Family group conferences for suicidal adolescents: Promising results from naturalistic case study research

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**ABSTRACT**

Can thwarted belongingness and perceived burdensomeness, risk factors for suicidal adolescents, be turned around by family group conferences? In this case study on Nick, a 17-year-old who undertook six suicide attempts, we (including Nick) share insights and learning opportunities on how family group conferences can be used. The thematic analysis suggests that family group conferences might be a promising intervention for suicidal adolescents. For Nick, the conference was a turning point in his life, correcting perceptions of being a burden, pushing back passiveness, and boosting connection with and support from the broad social network.

Suicide is the second leading cause of death among 15- to 29-year-olds worldwide (Spillane et al., 2020; World Health Organization [WHO], 2018). An increasing number of studies give insight into the profound influence of connection with and support from the social network on adolescents’ suicidal ideation (Czyz et al., 2019; Gunn et al., 2018; Lopez et al., 2020; Scardera et al., 2020; Standley & Foster-Fishman, 2021). Various theories on suicidal behavior acknowledge the social network’s influences, beginning with Durkheim’s (1897), Le Suicide, Schneidman’s (1993) Psychache Perspective, and Joiner’s (2005) Interpersonal Theory of Suicidal Behavior.

The Interpersonal Theory of Suicidal Behavior provides a framework for contextualizing personal risk factors, including suicidal adolescents (Hains et al., 2019; McClay et al., 2020; Opperman et al., 2015). The social influence is reflected in the constructs of thwarted belongingness and perceived burdensomeness. Thwarted belongingness refers to a low level of connectedness and support while perceived burdensomeness comprises self-hate and the perception that the social network would be better off if the person were dead. Although the Interpersonal Theory of Suicidal Behavior refers to a perceived condition, the level of reality is beyond dispute for the person (Smith, 2020). The combination of both conditions combined with the acquired capability to handle pain and fear can lead to suicidality (Barzilay et al., 2015; Joiner, 2005; Van Orden et al., 2010).

In reverse, the social network can work as a protective factor when an adolescent feels connected to and supported by them when facing depression or suicidal ideation (Czyz et al., 2019; Gunn et al., 2018; Lew et al., 2020; Lopez et al., 2020; McClay et al., 2020; Scardera et al., 2020; Standley & Foster-Fishman, 2021). Suicidal adolescents often lack connection, experience little social support, and perceive criticism from parents and friends (Barzilay et al., 2015; Gunn et al., 2018; Hagan & Joiner, 2017; Lopez et al., 2020). Stigmatizing or avoidant reactions made adult suicide survivors feel even more burdensome and isolated from their surroundings (Frey et al., 2017; Rimkeviciene et al., 2015).

Guidelines recommend strengthening the adolescent’s social connections and avoiding clinical admission (American Psychological Association [APA], 2003; WHO, 2018). To prevent a lethal outcome when suicidal behavior occurs, clinical admission, preferably a short period, is understandably frequently used (Lear & Pepper, 2018). Admission can, however, fuel feelings of burdensomeness, thwarted belongingness, and other...
adverse effects such as stigma, augmented self-harm and heightened suicide risk when reentering social life (Amitai et al., 2020; Gill, 2014; Lear & Pepper, 2018; Ougrin et al., 2011).

An antidote to these adverse effects and suicide risk can be appropriate social connection and support (Aggarwal & Patton, 2018; Lopez et al., 2020; Spillane et al., 2020). The growing awareness of the benefits of involving and activating social networks for suicidal adolescents has led to an increase in family-based interventions addressing social networks (Aggarwal & Patton, 2018; Calear et al., 2016; Frey & Hunt, 2018; Hoagwood et al., 2010; Iyengar et al., 2018). The social network addressed, in these interventions, is often limited to close relatives like parents, siblings, and occasionally several adults; we refer to as a narrow social network (Frey & Hunt, 2018). Adolescents and their parents have a wider social network like wider family, friends (from adolescent or parents), parents from friends, neighbors, sports team/coach, and school, to rely on for support; we refer to as a broad social network.

Each person has their influence on the situation and recovery of adolescents and parents. Some studies even showed a more significant influence on peer over family support (Barzilay et al., 2015; Gunn et al., 2018; McClay et al., 2020). Although the broad social network can be crucial to the adolescent’s recovery process, they are not frequently invited to support this. The youth nominated support group taps into the broad social network; approximately 3–4 caring adults were nominated by the adolescent for support after hospitalization and show promising results (King et al., 2019). Instead of appointing a few caring adults, one can also think of inviting the largest possible social network for adolescents and also parents, and siblings to spread knowledge and gather support. It is intricate for professionals to work with the broad social network since therapy takes place outside the social context, and the care system is often not set up for them (Gunn et al., 2018; Nguyen et al., 2017).

When we searched for an intervention to get the broad social network onboard, promote belongingness, and decrease perceived burdensomeness in suicidal adolescents, we came across Family Group Conferences (FGC). In child protection (Corwin et al., 2020; Hollinshead et al., 2017; Pennell et al., 2011; Rauktis et al., 2013; Skaaale Havnen & Christiansen, 2014) and adult mental health (De Jong et al., 2016; Meijer et al., 2017), FGCs helped to broaden social networks and enhance social support, child safety, empowerment, and perceived control over the situation. Some researchers criticize the evidence base of FGCs (Dijkstra et al., 2016; Hillebregt et al., 2019; McGinn et al., 2020), while others argue that the impact of FGC is hard to assess in general considering the complexity of both the intervention itself and the situations in which it is applied (Frost, 2014; Schout, 2020). FGC is, as far as we could verify, not previously used for suicidal adolescents; therefore, knowledge is lacking. As suicidal adolescents are another area in mental health, the available articles provide building blocks for future research like this article. We were eager to explore if FGCs could positively influence burdensomeness and belongingness for suicidal adolescents.

The study aims to explore and understand what a particular FGC brought about for all actors. Therefore, we share insights into the implementation and perceived outcomes of Nick’s FGC. Nick, a 17-year-old at the conference, had chronic suicidal problems, was hospitalized multiple times, and undertook six attempts. As we did not want to speak about Nick without him, he became a crucial knowledge partner and coauthor of this article. This role met his ambition to help other adolescents by telling his story.

### Family group conferences

FGC is a decision-making model that facilitates families to solve problems consistent with their culture, lifestyle, and history (Jackson & Morris, 1999). Clients and their broad social network come together and make a plan for the problematic situation supported by professional expertise. This gathering is called a conference which consists of three phases. The first phase is information sharing, where adolescents, parents, and professionals give information to and answer questions from the social network. In the second phase, private family time, the client, family, and social network construct a plan, describing the tasks and responsibilities of all stakeholders, they all agree on. In the third phase, the plan is presented to the coordinator and the professionals to get input about their concerns and eventually contentment.

FGCs have four characteristics: (1) *widening and strengthening the circle*: a process of seeking openness, support, and commitment of the broad network by inviting various stakeholders like friends/peers, wider family, neighbors, school, and professionals (Pennell et al., 2011); (2) *Independent FGC-coordinator*: a trained citizen organizes the conference free from ties to care organizations (Natland & Malmberg-Heimonen, 2014). The coordinator has over 30 hours to support the client in formulating a central question;
whom to invite (extending the social network); explaining, informing, and exploring viewpoints of the invitees; preparing the physical conference, this all guided by; “Who all want you to be well?” These efforts are critical when dispute or divorce alliances between family and friends are present. The final characteristics are (3) Connecting broad social network resources with professional expertise and (4) Private family time; to make an FGC plan without the presence of professionals or FGC coordinator (Merkel-Holguin, 2004).

The described features make an FGC a powerful instrument to influence perceived burdensomeness and belongingness by intensifying and ensuring the broad social network’s commitment. Surprisingly we have not found any articles that have investigated the impact of FGC on suicidal adolescents. Therefore, we want to contribute to an initial understanding of the process and impact of an FGC for suicidal adolescents through Nick’s case.

**Method**

To provide an in-depth understanding of the FGC’s perceived truth and meaning from multiple stakeholder perspectives, we used a naturalistic case study research design to study Nick’s FGC (Abma & Stake, 2014). Since FGC is a non-routine program with a high degree of ambiguity and a lack of knowledge about success indicators, we considered this study design appropriate (Harrison et al., 2017; Hyett et al., 2014). Nick’s case was studied because it drew the professionals’ and researchers’ attention, as the FGC appeared to work rather well. Furthermore, it was the first FGC for a suicidal adolescent, and it offered significant learning potential. Nick’s case is part of a responsive evaluation on the use of FGCs for suicidal adolescents.

**Participants**

Thirty-six participants were involved in the FGC – 33 were present at the conference, including 27 participants from the social network, of which 10 of Nick’s friends. Twelve participants were interviewed to obtain a representative cross-section of the participants. The participants ranged in age from 17 to 56 years (see Table 1).

As often described within qualitative research, the research team influences the study through their experience and knowledge. It was composed of a doctoral student (the first author), with expertise and interest in the field of FGC and psychiatry; a senior researcher in (public) mental health care who has

| Particpants | Sex | Present at FGC | Active role in FGC plan | Interviewed (Duration) | Remarks |
|-------------|-----|----------------|-------------------------|------------------------|---------|
| Nick        | M   | X              | X                       | X (37 min)             | Client and head person of the FGC |
| Mother      | F   | X              | X                       | X (28 min)             | Left the FGC before private family time. She was not mentioned in the plan. |
| Father/Step-mother | M/F | X              | X                       | X (42 min)             |         |
| Aunt/uncle  | M/F | X              | X                       | X (45 min)             |         |
| Sister Nick | F   | X              |                         |                        |         |

Friends Nick *'(10) | M/F | X | X | X (25 min)* |
Step-brother          | M   | X | X                        |                        |
Grandparents – mother’s side | M/F | X                          |                        |
Uncle                 | M   | X | X                        |                        |
Father’s niece/husband | F/M | X | X                        |                        |
Friend parents         | F   | X | X                        |                        |
Friend’s mother (2)   | F   | X | X                        |                        |
Befriended couple Father | M/F | X | X                        |                        |
Parents of Nick’s friend | M/F | X | X                        |                        |
Family therapist       | F   | X | X (29 min)               | From the group Nick stayed in when he was in care. |
FGC Coordinator       | F   | X | X (40 min)               | The person who proposed the FGC |
Group therapist        | F   | X | X (16 min)               | Supervisor of his treatment plan |
Head therapist         | F   | X | X (15 min)               |                        |
Psychiatrist           | F   | X | X (20 min)               |                        |

F: female; M: male (x) = number of male or female; X: Yes. *10 friends participated in the FGC, and one friend was interviewed.
studied FGC; Nick’s clinical psychologist who arranged and gave Nick treatment; a Professor Child and Adolescent Psychiatry who is a psychiatrist and researcher in the field of Child and Adolescent Psychiatry; a Professor of participation and diversity who has led several studies on FGC; and Nick, the head person who was added later and now works as an expert by experience.

Procedures

After the conference, Nick and his mother were asked and permitted to study their FGC. After this permission, we approached FGC participants for individual interviews. They signed written informed consent for this study. All interviewees were free to decide when and where the interviews were held; the social network chooses their homes and the professionals’ their offices. All names of people, streets, places, and organizations were replaced by a unique code only known by the interviewers. Further contact and participation of Nick were voluntary. The participants were not informed of other interviews from this case other than the aggregated preliminary findings presented in the group meeting. Nick did not have access to the interviews. The research proposal was submitted to the Amsterdam University Medical Center’s scientific research committee and approved under the condition of informed consent, taking into account safeguards concerning privacy, anonymity, and confidentiality (decision nr. 2016.432).

Data collection

A researcher conducted semi-structured interviews with stakeholders approximately 6 weeks after the conference. Interviews consisted of mainly open-ended and closed questions to facilitate a profound understanding of all stakeholders’ experiences and viewpoints. Questions were deduced from former FGC studies and updated for suicidal behavior in adolescence (De Jong et al., 2016; Meijer et al., 2017; Van Orden et al., 2010). New interviews were planned until saturation occurred; that is, no new perspectives and patterns emerged, and a “story” of the case arises. Saturation is an indicator of methodological quality in qualitative research (O’Reilly & Parker, 2013). All interviews were audio-recorded, transcribed verbatim, and a summary of the interview was made sent by email to the interviewee for verification and feedback (member check).

Twelve months after the conference, a group meeting (focus group) with the interviewees was organized to validate the findings of this single case based on a meaningful story (Abma & Stake, 2014). This meeting also provided an opportunity to evaluate the FGC’s influence after 12 months with the question; "To what extend is the main objective achieved" (Stewart et al., 2006). Three years after the FGC, Nick and his mother were interviewed about their view on FGC’s long-term consequences. Audio recordings and transcribes of these two meetings were made and used as data just as field notes made by researchers about noteworthy situations or reflections.

Data analysis

We started with a thematic analysis of the transcribed interviews via Atlas.ti software (Braun & Clarke, 2006). Two researchers independently extracted and coded (open coding) meaningful fragments; these were deliberately compared and discussed to achieve consensus on and increase the credibility of codes (Barbour, 2001; Meadows & Morse, 2001). All codes were labeled and combined to form group codes with closely related themes (data reduction-axial coding), and eventually, these group codes were linked to themes (selective coding). The researchers made a meaningful story (thick description) of the FGC with its main points using these themes (Barbour, 2001).

Transcripts of the group meeting discussion and field notes were used to support and validate the themes and deepen the understanding of this social intervention’s significance and value. The long-term interview transcribes with Nick and his mother was analyzed and compared with the findings of the FGC to determine what corresponded and differed after three years.

A year after this interview, we asked Nick, now an adult male in his twenties, to assist us in interpreting his story. He did this by giving feedback and validating the description of his case in this article. Therefore, the interpretation of this case is co-created by the group meeting participants and later reinforced with Nick’s help, letting the method evolve in a participatory member check (Abma et al., 2020).

The case: Nick, a 17-year-old with recurring suicidal episodes

Nick describes his life between the age of 15–16 years old as marked by turmoil; he was bullied at school, underwent eye surgery, his grandfather died, and his older sister required attention for her problems. Furthermore, he experienced ongoing hostility
between his divorced parents resulting in a loyalty conflict. The turmoil accumulated in severe suicidal thoughts, he kept for himself until a near-fatal suicide attempt with an air gun. After this, he was taken into care and started both psychological and pharmacological treatment. Nick was hard to activate in times of distress, according to his mother and therapists. During these periods, he withdrew himself from social life, felt alone and a burden to everyone. Hereafter he undertook another five suicide attempts before the FGC was brought up.

Nick and his therapist thought that feeling misunderstood by his network, loneliness, and conflicts with and among his parents were triggers for his suicidal behavior. Even after admission, stimuli eliciting his self-destructive behavior were still present, which increased his sense of hopelessness. Nevertheless, admission provided him with contact and understanding of the other clients. According to the therapist, he was not actively engaged in treatment. Nick explained, he had a hard time committing himself to work toward long-term goals in therapy. He often felt hopeless, thinking nobody could change his situation. According to Nick, this likely contributed to quitting school and hardly showing up on appointments with therapists. The negative atmosphere in his group and his inactivity hindered him from establishing a return-home plan. The interventions deployed up to that point did not show sufficient progress. Then his therapist suggested an FGC to him and his mother to breach this passivity:

Being hospitalized so often was a wrong choice because all of the people have problems. You understand each other, but it also influences the wrong direction. [Nick]

**Findings**

The main themes are divided into implementation and perceived outcomes of this FGC (Table 2).

### Implementation of family group conference

**Shame**

At first, Nick was ashamed and reluctant to the proposed FGC as he did not dare to talk to his family and friends about his problems. Besides, he did not want to pull them down. His mother also felt ashamed of not being able to help him and prevent his suicidal actions. She was desperate to find a solution, despite her shame and Nick’s reluctance, and agreed to an appointment with the FGC coordinator. The Center for Family Group Conferencing [Eigen Kracht Centrale] assigned a coordinator who made an appointment. During this appointment, Nick was in the same room behind his computer; nevertheless, he became involved in the conversation. The FGC coordinator commented, “I saw how he turned the volume down, and after that, he had some questions. He agreed on an appointment with the two of us and took an active role in the process.” Nick related that he finally agreed to the FGC because his best friend said, “Just do it.”

### Widening the circle

Determining whom to invite was difficult for Nick due to his shame and fear of burdening people. First, he asked his closets family and friends to keep it safe. He started with his best friend and mother’s family. He explained that after experiencing their willingness to come, he was inclined and activated to invite more people. The FGC coordinator described, “Nick was surprised that people were willing to do this for him and wanted to be a part of it. When he realized this, more people were allowed to come.”

Nick’s best friend recommended inviting his other friends as they knew about his attempt, and this could give them clarity on the situation. Due to his parents complicated divorce, their parents and families were not on speaking terms, making it hard to invite both sides. The FGC coordinator and group therapist tried to involve Nick’s father and his family as this was a delicate point. Although Nick’s mother thought their network was too small, 33 persons were present at the conference.

### Sharing

Nick formulated the leading question for the FGC with his therapist and the coordinator during preparation. It focuses on enhancing his sense of belonging, especially when he felt worthless: “You are informed about my emotions to understand me better, and if I am not feeling well, I can come to you, and I will not isolate myself instead. Do you want to think along to prevent this isolation?” This question was shared with
his social network during preparation and expressed again in the conference’s first part. After that, Nick and his family therapist shared information about his difficulties and made explicit what he needed from his social network. Nick explained, “When I cancel appointments, I don’t want contact, but people around me should hold on because it helps me feel better afterward.”

Nick’s open attitude, information, and the answers on questions brought about a social network with a more realistic view of his situation, needs, and how to react to his (suicidal) behavior.

People wanted to help but did not know how and what to do. There was also fear. People were afraid that they would do something wrong and that he would kill himself. In the FGC, Nick was open about his problems and about the most important thing they could do just to let him see he is not alone. [Father]

In the private family time information sharing changed in sharing viewpoints, emotions, and possible solutions for the FGC-plan. In the beginning, some of the participants felt tension related to divorce alliances and ongoing conflicts between parents. Nick intervened, with his friends’ support, in a quarrel between his father and his father’s niece, as he wanted to go on with the FGC plan. Mainly the adults came up with the FGC plan. Fortunately, his friends interfered when solutions were inappropriate for their age. Like filling his schedule, a whole week ahead.

**Implementation FGC plan**

The coordinator distributed the FGC plan to all the participants. Nick and his social network held three follow-up meetings to discuss the progress of the FGC plan in his father’s house. A neutral location was missing, given the tension between his parents and other participants. Nick reflected, “I think it would have helped if we had met in a neutral location. It felt as they (father and wife’s house) had an advantage, which was difficult. In a neutral environment, someone can leave.”

The professionals referred to the FGC plan when he had a hard time but never incorporated it in their crisis plan. At that time, Nick preferred to keep these two worlds and plans separated. He wanted the support of his social network as much as possible without burdening them in crisis times. In these times, safety and containment should come from the professionals. He said, “When you are in crisis, I think it is good to be protected for yourself, instead of sleeping for a night at your grandparent’s house.”

In retrospect, Nick and his psychiatrist saw the advantages of an integrated plan over a separated professional and FGC plan. The psychiatrist explained this gave Nick an advantage because:

He could escalate his behavior in contact with the professionals, and his network would not be confronted with that. As he said himself, such behavior had more consequences with his network than with the professionals.

Looking back, Nick and his social network would have preferred the FGC to be held earlier on. In reality, it was not that straightforward, while Nick needed more stability, and too much was going on after his first attempt.

**Short and long-term perceived outcomes**

**Belonging**

According to several participants, Nick’s behavior changed from a passive to a more active attitude during the preparation. He invited over 30 persons and felt responsible for co-organizing the FGC. Nick described the FGC as reinforcing his perception of being loved and belonged through the presence of people who actively supported and cared for him and his mother:

At first, you don’t want to involve people, but at an FGC, you see that people care for you, and knowing that makes it easier. Before the FGC, I went to my mother if something was bothering me, and after I knew, there are 25 people that I can call.

He remained allied with the social network that helped him organize (social) activities and a job. He started working, selected a school, got together with friends more often, and felt happier and less suicidal. He stayed activated with support from the FGC plan and commented, “Agreements you make, with the people around you, you have to catch up with. You can’t ask them something and do nothing yourself.”

**Understanding and support**

Nick experienced that his social network understood his needs and dealt with his problems in a more appropriate way due to the acquired information. Nick fueled their understanding by sharing knowledge and being open about his issues. Information boosted the mental and physical support of the social network. His aunt said, “In the FGC, we got a better idea about Nick’s problems, what we could do, and how to deal with his suicidal thoughts.” His friends were an essential part of his social network’s support; it was a big step to invite them. Nick described, “some I had not
seen for a long time; I hardly ever saw them. And then suddenly they support you, and you are given the feeling you are not alone. That impressed me the most."

Nick’s friends improved their understanding of Nick’s problems and his therapy through the conference. They supported and motivated him to go to therapy, school, and work with the obtained information. Friendships were renewed through the FGC resulting in frequent contact and doing fun activities together. Despite his problems, he felt cared for by his friends and they saw his progression. A friend commented, “Now he has fun and ingenious ideas. And before, he was a quiet boy. Now he loosened up a bit, and I think that’s funny. Indeed, if you see him almost every week, you see him progressing, which is nice.”

**Participation of Nick’s father**

Although Nick’s parents didn’t want to be in a room together, the coordinator managed to get them and their social networks at the FGC together. The neutral coordinator and location of the conference supported this. Nick’s family therapist asserted, “All respect for the people around them who have been able to put their problems aside to be there for Nick.” This led to increased and improved contact in the months after the FGC, this lessened tension between both social networks. According to Nick, he did not feel supported and understood by his father’s wife, making the three follow-up meetings in his father’s house challenging.

**Overcoming difficulties**

All participants noticed that Nick got more power to deal with his problems. He appeared more frequently on individual and systemic family therapy appointments and started working on painful issues. Nick reflected, “The contact with my friends helped me to be more indifferent regarding the quarrels of my parents. Sometimes I feel down, to have fun with my friends is a good distraction.”

**Durable outcomes**

The follow-up meetings contributed to retaining his network’s support and awareness of his needs. During the conference and follow-up meetings, the impact of the tension between his parents and Nick’s loyalty problems were not discussed. In hindsight, the participants acknowledged their possible de-escalating role. Nine months after the FGC, Nick withdrew himself from social life and quit school. The family therapist explained that Nick’s mom put pressure on him while his increased contact with his dad was challenging for her. In addition, Nick felt tension between him and his dad’s wife when visiting his dad and her. During this time, he contacted his therapists more often because he experienced more suicidal thoughts. When this got worse, he was hospitalized for a few days. Nick and his social network were glad he got special care for a few days. During these days, an additional meeting with his network was organized to make a plan to return home safely. Given this event, Nick’s psychiatrist regarded the plan to have failed because admission was needed; however, Nick saw it differently:

> Sometimes I feel so rotten, and then it is a relief to talk to therapists and be with others [adolescents in the treatment group] who know how it feels. When I feel a little bit better, I like to do activities with my friends again.

For a more durable outcome, the psychiatrist concluded that the professional and FGC plan have to be merged, with precise actions for the social network to do in case of suicidal behavior. According to the psychiatrist, the network should be activated during the process leading to a crisis.

**A turning point**

In the long-term, the FGC was the start of positive change in different areas of his life. Even after three years, he referred to it as a turning point in his life. Step by step, he learned to deal with his depressed moods by staying active. He still has a job, a fulfilling social life, and education; taking this into account, Nick rated his life a seven to eight out of 10: “The two years after [the FGC] were still a mess, but I have learned a lot and now know how to deal with it.”

Feeling lonely is not an all-pervasive part of Nick’s life. He talks to his uncle and best friend in difficult times. The FGC contributed to Nick’s confidence and helped him be open about his problems to his friends and family. In difficult moments, they metaphorically gave him a kick in the ass, which he accepts from them. He frequently meets up with his friends, and they support him when needed, like getting him a job when he stopped going to school. This job means income and a meaningful fulfillment of his day. In his view, he only needed the FGC to get his life on track. His mother is grateful of the positive effect the FGC has; the support she felt during and after the FGC; the way her son picked up his life. She commented, “It was just surviving; I still have very caring people around me, which helped me get through it.”
Discussion

FGC presents an alternative approach to redirect a pattern of social isolation, passive attitude, and short-term hospitalizations of an adolescent with chronic suicidal ideation by bolstering social support and connection. Through the turmoil in his life “the need to belong” was unmet, resulting in thwarted belongingness and perceived burdensomeness (Czyz et al., 2019). This pattern was redirected by support from his broad social network through a Family Group Conference. The FGC made belonging tangible and corrected his idea of being a burden as his social network came to the conference, made a plan, and carried this out. This resulted in an energetic attitude, more problem-solving capabilities, and a connection with his broad social network. As his social network understood his behavior, saw his needs, and felt capable of supporting him and his mother, this improved the quality and quantity of their support. His suicidality became less profound with sporadic setbacks and less or shorter hospitalization needed, as seen in other family-driven approaches (Frey & Hunt, 2018). Transfer to the social network, after hospitalization, was more fluent as they tended to support his sense of belonging. The impartial coordinator and the neutral conference location supported these results, providing safety to come and express themselves considering ongoing conflicts between his divorced parents. These findings are consistent with other studies on the application of FGC in different target groups (De Jong et al., 2016; Pennell et al., 2010, 2011; Rauktis et al., 2013; Skaale Havnen & Christiansen, 2014).

The durability of these outcomes is apparent as the FGC benefits were still present after three years. Instead of feeling lonely, he has a job, education, contact with his friends, and he relies on his best friend and uncle in challenging times. This sustainable impact seems to underline the importance of the social network’s active involvement in the care given to these adolescents and their families (Conner et al., 2007; Van Orden et al., 2008). Possibly the outcomes would have been bolstered by making a constructive plan for Nick’s loyalty problems with arrangements about de-escalating tension between his parents. As practiced in an FGC, the broad social network should be considered by professionals in suicide prevention for adolescents.

The study’s outcome could have been influenced by Nick’s psychological and pharmacological treatment and possibly numerous other factors and events. On the other hand, the focus of this study was on making sense of the perceived reality of the participants in the given context (Nicolini, 2012; Punnett et al., 2017). Considering the findings in this paper, further research is needed to deepen the lessons learned from this case study. Four issues arise.

First, the FGC led to a breakthrough of the negative spiral of dismissal, social isolation, readmission, increased hopelessness, and suicidal ideation. Could the FGC, applied in an earlier stage (for instance, before admission), have prevented this negative spiral and fulfilled his need for belongingness? Regarding the advice to hospitalize these adolescents as little and short as possible (APA, 2003), future research is needed into FGC’s capacity in activating social networks, ensuring safety, and preventing hospitalization in other cases of suicidal adolescents. Instead of resulting in procedures around FGCs, we suggest making active use of the right to plan with the broad social network when safety problems arise. Recommendations on implementing FGC could be made with best practices from future implementation and research to optimize FGC based on expert knowledge and learning experiences of those involved.

Second, before the FGC, Nick’s family expressed their worries, tended to take over, and doing so subsequently increased his feelings of being a burden. They needed to go through a process of awareness about how to interact with each other and to activate and widen the social network for his wellbeing. Professionals are the first to make adolescents aware of the possibility of an FGC. They can motivate them to use FGC as a platform to create openness, discuss feelings of being a burden, express needs, and take the lead. This requires professionals with insights into the dynamics of suicide and the modesty to let the social network do the work armed with professional knowledge. Further research is needed into the delicate process of shame about the suicidal ideation, giving information and asking attention for provoking factors, like a complicated divorce, without the professionals taking over the process.

Third, due to the tensions between his parents, Nick faced loyalty problems and limited room for maneuver. These problems fueled his feelings of perceived burdensomeness and thwarted belongingness and, consequently, his suicidal behavior. In hindsight, most participants acknowledge that his loyalty problems should have been discussed and considered in the FGC plan. While many people who die by suicide come from broken homes, this appears to be relevant...
for future cases (Bridge et al., 2006). The FGC could bring a broader network to the stage diminishing the tensions and bringing more balance for the adolescent in the conflict between the parents.

Fourth, looking back, the psychiatrist and Nick missed an integrated plan. The separated professional and FGC-plan were like two ships that pass in the night, revealing how difficult it is to combine contexts which speak different languages and are not used to work together. When professionals actively pursue, contribute, and reinforce an integrated FGC plan, the impact of FGC’s might even increase. In future FGC use, it is recommended to make and use an integrated plan.

This case demonstrates that involving the broad social network through an FGC is a potentially powerful and practical approach to change perceptions of belongingness and burdensomeness, as suggested in several studies (Gunn et al., 2018; Lopez et al., 2020; McClay et al., 2020). Connecting the adolescent with his broad social network through an FGC materialized belongingness. All participants expressed interest and offered to support him and his parents with their acquired knowledge. Based on these insights, we suggest that involving the broad social network for suicidal adolescents should always be considered. These insights provide a starting point for future research on broad social networking for suicidal adolescents in mental health care. To promote a sense of ownership for all actors, we recommend participatory health research (Abma et al., 2019) to foster a learning community to explore conditions for ensuring safety, strengthening the feeling of belonging, changing the perception of being a burden, and how to attune the contribution of formal and informal care.

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