulthood. These stressful events were: parental divorce, chronic illness, mental illness in the family, sexual abuse and ill-treatment.

Thirdly, the conclusion from this study is that feeling hopeless, depressed and anxious mental illness symptoms are strongly linked to suicidal behaviours among emerging adults. Furthermore, the top five common psychological stressors compelling emerging adults to engage in suicidal behaviour were: financial difficulties, family conflicts, academic challenges, sexual abuse and problems in an intimate relationship. The study concluded that negative responses to psychological stressors like; being insecurely attached, placating, super reasonable, having negative feelings, beliefs and expectations of self and the context were linked to suicidal behaviours. The final conclusion drawn from this study is that spirituality was both a risk and protective factor against suicidal behaviours. Both the interpersonal and intrapersonal aspects of spirituality work together to support emerging adults' well-being.

Recommendations

Generally, emerging adults in the university are engaging in suicidal behaviours. There is a clear need for more university involvement to reduce suicidal behaviours. More prevention and intervention programs for private universities, female students, younger students, and second-year and fourth-year students are recommended. It is recommended that universities create more awareness of suicidal behaviours, reduce stigma for seeking help, and provide information on what to do when faced with psychological stressors.

In addition, this study recommends increasing the number of university counsellors to manage the student population and encourage all students to use counselling services at least once every year. Although the focus of a university is academic, it is paramount for lecturers, mentors and staff at the university to provide support and normalize the help-seeking culture so that seeking therapy is not seen as punitive but protective. All departments in the universities need to understand and redirect students under their care to be aware of the psychological

resources available to them and provide emergency contacts for students involved in suicidal behaviours.

Another recommendation to the university counsellors is to assess every student coming for counselling for the risk of suicidal behaviours, family relations problems, self-esteem, attachment styles, problem-solving skills and childhood stressful life events. This should be done to increase awareness, psycho-educate, build resilience and heal childhood traumatic experiences among the students. It is recommended that university counsellors, psychologists, and marriage and family therapist need to understand the emerging adults' stressors compelling them to engage in suicidal behaviours. Based on this study, mental health professionals working with university students should integrate family therapy models like family life course development, attachment and Satir models.

A further recommendation is for parents and guardians to create a warm, close and supportive relationship with the emerging adults. Democratic parenting style, open and honest communication are recommended in the parent-emerging adult relationship with emerging adults. It is critical for those who play parental roles as guardians and step-parents need to strive and build a healthy relationship free from abuse and emotional hurt to reduce the risk for suicidal behaviours among emerging adults. Parents need to be wise and realistic when weaning off their support for emerging adults. Based on this study, it is recommended that parents plan the weaning off support in consultation with their children after they have attained the necessary skills to support themselves.

Reducing family conflicts is recommended, as well as keeping communication channels open. As parents invest in emerging adults' education, they need to listen, provide guidance and equip them with problem-solving, coping skills and intimate relationships skills. It is

recommended that parents and family members take emerging adults' suicidal thoughts, plans, attempts and self-harm as a serious sign of psychological ill-health rather than a way of seeking attention. To support this, it is recommended that families grow in their knowledge of mental health problems such as fatigue, burnout, stress, post-traumatic stress disorder, depression and anxiety. It is recommended that families help emerging adults unlearn negative attitudes towards help-seeking activities and normalize mental health problems. It is recommended that parents going through divorce, chronic illness, and mental illness establish positive ways of dealing with these stressors to support their children's well-being.

This study recommends that religious institutions grow in knowledge and skills to support emerging adults in reducing suicidal behaviours. These institutions are recommended to take a lead role in supporting parents to use democratic parenting styles, build strong bonds, openly communication and help children process stressful events. It is recommended that religious communities help to correct erroneous views on parenting, mental illness and emerging adulthood associated with suicidal behaviours. Due to the increase in marital problems, a recommendation is to religious institutions to help guardians and blended families to reduce distance negative interactions and eliminate ill-treatment in children and emerging adults. In addition, it is recommended that religious institutions take a key role in equipping emerging adults with practical and faith-based resources to solve problems and cope with challenges in life. It is recommended that religious institutions do more than condemn suicidal behaviours. They can open up these conversations and direct emerging adults to professionals to help them deal with suicidal behaviours. Additionally, religious communities are recommended as a support system where emerging adults can find love, acceptance, validation and meaningful living.

As evident in the study, suicidal behaviours are prevalent. It is recommended that the community create forums to inform the general public on ways to prevent and intervene in suicidal behaviours among emerging adults. Another recommendation for the government through child welfare is to ensure that guardians and step-parents support healthy growth in children, adolescents and emerging adults under their care. It is recommended that reports of maltreatment and sexual abuse be taken more seriously medically, psychologically and legally by families and the justice system.

It is evident from this study that the majority of university students live in hostels outside the university. In the same breath, living in a hostel outside the university is a risk factor for suicidal behaviours. Therefore, it is recommended that the Commission for Higher Education, Ministry of Housing, University Administration and parents/guardians make a policy for hostel owners to provide mandatory psychological care emergency contact. In so doing, most students living away from their families have a chance to be helped reduce suicidal behaviours.

Further Research

There is a need for further studies involving more universities in different counties in Kenya to confirm these findings. Such a study should involve a bigger sample size of students and university counsellors over and over some time. Such a longitudinal study can help track emerging adults' suicidal behaviours from the first to fourth year to reduce suicidal behaviours in the universities.

Another similar research needs to be done to capture the suicidal behaviours and psychological stressors based on students' narratives. Qualitative research will provide insight into areas of clinical intervention for marriage and family therapists, university counsellors and other psychologists who work with emerging adults.

Further research is recommended to explore social media's role in emerging adults' suicidal behaviours. This study described emerging adults as people born at a time of advanced technology and using multiple social media platforms for learning, social life and entertainment. Based on these factors, it is vital to explore whether social media is a risk or protective factor for emerging adults' suicidal behaviours.

Lastly, this study calls for further clinical research on applying different frameworks in assessing and intervening for emerging adults' suicidal behaviours. First, have clinical research to screen and intervene for the early family environment feature linked to suicidal behaviour in emerging adults using the fuller version of the family environment scale. Second, clinical research employs Satir's Iceberg model to assess and intervene in emerging adults' suicidal behaviour for at least two to four years.

Original Contribution

This study has provided new knowledge on emerging adults and suicidal behaviours among university students. First, it has provided empirical findings on the prevalence of suicidal behaviours in the Kenyan context. This was key as it provided prevalence rates of self-harming behaviours among university students. Secondly, this study has provided a comparative view of suicidal behaviours in private and public universities. Thirdly, this study has revealed new knowledge that living in the hostels outside the university was a risk factor for all suicidal behaviours among emerging adults. Fourthly, the study has added new knowledge on the use of the Family Environment Scale (FES) in the Kenyan context. Fifthly, this study has provided knowledge on the interaction between early family environments and emerging adults' suicidal behaviours. Sixthly, this study has added empirical knowledge on the use of Satir's iceberg in the study and possible intervention for emerging adults' suicidal behaviours. Finally, this research

has provided knowledge on the role of spirituality in emerging adults' suicidal behaviours to help in the prevention and intervention of the same in this population.

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Appendix I

Certificate of Ethical Clearance

Certificate of Ethical Clearance

PAN AFRICA CHRISTIAN UNIVERSITY

RESEARCH ETHICS REVIEW COMMITTEE (RERC)

This Certificate is awarded to

MARION KIRUMBA MUTWIRI

For the research titled

EARLY FAMILY ENVIRONMENT AND EMERGING ADULTS' SUICIDAL BEHAVIORS: A STUDY OF SELECTED UNIVERSITIES IN NAIROBI COUNTY, KENYA

having complied with PAC University Research Ethics Review Committee's guidelines and Standard Operating Procedures for ethical clearance.

This Certificate is issued subject to compliance with the following requirements:

i. Before commencing the study, you are required to obtain a Research Permit from the National Commission for Science, Technology and Innovation (NACOSTI) as well as other institutional clearances as and where needed.
ii. Only approved documents including research instruments and informed consent forms will be used.
iii. All changes including amendments and/or deviations are to be submitted for review and clearance by PAC University Research Ethics Review Committee before use.
iv. Any expected or unexpected changes that may increase the risks to study participants or affect the integrity of the study must be reported to in writing to PAC University Research Ethics Review Committee within three days.
v. Any request for renewal or approval must be submitted to PAC University Ethics Review Committee at least six weeks prior to the expiry of this Certificate and must be accompanied by a comprehensive progress report to support the renewal.

Date of issue	30th Sept 2021	**Expiry date**	30th Sept 2022

Signed: _____

Dr. Josh T. Amwago, PhD

Chairman, PAC University Research Ethics Review Committee

Appendix II

National Commission for Science, Technology & Innovation

REPUBLIC OF KENYA

NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Ref No: **482805**

Date of Issue: **15/October/2021**

RESEARCH LICENSE

This is to Certify that Miss.. Marion Kirumba Mutwiri of Pan African Christian University College, has been licensed to conduct research in Nairobi on the topic: Early Family Environment and Emerging Adults' Suicidal Behaviors: A Study of Selected Universities in Nairobi County, Kenya for the period ending : 15/October/2022.

License No: **NACOSTI/P/21/13571**

482805

Applicant Identification Number

Director General
NATIONAL COMMISSION FOR SCIENCE,TECHNOLOGY & INNOVATION

Verification QR Code

NOTE: This is a computer generated License. To verify the authenticity of this document, Scan the QR Code using QR scanner application.

Appendix III

Informed Consent

Marion K. Mutwiri,
Pan Africa Christian (PAC) University,
P. O. BOX 56875-00200,
NAIROBI, KENYA.

RE: INFORMED CONSENT TO PARTICIPATE IN RESEARCH

I am a student at Pan Africa Christian University, pursuing a Doctor of Philosophy Degree (PhD) in Marriage and Family Therapy. Part of my study requires that I carry out research as the partial requirement for attaining the PhD. My research topic is 'Early Family Environment and Emerging Adults' Suicidal Behaviours: A Study of Selected University in Nairobi County, Kenya."

My study focus is on university students aged 18 to 25 years. In order to collect the information needed for this study, I am requesting your VOLUNTARY participation, which will be highly appreciated. By filling out a questionnaire or accepting to be involved in the focus group discussion, you will contribute to my university requirement and provide useful information that will provide society and policymakers valuable information on the area of study. The survey will take approximately 30 minutes of your time or 60 minutes for the focus group discussion. NOTE there are no right or wrong answers. Your participation or lack of the same will not in any way affect the credibility of the university.

ALL information you give on this sensitive topic will be treated with CONFIDENTIALITY and ANONYMITY. In case you are currently under treatment for any mental illness or you are experiencing any mental disturbance like extreme sadness, hopelessness, loneliness or self-harming thoughts, you are EXEMPTED from this study. In case you experience any physical or emotional disturbance after filling out the questionnaire or after the focus group discussion, please report IMMEDIATELY so that debriefing is provided.

Yours Sincerely,

Mkmutwiri

Marion K. Mutwiri.
Student Identification NO. PMFT 6478/16

Are you willing to participate in this survey or focus group discussion?
Signature: _____

Appendix IV

Survey Questionnaire

Questionnaire on Suicidal Behaviours in University Students in Kenya. CODE: _____

SECTION A: Respondent's Demographic Profile

This section asks you general information about yourself and your family. Tick where applicable, and if the category does not fit, you specify in the blank space marked '*other'*.

1. Please indicate your County or Nationality: _____

2. Gender: ☐ Male ☐ Female ☐ Other _____

3. Age: ☐ 18 below ☐ 18 – 19 years

   ☐ 20- 21 years ☐ 22 – 23 years ☐ 24 – 25 years

   ☐ 26 and above

4. Year of study: ☐ 1st year ☐ 2nd year ☐ 3rd year ☐ 4th year ☐ 5th year and above

5. Program of study: ☐ Education ☐ Business ☐ Communication/Journalism
   ☐ Information ☐ Technology(IT)
   ☐ Psychology/counselling ☐ International
   ☐ Relations ☐ Medicine/pharmacy
   ☐ Sociology ☐ Other _____

6. What is your religious affiliation?

   ☐ Roman Catholic ☐ Muslim
   ☐ Protestant ☐ Hindu
   ☐ Atheist ☐ Other _____

7. What type of family do you come from?

☐ Single parent male only parent
☐ Single parent female only parent
☐ Both biological parents (mother & father)
☐ Blended (one biological parent)
☐ Brother/sister only
☐ Guardian

8. How would you define your parents/guardians?

☐ Controlling ☐ Democratic ☐ Uninvolved ☐ Very easy

9. Parents/guardians' highest education level

☐ Did not finish primary school ☐ Primary school ☐ Secondary/high school
☐ College graduate ☐ University graduate ☐ Post graduate educated

10. What number of birth are you?

☐ 1st born ☐ 2nd born ☐ 3rd born ☐ 4th born ☐ 5th born ☐ Other_____

11. Where do you live when the university is in session?

☐ At home ☐ Hostels around the university

☐ In the university hostels ☐ Hostels away from the university

12. When you are on campus or during the school period, who do you live with?

☐ Parents/guardian & siblings ☐ School mate ☐ Parents/Guardian only
☐ Siblings only ☐ Alone ☐ Intimate partner

13. Who do you confide in?

☐ Mother ☐ Sibling (brother/sister) ☐ Peers/friends
☐ Father ☐ Relatives ☐ Pastor/Religious leader
☐ No one ☐ Other _____

SECTION B:

Early Family Environment

This section asks you to reflect on how your family operated when you were below12 years old. These questions may require personal and sensitive information. Please note that any information you give will be handled with total confidentiality.

Please read the following statements below and circle what describes your family growing up. Not applicable (0), Never (1), Rarely (2), Sometimes (3), Often (4), and Regularly (5).

Please respond to each statement.

	In my family . . .	*Never*	*Rarely*	*Sometimes*	*Often*	*Regularly*
1.	I had a strong bond with my one or both of my parent/guardian (s).	1	2	3	4	5
2.	We were allowed to express our thoughts and feelings freely.	1	2	3	4	5
3.	My family was supportive for me to develop a positive view of myself.	1	2	3	4	5
4.	My parents were reliable in doing what they promised to do for us.	1	2	3	4	5
5.	I felt loved and wanted in my family.	1	2	3	4	5
6.	Conflicts were managed without blaming anyone in the family.	1	2	3	4	5
7.	We openly voiced conflicts with one another.	1	2	3	4	5
8.	I was allowed to decide what I wanted to wanted like what to wear.	1	2	3	4	5
9.	I was encouraged to form close relationships outside the family.	1	2	3	4	5
10.	I was encouraged to seek help when in need or in trouble.	1	2	3	4	5

		Never	Rarely	Sometimes	Often	Regularly
11.	I was encouraged to manage my negative emotions when angry, sad or disappointed.	1	2	3	4	5
12.	I learnt to hide my negative emotions when angry, sad or disappointed.	1	2	3	4	5
13.	I was encouraged to constructively solve problems.	1	2	3	4	5
14.	We were encouraged to openly communicate our wishes in the family.	1	2	3	4	5
15.	Morality was valued and encouraged.	1	2	3	4	5
16.	We faithfully attended religious meetings at least once a week.	1	2	3	4	5
17.	Religious practices like praying, reading religious writings, helping others . . .were part of the family culture.	1	2	3	4	5
18.	My family was flexible and coped well to change.	1	2	3	4	5
19.	We maintained connection and communication in crises.	1	2	3	4	5
20.	My family was hopeful about life, even in the face of stressful life events.	1	2	3	4	5
21.	External support was sort to help the family in times of need.	1	2	3	4	5

22. Please tick ALL the Stressful Family Life Events you experienced growing up before you turned 12 years old.

a) Mental illness in the family ( ) Yes ( ) No

b) Sexually abuse (incest/rape/assault) ( )Yes ( ) No

c) Ill-treatment ( )Yes ( ) No

a) Rejection by a parent ( )Yes ( ) No

b) Death of a parent ( )Yes ( ) No

c) Death of a family member ( )Yes ( ) No

d) Chronic illness in the family ( )Yes ( ) No

e) h. Parents Separation ( ) Yes ( ) No

f) Parents divorced	( )Yes	( ) No
j) Domestic violence	( )Yes	( ) No
k) Suicide death in the family	( )Yes	( ) No
l) Increased arguments with parents	( )Yes	( ) No
m) Alcohol & drug abuse	( ) Yes	( ) No
n) A troubled sibling	( ) Yes	( ) No

SECTION C

Suicidal Behaviours and Self-harm

This section intends to capture individual thoughts and activities regarding suicidal behaviours and self-harm. This will require some personal and sensitive information. Please note that any information you give will be held in confidence.

In the last 12 to 24 months, have you thought or engaged in suicidal behaviours or self-harm? If YES, please indicate the number of times you thought or engaged in the activity.

	Suicidal ideations /thoughts	No	Yes	Frequency if yes
1.	I have felt that life is not worth living.	0	1	__
2.	I have wished myself dead.	0	1	__
3.	I have thought dying is better than living.	0	1	__
4.	I have browsed online for ways to end my life?	0	1	__
5.	I have told someone my thoughts of ending my life?	0	1	__
	Suicidal attempt	No	Yes	Frequency if yes
6.	I have come close to taking away my own life.	0	1	__
7.	I have attempted to take away your life.	0	1	__
8.	I have interrupted the attempt to take away my life.	0	1	__
9.	I have abandoned an attempt to kill myself.	0	1	__
10.	I have told someone that I attempted to take my life?	0	1	__
	Suicidal Plan	No	Yes	Frequency if yes
11.	I have planned on how to end my life.	0	1	__
12.	I have sort, visited or purchased an item your plan to end your life with?	0	1	__
13.	I have had a specific plan on how to end my life.	0	1	__
14.	I have abandoned a set plan to kill myself.	0	1	___
15.	I have told someone how I plan to end my life.	0	1	___
	Self-harm			
16.	Tick ALL the activities you have engaged in	No	Yes	Frequency if yes
	a) Cutting	0	1	_____
	b) Biting	0	1	_____
	c) Piercing with a sharp object	0	1	_____
	d) Burned	0	1	_____
	e) Overdosed on a drug/substance	0	1	_____
	f) Other ____	0	1	_____

SECTION D

Psychological stressors associated with Suicidal Behaviours

This section asks you to share some of the psychological stressors that have or might make you consider self-harm, think, plan and attempt suicide.

What drove you or would drive you to consider engaging in suicidal thinking, planning and attempts? Please tick ALL the words and phrases that describe reasons you engaged or would engage in suicidal behaviours.

a) Academic challenges	( ) Yes	( ) No
b) Financial difficulties	( ) Yes	( ) No
c) Family Conflicts	( ) Yes	( ) No
d) Intimate relationship problems	( ) Yes	( ) No
e) Contracted HIV/AIDS	( ) Yes	( ) No
f) Sexually abused (incest/rape/assault)	( ) Yes	( ) No
g) Diagnosed with a mental disorder	( ) Yes	( ) No
h) Feeling very depressed	( ) Yes	( ) No
i) Feeling very anxious	( ) Yes	( ) No
j) Feeling very hopeless	( ) Yes	( ) No
k) Other _____		

Please tick ALL the words and phrases that describe the reasons you engage or would engage in self-harming behaviours.

a) Sexually abused (incest/raped/assaulted)	( ) Yes	( ) No
b) Trouble with intimate relationship	( ) Yes	( ) No
c) Broke up with an intimate partner	( ) Yes	( ) No
d) Distressed with schoolwork	( ) Yes	( ) No
e) Conflict with parent (guardians	( ) Yes	( ) No
f) Other _____		

1) Please indicate by ticking if, in the last 12 to 24 months, you have been diagnosed with any of the following mental illnesses.

☐ Major Depressive disorders ☐ Post-traumatic stress disorder

☐ Anxiety disorders ☐ Postpartum depressive disorders

☐ Bipolar disorders ☐ Schizophrenia disorders

Any Other _____

SECTION E:

Feelings, Beliefs and Responses in Distress

This section asks you to share some of your responses, feelings and beliefs you had the time you considered or if you were in a situation that would make you consider suicide and self-harm.

1. I was or would be (*pick one word below*) to tell my parents/guardian about my current challenges.

☐ Safe ☐ Anxious

☐ Fearful ☐ Unsure

2. I or would (*pick one phrase below*) for the distress or troubled was/would be in.

☐ Blaming others ☐ Blaming myself

☐ Analyzing the situation ☐ Ignoring everything and everyone

Please give a response to each of the statements below. Tick either *YES* or *NO* based on what you did or would do in a distressing situation that made you consider or make

3. Do you . . .

a) Feel it serves me right to be in this distressing situation? ( ) Yes ( ) No

b) Feel that others are responsible for my distress? ( ) Yes ( ) No

c) Feel that the context is fully responsible for the distress? ( ) Yes ( ) No

d) Belief you can solve the challenges you are experiencing? ( ) Yes ( ) No

e) Belief someone else holds the solving your current challenges? ( ) Yes ( ) No

f) Belief your current situation will change for the better? ( ) Yes ( ) No

g) Expect good from life's challenges? ( ) Yes ( ) No

h) Expect understanding and support from others in times of need? ( ) Yes ( ) No

i) Expect things to change for the better in the future? ( ) Yes ( ) No

4. I am yearning for . . .

a) Love ( ) Yes ( ) No

b) Acceptance ( ) Yes ( ) No

c) Validation ( ) Yes ( ) No

d) A purposeful life ( ) Yes ( ) No

e) Meaningful living ( ) Yes ( ) No

f) Freedom make my own choices ( ) Yes ( ) No

5. I am . . .

a) A spiritual being ( ) Yes ( ) No

b) A lovable person ( ) Yes ( ) No

c) Hopeful of a bright future ( ) Yes( ) No

d) Important in the universe ( ) Yes ( ) No

THANK YOU FOR YOUR TIME AND PARTICIPATION!

Appendix V

Questionnaire on Suicidal Behaviours in University Students in Kenya.

SECTION A:

Prevalence of Suicidal Behaviours: suicidal thinking, planning, attempts and Self-harm.

- How frequently do students think, plan, attempt and self-harm in your university?
- Do you personally know someone in the university with has suicidal thoughts, planning, attempts and self-harm? (how many and what happened).

SECTION B:

Early Family Environment and Childhood Life Stressors

- What is the impact of family experiences in childhood on a student's suicidal behaviours?
- In what ways do family relations: strong bond with parent/guardians, family closeness, honest emotional expression and reliable family support affect how emerging adults deal with life challenges?
- How did the families of emerging adults enhance their personal growth of positive self-esteem; emotional regulation; seeking help when in need; making personal decisions, and forming relationships outside of the family?
- What value does family involvement in religious and spiritual activities, encouraging moral and spiritual practices, impact student decisions today?
- How did your family receive change or stressful life events growing up?
- What did it take the family to recover from the changes or stressful events?
- What is the relationship between how you solve problems and how your family solved problems?
- What are some of the worst childhood life stressors did you experience before age 12?
- What is the contribution of these childhood life stressors on students' suicidal behaviours?

SECTION C:

Types of Suicidal Behaviours in the University

What suicidal behaviours are university students in your campus engaging in?

What is the general view of your students on mental health and suicidal behaviours?

In what ways are students expressing thoughts of ending their lives?

- How do other students respond to a student, male or female, who expresses death wishes?
- What plans do students make in readiness to end their lives?
- In what ways do students attempt to end their lives?
- What do students think about a student, male or female, who has planned and attempted suicide?
- What self-harming activities are students in your campus engaging in? How frequent?
- What is your estimated prevalence of the number of students engaging in self-harming behaviours?
- What do students do when they know a student, male or female, is engaging in self-harm?
- What can you do to assist a student engaging in suicidal behaviours at your university?

SECTION D:

Reasons and Protective Factors for Suicidal Behaviours

- What are the psychological stressors causing emerging adults in your university to consider suicidal behaviours?
- What is the role of social media, movies, series, and the internet play in emerging adults' suicidal behaviours?
- What emotions are associated with emerging adults struggling with suicidal thoughts, plans, attempt and self-harm?
- How does being spiritual/ religious affect an emerging adult's decision to participate or not participate in suicidal behaviours?
- How do: self-esteem/self-worth, having meaning in life and being hopeful in life influence students' decision to engage or not engage in suicidal behaviours?

SECTION E:

Alternative Responses and Interventions for Suicidal Behaviours.

What can be done at the family front to protect emerging adults in university from engaging in suicidal behaviours?

- What is your university doing to reduce and intervene in emerging adults' suicidal behaviours?

- What resources are available in your university if you have suicidal thoughts, plans, attempts and self-harm?
- Do students use them? If not, what holds them back from using these resources?
- What more should be done to reduce and intervene for emerging adults with suicidal behaviours?
- What can your friends and fellow emerging adults do when they realize a peer is engaging in thinking, planning, attempting to end their lives or is self-harming?

THANK YOU FOR YOUR PARTICIPATION!

Appendix VI

Delphi Tool Round 1 Questionnaire

Marion K. Mutwiri,
Pan Africa Christian (PAC) University,
P. O. BOX 56875-00200,
NAIROBI, KENYA.

RE: INVITATION TO PARTICIPATE AS AN EXPERT IN RESEARCH

I am a student at Pan Africa Christian University, pursuing a Doctor of Philosophy Degree (PhD) in Marriage and Family Therapy. I am required to carry out a research–based dissertation as a partial fulfilment of the doctoral program. My research topic is "The Influence of Early Family Environment on Millennials' Suicidal Behaviours and Self-Harm Among University Students in Nairobi and Kiambu counties, Kenya.'

This study employs the Delphi technique that involves expert opinion with the aim of arriving at a consensus on a topic. The technique involves filling out three questionnaires (also known as rounds), each of which will take 15 to 30 minutes of your time. The aim is to obtain expert consensus on this important topic. As a university therapist/ counsellor, your professional voice on this topic will be highly appreciated. Your participation will be valuable in this research, and hopefully, it will add to your clinical knowledge to assist in the prevention and intervention of suicidal behaviours and self-harm in your university.

The inclusion criteria that I think you might meet include the following:

- A 3-year experience in the counselling/therapy practice.
- Currently working as a university counsellor/therapist.
- Are willing to participate in the study.

If you meet these criteria, I request your VOLUNTARY participation, which will be highly appreciated. There are no right or wrong answers to the questions. The study is seeking your expert opinion. All the information you give on this topic will be treated with anonymity and confidentiality.

Codes will be given to each expert to enhance confidentially.

I think you will find this study process interesting and worth your time. At the end of the study, the results from the consensus opinion will be provided to you. The return of completed Delphi rounds will be considered as consent to participate. Please complete the consent below, and you will receive the round 1 questionnaire. If you have any questions, please email me at marionfly67@gmail.com.

Thank you for your time, and any help you are able to give to this study will be highly appreciated.

Yours Sincerely,
Marion K. Mutwiri
~~*Mkmutwiri*~~
Student ID Number. PMFT6578/16

Are you willing to participate in this study?

If yes, please append your Signature: _____

Questionnaire on Suicidal Behaviours in University Students in Kenya.

Instructions:

This first round of Delphi asks you to answer seven questions. Answer the questions in the provided space, and feel free to give details to your responses. Please begin by completing the demographic questions, as they are important in a Delphi study because they will help the researcher record each panel member's response to the process. After completing the questionnaire, please email it back to the researcher at the email address provided.

Demographic Data

Name: _____

Job title: _____

Department: _____

Employing organization: _____

Gender: ☐ Male ☐ Female

What age are you:

☐ 18 – 25 years ☐ 35 – 44 years ☐ 55 – 65 years

If applicable, please indicate your qualifications.

_____

How many years have you worked with university students since your qualifications?

_____

If applicable, do you work for the university as a full-time or part-time employee?

☐ Full- time ☐ Part-time

Please tick which mental health category you operate in

☐ Psychologist ☐ Counselling Psychologist ☐ Marriage and Family Therapist

☐ Counsellor ☐ Clinical Psychologist ☐ VCT Counsellor

☐ Psychiatri ☐ Career Counsellor ☐ Other _____

Student profile and prevalence of suicidal behaviour and self-harm

a) Describe the profile of university student known as emerging adults aged 18 to 25 years.

_____

_____

b) In your view, how serious is suicidal ideation, suicidal planning, suicidal attempt and self-harm like cutting among emerging adults in the university? (Rate the prevalence on a scale of 1 – 10 where 1 means it is not very serious and 10 means the behaviour is very serious).'

Suicidal ideation or thinking_____ Suicidal planning _____

Suicidal attempt____ Self-harm _____

c) What is the gender ratio you have observed in male and female students in light of suicidal behaviours? (*Male: Female*)

Suicidal ideation or thinking:__:___ Suicidal planning___: _____

Suicidal attempt: _____:_____ Self-harm_____: _____

According to the literature review, early family environment and childhood adversity have been associated with young adult suicidal behaviours and self-harm. A Family Environment Scale by Omar et al. (2010) identifies these four categories as the main dimensions in assessing the family environment. This study will evaluate only two categories, along with stressful life events.

In your clinical experience, which category of the early family environment is the strongest contributor to emerging adults' suicidal behaviours? Please order them from the strongest to the weakest, highlighting the specific area and the reasons for the positioning.

1) Family *Relations* (Strong parent-child bond, closeness, emotional expressiveness, responsive and reliability in times of need)

2) *Personal Growth* (support for positive self-esteem, freedom to make choices, support to self-regulate, solve problems, form close relationships outside the family, seek help).

3) Identify the top 5 *Childhood adversities or Stressful life events* in students' childhood years strongly associated with suicidal ideation, planning, attempts and self-harm.

4) Apart from the early family environment and childhood adversities, what are the top 5 common factors driving students to suicidal behaviours and self-harm?

5) What are the common indicators that a student is thinking, planning, has attempted suicide or is harming themselves? _____

6) In your view, what role does the following play in a student's decision to engage in suicidal behaviours and self-harm in times of distress?

   a. Secure attachment to a parent/guardian

   b. Self-esteem

   c. Devotion to spirituality/ religion

   d. Self-regulation

   e. Problem-solving skills

   f. Social connections

   g. Hope

   h. Congruence

   i. Social media and the internet

7) What resources are available to students to help them deal with suicidal behaviours and self-harm?

   b) Do the students use these resources? ( ) Yes ( ) No

i. If YES, how effective are these resources in dealing with these behaviours?

ii. If NO, what makes them shy away from using the available resources?

_____
_____
_____

8. In your view, which therapeutic model has been effective for you when helping students eliminate or reduce suicidal behaviours and self-harm?

a) Individual therapy models _____

_____

b) Family therapy models _____

_____

c) Medical models

_____

_____

d) Combination models (which is the best combination)

_____

_____

9. Give your professional recommendation on what can be done to reduce suicidal behaviour and self-harm among university students in Kenya.

_____

_____

THANK YOU FOR YOUR TIME AND PARTICIPATION.

Appendix VII

Delphi Tool Round 2 Questionnaire

Thank you for participating in the round one Delphi interview. Welcome to round two out of three rounds of the Delphi interview. This round presents the opinions of the panellists involved in the first round of the Delphi interview. You are required to tick the box with the response you identify with.

Questionnaire on Suicidal Behaviours in University Students in Kenya.

Instructions:

This second round of Delphi asks you to answer seven questions. Identify the response that you agree with on this Google form and send it back. Each panellist has a unique code assigned to you after the first round. This is your identity for the study. Please remember to indicate the code you have been assigned as you fill the second and third rounds of the study because they are important in a Delphi study, as they will help the researcher record each panel member's response on the process.

Panelist Code: _____

SECTION A

Student Profile and Prevalence of suicidal behaviour and Self-harm

b) Please indicate a suitable response that describes the emerging adult in your university. Ensure you respond to each statement.

	Physical characteristics	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1.	Majority are between the age of 18 to 29 years.	1	2	3	4	5
2.	Strong, fit and energetic.	1	2	3	4	5
3.	Achieved the body shape of an adult.	1	2	3	4	5
4.	Living apart from their parents or guardians.	1	2	3	4	5
5.	Struggling with body image.	1	2	3	4	5
6.	Working/running a small business to be financially free from parents/ guardians.	1	2	3	4	5
	Psychological Characteristics	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
7.	Exploring independent identity from the family.	1	2	3	4	5
8.	Changing support systems	1	2	3	4	5
9.	Making important education and career choices.	1	2	3	4	5
10.	Desiring to appear ‘normal’.	1	2	3	4	5
11.	Self-focused	1	2	3	4	5
12.	Optimistic that anything is possible.	1	2	3	4	5
13.	Open to seeking help whenever they are experiencing psychological distress.	1	2	3	4	5

	Social Characteristics	*Strongly Disagree*	Disagree	Neutral	Agree	*Strongly Agree*
13.	Influenced by peer opinions.	1	2	3	4	5
14.	Experimenting with drugs and alcohol.	1	2	3	4	5
15.	Establishing intimate relationships.	1	2	3	4	5
16.	Experimenting with casual sex.	1	2	3	4	5
17.	Developing personal spiritual values independent from the family.	1	2	3	4	5
18.	Actively engaged in a spiritual community.	1	2	3	4	5
19.	Actively use multiple social media					

c) In your view, how serious is suicidal ideation, suicidal planning, suicidal attempt and self-harm like cutting among emerging adults in the university? Rate the prevalence by ticking or circling one of the alternatives for each sentence. (Note the scale was grouped based on the first round questionnaire)

	Prevalence of Suicidal Behaviours	*Not Very Serious* (0 - 2	*Somewhat not Serious* 3 - 4	*Average* 5 – 6	*Serious* 7 – 8	*Very Serious* *9 -10*
1.	Suicidal thinking	1	2	3	4	5
2.	Suicidal planning	1	2	3	4	5
3.	Suicidal attempt	1	2	3	4	5
4.	Self-harming behaviours	1	2	3	4	5

d) In your view, what is the gender ratio you have observed in male and female students in light of suicidal behaviours? (*Male: Female*). Please tick or circle one number to represent the male rate and one number on the female rate to form your ratio of the behaviour stated. (The scale stands for 1 = very low; 2 = low; 3=average; 4=high and 5 = very high)

	The Ratio of Suicidal Behaviours by Gender	Male rate	Is to	Female rate
1.	Suicidal thinking	1 2 3 4 5	:	1 2 3 4 5
2.	Suicidal planning	1 2 3 4 5	:	1 2 3 4 5
3.	Suicidal attempt	1 2 3 4 5	:	1 2 3 4 5
4.	Self-harming behaviours	1 2 3 4 5	:	1 2 3 4 5

SECTION B

Family Environment and Childhood Adversities

1. This section assesses the early family environment and childhood adversities that have been associated with emerging adults' suicidal behaviours.

c) In your clinical experience, which category of the early family environment is the strongest contributor to emerging adults' suicidal behaviours? Please order them from the strongest to the weakest, highlighting the specific area and the reasons for the positioning

Family relations	*Very Weak*	*Weak*	*Neutral*	*Strong*	*Very Strong*
Strong parent-child bond	1	2	3	4	5
Closeness with other family members	1	2	3	4	5
Emotional Expressiveness	1	2	3	4	5
Responsiveness and reliability to members in times of need.	1	2	3	4	5
Support for personal growth					
Support to form a positive self-esteem	1	2	3	4	5
Freedom to make choices	1	2	3	4	5
Support to self-regulate emotions and life setbacks	1	2	3	4	5

Develop problem-solving skills	1	2	3	4	5
Form close relationships with people outside of the family	1	2	3	4	5
Encouraged to seek help whenever one is in need.	1	2	3	4	5

d) Identify in order of strength the Childhood adversities or Stressful life events influencing emerging adults to suicidal thinking, planning, attempts and self-harming behaviours. On the left, write the order of strength, and on the left, indicate how influential the category is.

Childhood adversities or stressful life events	*Very Weak*	*Weak*	*Neutral*	*Strong*	*Very Strong*
Sexual Abuse	1	2	3	4	5
Maltreatment (physical, verbal & psychological abuse).	1	2	3	4	5
Domestic violence in the family	1	2	3	4	5
Separation/Divorce	1	2	3	4	5
Death of a parent or parents	1	2	3	4	5
Absent parents	1	2	3	4	5
Childhood neglect	1	2	3	4	5
Mental illness in the family	1	2	3	4	5
Death by suicide of a family member	1	2	3	4	5
Comparison and favouritism by parents	1	2	3	4	5
Rejection by a parent/guardian	1	2	3	4	5

e) Identify in order of strength the Current Psychological Stressors influencing emerging adults to suicidal thinking, planning, attempts and self-harming behaviours. On the left, write the order of strength, and on the left, indicate how influential the category is.

Current Psychological Stressors	*Very Weak*	*Weak*	*Neutral*	*Strong*	*Very Strong*
Rejection by a significant other	1	2	3	4	5

Problems in a romantic relationship	1	2	3	4	5
Relationship break up	1	2	3	4	5
Drug and alcohol use	1	2	3	4	5
Dealing with the death of a parent/guardian.	1	2	3	4	5

Current Psychological Stressors	*Very Weak*	*Weak*	*Neutral*	*Strong*	*Very Strong*
Academic struggles	1	2	3	4	5
Financial problems	1	2	3	4	5
Having mental symptoms or/and illness	1	2	3	4	5
Peer pressure (YOLO – you only live once)	1	2	3	4	5
Having ongoing family conflicts	1	2	3	4	5

SECTION C

INDICATORS AND PREVENTATIVE FACTORS FOR SUICIDAL BEHAVIOURS

8. What are the common indicators that a student might be thinking, planning, has attempted suicide or is harming themselves?

	Common indicators of suicidal behaviours	Very Very Uncommon	Uncommon	Neutral	Common	
1.	Withdrawing from peers	1	2	3	4	5
2.	Feeling that one is a burden.	1	2	3	4	5
3.	Feeling that the world is better off without them	1	2	3	4	5
4.	Posting messages on social media indicating loss of hope	1	2	3	4	5
5.	Telling someone about the suicidal thoughts	1	2	3	4	5
6.	Telling a friend of their suicidal plan	1	2	3	4	5
7.	Giving away personal belongings	1	2	3	4	5

8.	Having self-harming marks on their body	1	2	3	4	5
9.	Telling a friend of their suicidal attempt	1	2	3	4	5
10.	Having persistent depressive mood symptoms such as hopelessness, helplessness, poor appetite, sleep problems)	1	2	3	4	5
11.	Having trouble keeping up with their academic expectations (trouble attending class, poor concentration and handing in assignments)	1	2	3	4	5
12.	Increase in alcohol and drug use	1	2	3	4	5

9. In your view, what role does the following play in a student's decision on whether to engage in suicidal behaviours in times of distress?

	Factors and their role in the decision to engage in suicidal behaviours	Not Significant	Somehow Significant	Not sure	Significant	Very Significant
1.	Secure attachment to a parent/guardian	1	2	3	4	5
2.	Positive self-esteem	1	2	3	4	5
3.	Devotion to spirituality	1	2	3	4	5
4.	Ability to self-regulate one's emotions	1	2	3	4	5
5.	Having problem-solving skills	1	2	3	4	5
6.	Strong social connections	1	2	3	4	5
7.	Having hope in life					
9.	Congruence (ability to accept self, others and one's prevailing context)	1	2	3	4	5

10.	Involvement in social media and the internet	1	2	3	4	5

SECTION D

University resource to support Students against Suicidal behaviours.

a) Please tick or circle the resources available to students to help them deal with suicidal behaviours and self-harm.

	Resources available to prevent suicidal behaviours	Not Available	Somehow Available	Not sure	Available	Always Available
1.	Reading/audio/video materials such as brochures, recordings/videos and articles on enhancing mental well-being.	1	2	3	4	5
2.	Counselling/therapy at the University counselling centre.	1	2	3	4	5
3.	Peer counsellors to support students at risk.	1	2	3	4	5
4.	Frequent suicidal awareness talks	1	2	3	4	5
5.	Emergency call numbers in case one has suicidal behaviours	1	2	3	4	5
6.	Instructions in the student handbook explaining how to identify and help students with suicidal behaviours.	1	2	3	4	5
7.	Mental health disclosure required during registration	1	2	3	4	5
8.	Faculty send students exhibiting academic and/or psychological challenges for counselling/therapy.	1	2	3	4	5

b) Based on your experience, identify the uses and reasons students have for using or not using the available resources to prevent and intervene in suicidal behaviours.

		Never	Rarely	Sometimes	Often	Always
i)	How do students use these resources?	1	2	3	4	5
ii)	Students use these resources because:					
	They exhibited suicidal behaviours	1	2	3	4	5
	Someone recommended it.	1	2	3	4	5
	They know this is what they need	1	2	3	4	5
	It has helped them or someone known to them before.					
	Their friends believe it is okay to use these resources.					
iii)	Students do not use these resources because:	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
	Fear of stigma	1	2	3	4	5
	Unaware of the resources	1	2	3	4	5
	Ignorant of the signs of mental ill-health	1	2	3	4	5
	Seen as a punishment rather than as supportive tools.	1	2	3	4	5
	The belief that they do not need help	1	2	3	4	5
	Friends disapprove these resources	1	2	3	4	5

SECTION E

Common therapeutic models applied by University Counsellorss

In your view, which therapeutic model has been effective for you when helping students eliminate or reduce suicidal behaviours and self-harm?

Effectiveness of therapeutic models to intervene for suicidal behaviours	Not at all Effective	Slightly Effective	Moderately Effective	Very Effective	Extremely Effective
Individual Theories					
Cognitive Behavioural Therapy (CBT)	1	2	3	4	5
Rational Emotive Behaviour Therapy (REBT)	1	2	3	4	5
Positive psychology	1	2	3	4	5
Dialectical Behaviour Therapy	1	2	3	4	5
Family Therapy Models					
Attachment Theory	1	2	3	4	5
Solution Focused Therapy	1	2	3	4	5
Narrative Therapy	1	2	3	4	5
Bowenian Model	1	2	3	4	5
Satir Model	1	2	3	4	5
Medical Model					
Pharmacological treatment only	1	2	3	4	5
Combined Models					
Individual therapy & Pharmacological treatment	1	2	3	4	5
Individual Therapy, Pharmacology and Family Therapy	1	2	3	4	5

SECTION F

Professional recommendations for reducing suicidal behaviours in Kenyan universities.

Give your professional recommendation on what can be done to reduce suicidal behaviour and self-harm among university students in Kenya.

	Strongly Agree	Disagree	Neither Agree nor Dis Agree	Agree	Strongly Agree
Encourage students to visit the university counselling centres for better well-being.	1	2	3	4	5
Build resilience in students	1	2	3	4	5
Explore talents to keep students busy	1	2	3	4	5
Encourage students with adverse childhood experiences to work through them	1	2	3	4	5
Empower students with problem-solving skills	1	2	3	4	5
Educate students to support their friends when going through psychological distress.	1	2	3	4	5
Increase awareness of risks and preventative factors for suicidal behaviours.	1	2	3	4	5
Encourage frequent psychological screening for mood disorders.	1	2	3	4	5

THANK YOU FOR YOUR TIME AND PARTICIPATION.

Appendix VIII

Delphi Tool Round 3 Questionnaire

Thank you for participating in the round one Delphi interview. Welcome to the last out rounds of the Delphi interview. This round presents the opinions of the panellists involved in the first round of the Delphi interview. You are required to tick the box with the response you identify with.

Questionnaire on Suicidal Behaviours in University Students in Kenya.

Instructions:

This third round of Delphi asks you to answer 7 questions. Identify the response that you agree with on this Google form and send it back. Each panellist has a unique code assigned to you after the first round. This is your identity for the study. Please remember to indicate the code you have been assigned as you fill the second and third rounds of the study because they are important in a Delphi study, as they will help the researcher record each panel member's response on the process.

Panelist Code: _____

SECTION A

Student Profile and Prevalence of suicidal behaviour and Self-harm

e) Please indicate a suitable response that describes the emerging adult in your university. Ensure you respond to each statement.

	Physical characteristics	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1.	Majority are between the age of 18 to 29 years.	1	2	3	4	5
2.	Strong, fit and energetic.	1	2	3	4	5
3.	Achieved the body shape of an adult.	1	2	3	4	5
4.	Struggling with body image.	1	2	3	4	5
	Psychological Characteristics	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1.	Exploring independent identity from the family.	1	2	3	4	5
2.	Changing support systems	1	2	3	4	5
3.	Making important education and career choices.	1	2	3	4	5
4.	Desiring to appear ‘normal’.	1	2	3	4	5
	Sociological Characteristics	*Strongly Disagree*	*Disagree*	*Neutral*	*Agree*	*Strongly Agree*
1.	Influenced by peer opinions.	1	2	3	4	5
2.	Experimenting with drugs and alcohol.	1	2	3	4	5
3.	Establishing intimate relationships.	1	2	3	4	5
4.	Experimenting with casual sex.	1	2	3	4	5
5.	Actively use multiple social media	1	2	3	4	5

f) In your view, how serious is suicidal ideation, suicidal planning, suicidal attempt and self-harm like cutting among emerging adults in the university? Rate the prevalence by ticking or circling one of the alternatives for each sentence. (Note that the scale was grouped based on the first round questionnaire)

	Prevalence of Suicidal Behaviours	*Not Very Serious* (0 - 2	*Somewhat not Serious* 3 - 4	*Average* 5 – 6	*Serious* 7 – 8	*Very Serious* *9 -10*
1.	Suicidal thinking	1	2	3	4	5
2.	Suicidal planning	1	2	3	4	5
3.	Suicidal attempt	1	2	3	4	5
4.	Self-harming behaviours	1	2	3	4	5

g) In your view, what is the gender ratio you have observed in male and female students in light of suicidal behaviours? (*Male: Female*). Please tick or circle one number to represent the male rate and one number on the female rate to form your ratio of the behaviour stated. (The scale stands for 1 = very low; 2 = low; 3=average; 4=high and 5 = very high)

	The ratio of Suicidal Behaviours by Gender	Male rate	Is to	Female rate
1.	Suicidal thinking	1 2 3 4 5	:	1 2 3 4 5
2.	Suicidal planning	1 2 3 4 5	:	1 2 3 4 5
3.	Suicidal attempt	1 2 3 4 5	:	1 2 3 4 5
4.	Self-harming behaviours	1 2 3 4 5	:	1 2 3 4 5

SECTION B

Family Environment and Childhood Adversities

1. This section assesses the early family environment and childhood adversities that have been associated with emerging adults' suicidal behaviours.

    f) In your clinical experience, which category of the early family environment is the strongest contributor to emerging adults' suicidal behaviours? Please order them from the strongest to the weakest, highlighting the specific area and the reasons for the positioning

Family relations	*Very Weak Strong*	*Weak*	*Neutral*	*Strong*	*Very*
Strong Parent-child bond	1	2	3	4	5
Emotional Expressiveness	1	2	3	4	5
Responsiveness and reliability to members in times of need.	1	2	3	4	5
Support for personal growth					
Support to form a positive self-esteem	1	2	3	4	5
Support to self-regulate emotions and life setbacks	1	2	3	4	5
Develop problem-solving skills	1	2	3	4	5
Form close relationships with people outside of the family	1	2	3	4	5
Encouraged to seek help whenever one is in need.	1	2	3	4	5

g) Identify in order of strength the Childhood adversities or Stressful life events influencing emerging adults to suicidal thinking, planning, attempts and self-harming behaviours. On the left, write the order of strength, and on the left, indicate how influential the category is.

Childhood adversities or stressful life events	*Very Weak*	*Weak*	*Neutral*	*Strong*	*Very Strong*
Sexual Abuse	1	2	3	4	5
Maltreatment (physical, verbal & psychological abuse).	1	2	3	4	5
Separation/Divorce	1	2	3	4	5
Childhood neglect	1	2	3	4	5
Comparison and favouritism by parents	1	2	3	4	5
Rejection by a parent/guardian	1	2	3	4	5

h) Identify in order of strength the Current Psychological Stressors influencing emerging adults to suicidal thinking, planning, attempts and self-harming behaviours. On the left, write the order of strength, and on the left, indicate how influential the category is.

Current Psychological Stressors	*Very*	*Weak*	*Neutral*	*Strong Strong*	*Very Weak*
Rejection Parent	1	2	3	4	5
Problems in a romantic relationship	1	2	3	4	5
Relationship break up	1	2	3	4	5
Drug and alcohol use	1	2	3	4	5
Having mental symptoms or/and illness	1	2	3	4	5
Having ongoing family conflicts	1	2	3	4	5
Financial problems	1	2	3	4	5

SECTION C

INDICATORS AND PREVENTATIVE FACTORS FOR SUICIDAL BEHAVIOURS

10. What are the common indicators that a student might be thinking, planning, has attempted suicide or is harming themselves?

	Common indicators of suicidal behaviours	Very Very Uncommon	Uncommon	Neutral	Common	Common
1.	Withdrawing from peers	1	2	3	4	5
2.	Feeling that one is a burden.	1	2	3	4	5
3.	Feeling that the world is better off without them	1	2	3	4	5
4.	Posting messages on social media indicating loss of hope	1	2	3	4	5
5.	Telling someone about the suicidal thoughts	1	2	3	4	5
6.	Telling a friend of their suicidal plan	1	2	3	4	5
7.	Having self-harming marks on their body	1	2	3	4	5
8.	Telling a friend of their suicidal attempt	1	2	3	4	5
9.	Having persistent depressive mood symptoms such as hopelessness, helplessness, poor appetite, sleep problems)	1	2	3	4	5
10.	Having trouble keeping up with their academic expectations (trouble attending class, poor concentration and handing in assignments)	1	2	3	4	5
11.	Increase in alcohol and drug use	1	2	3	4	5

11. In your view, what role does the following play in a student's decision on whether to engage in suicidal behaviours in times of distress?

	Factors and their role in the decision to engage in suicidal behaviours	Not Significant	Somehow Significant	Not sure	Significant	Very Significant
1.	Secure attachment to a parent/guardian	1	2	3	4	5
2.	Positive self-esteem	1	2	3	4	5
3.	Devotion to spirituality	1	2	3	4	5
4.	Ability to self-regulate one's emotions	1	2	3	4	5
5.	Having problem-solving skills	1	2	3	4	5
6.	Strong social connections	1	2	3	4	5
7.	Having hope in life					
9.	Congruence (ability to accept self, others and one's prevailing context)	1	2	3	4	5

SECTION D

University resource to support Students against Suicidal behaviours and self-harm

a) Please tick or circle the resources available to students to help them deal with suicidal behaviours and self-harm.

	Resources available to prevent suicidal behaviours	Not Available	Somehow Available	Not sure	Available	Always Available
1.	Reading/audio/video materials such as brochures, recordings/videos and articles on enhancing mental well-being.	1	2	3	4	5
2.	Counselling/therapy at the University counselling centre.	1	2	3	4	5
3.	Peer Counsellors to support students at risk.	1	2	3	4	5
4.	Frequent suicidal awareness talks	1	2	3	4	5
5.	Emergency call numbers in case one has suicidal behaviours	1	2	3	4	5
6.	Faculty send students exhibiting academic and/or psychological challenges for counselling/therapy.	1	2	3	4	5

b) Based on your experience, identify the uses and reasons students have for using or not using the available resources to prevent and intervene in suicidal behaviours.

		Never	Rarely	Sometimes	Often	Always
i)	How do students use these resources?	1	2	3	4	5
ii)	Students use these resources because:					
	A lecturer or Staff member recommended it.	1	2	3	4	5
	They wanted help.	1	2	3	4	5
	A friend encouraged them to seek help	1	2	3	4	5
	It has helped them or someone known to them before.	1	2	3	4	5
iii)	Students do not use these resources because:	Strongly Disagree	Disagree	Neither agree nor disagree	Agree	Strongly Agree
	Fear of stigma	1	2	3	4	5
	Unaware of the resources	1	2	3	4	5
	Ignorant that suicidal behaviour is a sign of mental ill-health.	1	2	3	4	5
	Seen as a punishment rather than as supportive tools.	1	2	3	4	5
	The belief that they do not need help	1	2	3	4	5
	Friends disapprove these resources	1	2	3	4	5

SECTION E

Common therapeutic models applied by university counsellors

In your view, which therapeutic model has been effective for you when helping students eliminate or reduce suicidal behaviours and self-harm?

Effectiveness of therapeutic models to intervene for suicidal behaviours	Not at all Effective	Slightly Effective	Moderately Effective	Very Effective	Extremely Effective
Individual Theories					
Cognitive Behavioural Therapy (CBT)	1	2	3	4	5
Rational Emotive Behaviour Therapy (REBT)	1	2	3	4	5
Dialectical Behaviour Therapy	1	2	3	4	5
Family Therapy Models					
Attachment Theory	1	2	3	4	5
Solution Focused Therapy	1	2	3	4	5
Narrative Therapy	1	2	3	4	5
Bowenian Model	1	2	3	4	5
Satir Model	1	2	3	4	5
Medical Model					
Pharmacological treatment only	1	2	3	4	5
Combined Models					
Individual therapy & Pharmacological treatment	1	2	3	4	5
Individual Therapy, Pharmacology and Family Therapy	1	2	3	4	5
Individual Therapy and Family Therapy	1	2	3	4	5

SECTION F

Professional recommendations for reducing suicidal behaviours in Kenyan universities.

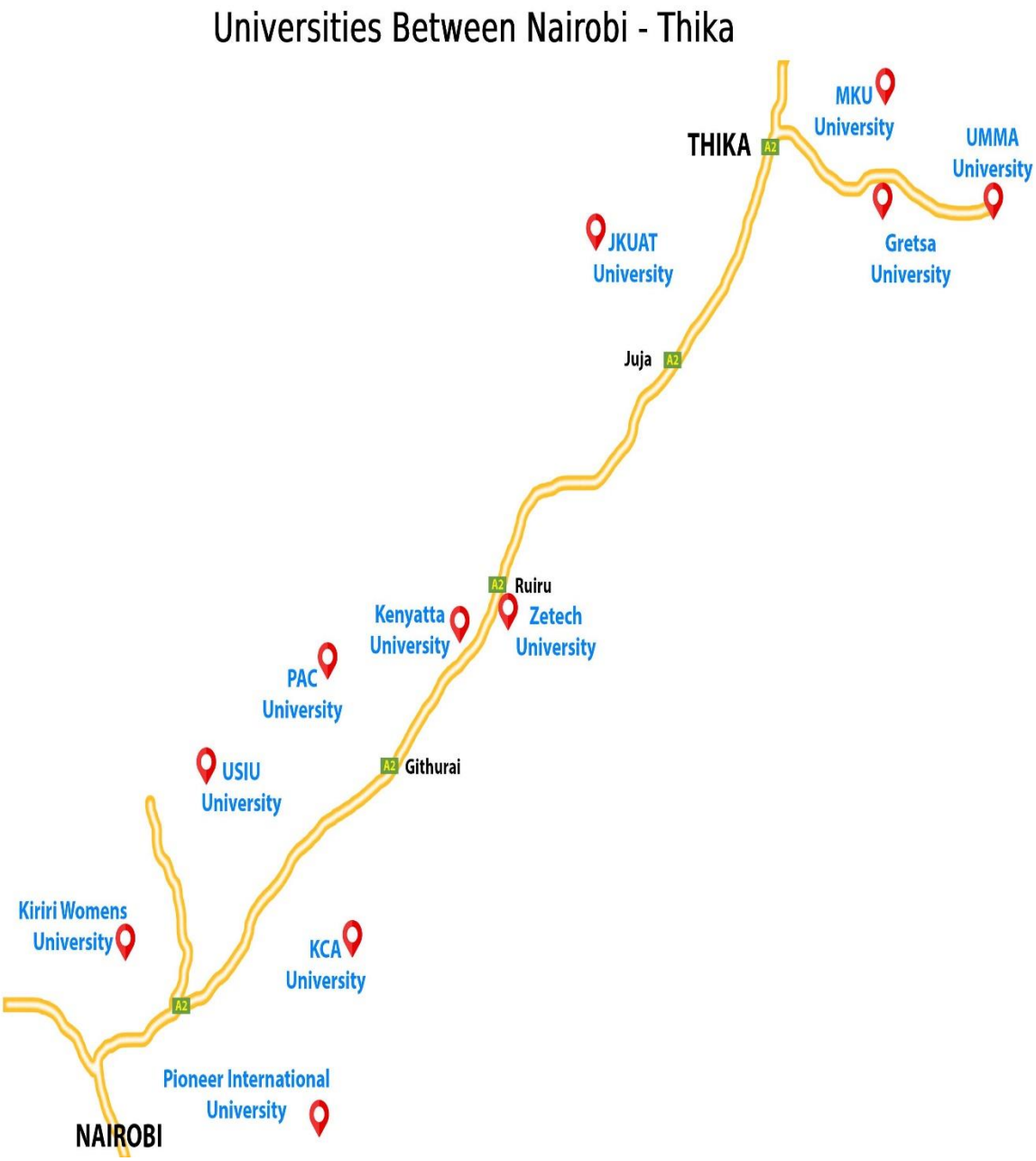
Give your professional recommendation on what can be done to reduce suicidal behaviour and self-harm among university students in Kenya.

	Strongly Agree	Disagree	Neither Agree nor Dis Agree	Agree	Strongly Agree
Encourage students to visit the university counselling centres for better well-being.	1	2	3	4	5
Build resilience in university students	1	2	3	4	5
Explore talents to keep students busy	1	2	3	4	5
Encourage students with adverse childhood experiences to work through them	1	2	3	4	5
Empower students with problem-solving skills	1	2	3	4	5
Educate students to support their friends when going through psychological distress.	1	2	3	4	5
Increase the number of university counsellors.					
Increase awareness of risks and preventative factors for suicidal behaviours.	1	2	3	4	5
Integrate family therapy into the treatment plan.	1	2	3	4	5

THANK YOU FOR YOUR TIME AND PARTICIPATION.

Appendix IX

The Map of Universities Located Between Nairobi City to Thika



Appendix X

Social Statistics for the Survey Respondents and Suicidal Behaviours

	Suicidal thinking	Suicidal planning	Suicidal attempt	Self-harm
Type of university (Private=0, Public=1)	-0.402**	-0.026	-0.264*	-0.177
	(0.182)	(0.121)	(0.138)	(0.111)
Gender (Male=0, Female=1)	0.381**	0.159	0.279**	0.129
	(0.158)	(0.106)	(0.120)	(0.097)
Age in years	-0.171**	-0.110*	-0.102	-0.073
	(0.086)	(0.057)	(0.065)	(0.052)
Year of study				
1st year	Omitted due to collinearity			
2nd year	0.437	0.110	0.117	0.071
	(0.290)	(0.194)	(0.219)	(0.177)
3rd year	0.195	0.058	-0.051	-0.081
	(0.275)	(0.184)	(0.208)	(0.168)
4th year	0.157	0.228	0.200	0.121
	(0.291)	(0.194)	(0.220)	(0.178)
5th year and above	0.199	0.090	0.144	0.032
	(0.394)	(0.263)	(0.298)	(0.241)
Religious affiliation				
Roman Catholic	0.041	0.134	0.532	0.157
	(1.490)	(0.994)	(1.127)	(0.910)
Muslim	-0.105	0.243	0.306	0.179
	(1.503)	(1.003)	(1.137)	(0.918)
Protestant	-0.197	0.090	0.454	0.100
	(1.488)	(0.993)	(1.125)	(0.909)
Hindu	Omitted due to collinearity			
Atheist	0.374	0.705	1.158	0.389
	(1.538)	(1.027)	(1.164)	(0.940)
Other	0.355	-0.007	0.448	0.281
	(1.501)	(1.002)	(1.136)	(0.917)
Family Structure				
Single parent male only parent	0.471	0.008	-0.133	-0.180
	(1.155)	(0.771)	(0.873)	(0.705)
Single parent female only parent	0.539	-0.042	-0.170	-0.136
	(1.114)	(0.743)	(0.842)	(0.680)
Both biological parents(mother and father)	0.661	0.072	0.054	0.013
	(1.095)	(0.731)	(0.828)	(0.669)
Blended family	0.852	0.045	0.416	-0.008
	(1.147)	(0.765)	(0.867)	(0.701)
Brother/sister only	Omitted due to collinearity			

Guardian	1.776 (1.229)	1.103 (0.820)	0.854 (0.930)	1.232 (0.751)
	Suicidal thinking	Suicidal planning	Suicidal attempt	Self-harm
Parenting Styles				
Controlling	0.330 (1.550)	-0.029 (1.035)	0.139 (1.172)	-0.393 (0.947)
Democratic	-0.198 (1.548)	-0.142 (1.033)	-0.059 (1.171)	-0.391 (0.946)
Uninvolved	0.263 (1.571)	-0.016 (1.049)	0.029 (1.188)	-0.266 (0.960)
Very easy	-0.145 (1.567)	-0.340 (1.046)	-0.261 (1.185)	-0.692 (0.957)
Parent's Highest education Level	0.032 (0.061)	0.061 (0.041)	0.005 (0.046)	0.020 (0.038)
Birth Position				
1st born	0.261 (0.337)	0.016 (0.225)	0.116 (0.255)	-0.083 (0.206)
2nd born	0.160 (0.346)	-0.138 (0.231)	-0.028 (0.262)	-0.161 (0.211)
3rd born	0.215 (0.365)	-0.057 (0.244)	-0.063 (0.276)	-0.033 (0.223)
4th born	-0.209 (0.385)	-0.329 (0.257)	-0.260 (0.291)	-0.431* (0.235)
5th born		Omitted due to collinearity		
Other	0.305 (0.438)	-0.209 (0.293)	0.405 (0.331)	0.213 (0.268)
Living arrangements in session				
At home	-0.015 (0.278)	-0.059 (0.186)	-0.038 (0.210)	-0.152 (0.170)
In a hostel around the university	0.252 (0.231)	0.033 (0.154)	0.075 (0.175)	0.007 (0.141)
In the university hostels	-0.370 (0.308)	0.091 (0.206)	-0.076 (0.233)	0.005 (0.188)
In hostels away from the university		Omitted due to collinearity		
Who you live with				
Living with Parents/guardians and siblings	0.082 (0.513)	0.058 (0.342)	0.067 (0.388)	-0.129 (0.313)
School mate	0.341	0.036	0.248	-0.170

	(0.554)	(0.370)	(0.419)	(0.339)
Parent/guardians only		Omitted due to collinearity		
Siblings only	0.178	-0.130	0.136	0.172
	(0.641)	(0.428)	(0.485)	(0.391)
Alone	0.563	0.333	0.267	0.112
	(0.541)	(0.361)	(0.409)	(0.330)
Intimate partner	0.490	0.400	0.344	0.189
	(0.623)	(0.416)	(0.471)	(0.380)
	Suicidal thinking	Suicidal planning	Suicidal attempt	Self-harm
Who you confide in				
Mother	0.094	0.142	-0.094	0.545
	(0.589)	(0.393)	(0.446)	(0.360)
Father	0.020	0.249	-0.207	0.464
	(0.654)	(0.437)	(0.495)	(0.400)
Sibling(brother/sister)	-0.251	0.036	-0.236	0.365
	(0.614)	(0.410)	(0.465)	(0.375)
Relatives	Omitted?			
Peers/friends	0.274	0.394	0.016	0.472
	(0.584)	(0.390)	(0.442)	(0.357)
Pastor/religious leader	0.815	0.652	0.042	0.895
	(0.897)	(0.599)	(0.678)	(0.548)
No one	0.162	0.321	0.194	0.613*
	(0.597)	(0.398)	(0.451)	(0.364)
Other	0.050	0.223	-0.183	0.280
	(0.664)	(0.443)	(0.502)	(0.406)
Constant				
	-0.059	-0.128	-0.032	0.406
	(2.580)	(1.722)	(1.952)	(1.576)
Observations	397	397	397	397
R-squared	0.182	0.157	0.149	0.144

Standard errors are in parentheses
**** p<.01, ** p<.05, * p<.1*