IT TAKES A VILLAGE: THE ROLE OF FAMILIAL SUPPORT ON SUICIDAL IDEATION IN YOUNG RAINBOW (LGBTQIA+) MĀORI AND PASIFIKA ADULTS

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ABSTRACT

Aotearoa New Zealand has some of the highest suicide rates for young people in the OECD, particularly among Māori and Pasifika aged under 25. The impact of colonisation, globalisation, and acculturation poses a challenge to the mental health of many Māori and Pasifika, particularly those who face multiple sources of stigmatisation by belonging to an ethnic minority as well as identifying with a diverse gender, sexuality, or both. As collectivistic cultures, family has been highlighted as essential for the wellbeing of these communities. The current study investigated whether familial support protected against passive suicidal ideation in young rainbow (LGBTQIA+) Māori and Pasifika adults. Additionally, group differences between rainbow and non-rainbow participants on suicidal ideation and familial support were also explored. A non-purposive sample of 63 young adults who identified as Māori, Pasifika, or both, were recruited through community postings and undergraduate psychology courses. Participants completed an online survey including questions about demographics, familial support, and passive suicidal ideation. Higher levels of familial support were associated with lower levels of suicidal ideation for both rainbow and non-rainbow participants, with rainbow participants experiencing lower levels of familial support, on average, compared to their non-rainbow counterparts. Rainbow participants also had higher levels of suicidal ideation compared to the non-rainbow participants, however, rainbow identification alone did not predict suicidal ideation when accounting for familial support. These findings reaffirm and expand on past research and are discussed within their cultural contexts. The present study emphasises the intertwined nature of Māori and Pasifika families and the importance of considering family inclusion in mental health interventions for these populations. In addition, the findings suggest that families may need to be equipped with culturally appropriate resources in order to better support their rainbow loved ones.

INTRODUCTION

Suicide is a major public health concern, close to 800 000 people die by suicide every year, which is one person every 40 seconds (World Health Organisation (WHO hereafter), 2018). Globally, suicide was the second leading cause of death among 15-29 year olds in 2016 and in Aotearoa New Zealand the suicide rate for young adults is ahead of most other OECD[1] nations (26.87 deaths per 100,000 people aged 20-24 years between July 2018 – June 2019; Coronial Services of New Zealand, 2019; WHO, 2018). Deaths by suicide for Māori and Pasifika[2] populations have recently peaked in 2018/2019, with suicides clustered in the youth age range of 15 – 24 years before gradually declining over the age span (Coronial Services of New Zealand, 2019; Tiatia-Seath et al., 2017). Recently, it was found that over half of suicide deaths among Pasifika in New Zealand were among those aged under 25 years (Teevale et al., 2016).

Within this cohort aged under 25, the rainbow (sexual minority and gender diverse) sub-population experiences myriad health disparities compared to their cisgender (denoting or relating to a person whose gender corresponds with their sex assigned at birth) heterosexual counterparts (Fraser, 2019; Lucassen et al., 2011). Research on the intersection of ethnicity and gender and sexual identity is sparse, however, one nationally representative survey among high-school aged Māori students revealed that those who identified as gay, lesbian, or bisexual were at higher odds for attempting suicide (Clark et al., 2013). Similarly, there is little research on the LGBTQIA+ (lesbian, gay, bisexual, transgender, queer, intersex, asexual, and others) Pasifika population, however some evidence suggests that sexuality and sexual orientation are risk factors for suicide among Pasifika youth (Bathgate & Pulotu-Endemann, 1997; Puna, 2014). The health inequities of the Māori, Pasifika, and rainbow communities have been well

[1] Organisation for Economic Cooperation & Development.
[2] *Pasifika* is a collective term referring to people of Melanesian, Micronesian, or Polynesian descent, heritage, or ancestry who have migrated to or have been born in Aotearoa New Zealand (Ministry of Education, 2013).

documented, however, one facet that has been continuously highlighted as protective for all three communities is the presence of family connection and support (Lucassen et al., 2014; Newcomb et al., 2019; Teevale et al., 2016). The focus of the present study is to build on what works in these communities. In particular, whether familial support is also a protective factor in young rainbow Māori and Pasifika adults, a sub-population whose presence in research is yet to be established.

Suicide in Aotearoa New Zealand

Suicide rates in Aotearoa New Zealand have slowly climbed over the years. Rates first peaked in 1998 when 577 people died by suicide with the country bearing the highest number of youth suicides in the OECD (WHO, 1999). In that same year, suicide was the second leading cause of death in the 15 – 24 age group, after motor vehicle accidents (Parliament, 2000). Although suicide rates have fluctuated throughout the years, the previous years' findings document 685 people died by suicide between June 2018 and June 2019, the highest number of recorded deaths by suicide to date (Coronial Services of New Zealand, 2019). During this same period, 164 people from the ages of 15 – 24 died by suicide, representing nearly a quarter of the total. More recently, suicide rates have fallen to 654 suicide deaths in total between June 2019 and June 2020 (Coronial Services of New Zealand, 2020), however, these numbers are still concerning. Suicide rates have increased among youth and young adults (aged from 15 – 24) in contrast to adults aged 45 years and older (Snowdon, 2017). A number of intersecting factors associated with youth suicide attempts include socioeconomic demographic factors, constrained education opportunities, poor family relationships, hopelessness, internalising behaviour (e.g. depression and anxiety), externalising behaviour (e.g. anti-social behaviours and aggression), and a history of suicidal behaviour among close contacts (Gluckman et al., 2017). The changing environmental, financial, technological, and sociological climate has been

recognised as being a potential driver of youth suicide; with young people facing a higher number of choices and a higher level of future uncertainty than ever before.

Suicide in Māori Communities

Suicide rates are disproportionately higher for Māori than the general population. Since suicide rates were first recorded in 1996, rates for Māori have gradually climbed, while rates for non-Māori have generally declined (Coronial Services of New Zealand, 2020; Snowdon, 2017). More recently, rates for Māori have marginally decreased between 2018/2019 to 2019/20 from 21.78 to 20.24 deaths per 100,000. Unequal health outcomes for Māori are reflected in higher levels of lifetime risk for mental health conditions, higher levels of sectioning under the Mental Health Act, higher reports of depressive symptoms over the previous two weeks, and higher suicide rates, compared to other ethnic groups in Aotearoa New Zealand (Baxter, 2008; Coronial Services of New Zealand, 2020; Ministry of Health, 2017; Russell, 2018). Findings from the New Zealand Mental Health Monitor and Health and Lifestyles Survey revealed that the majority of Māori feel happy and positive about their lives, however, despite this positivity a large proportion of Māori still face significant mental distress compared to their non-Māori counterparts (Russell, 2018). Rangatahi Māori (youth) aged from 15 to 24 were significantly more likely to report feeling unable to cope with stressors compared to any other age group. These findings are in line with the higher rate of suicide among young Māori compared to older Māori, whose suicide rates are lower than those of their non-Māori counterparts (Beautrais & Fergusson, 2006). One explanation attributes these higher rates of suicide among rangatahi Māori to disadvantage experienced within Aotearoa - seen in health, education, welfare, and justice sectors (Durie, 2001). This explanation assumes that when disadvantaged experiences are accounted for, suicide rates should be similar for both Māori and non-Māori of similar backgrounds (Ferguson, 2005).

Another explanation posits that higher rates of suicide are unique for Māori and indigenous populations due the impact and experiences of colonisation. These experiences include cultural alienation, land loss, economic impoverishment, social change, and institutional racism which hold negative long-lasting effects for Māori (Lawson-Te Aho, 1998). Colonisation has resulted in Māori having less access to services and less favourable outcomes from services that are accessed (Health Quality & Safety Commission New Zealand, 2019). In Youth 2000, a nationally representative secondary school survey, it was found that having a strong cultural identity was integral for positive mental health outcomes in rangatahi Māori. However, ethnic discrimination affected this relationship and was associated with poorer wellbeing, increased depressive symptoms, and suicide attempts (Williams et al., 2018). Causes for higher suicide rates for rangatahi Māori may also lie in the individualisation of society, which is in conflict with Māori (and other indigenous) traditional values of identifying as a collective, first, and an individual, second (Robson & Reid, 2001).

Families in Māori Communities

Whānau is essential for identity, belonging, and wellbeing. Whānau includes nuclear and extended family but also encompasses emotional and spiritual dimensions based on whakapapa (ancestry) (Moeke-Pickering, 1996). Family connection is associated with lower suicide risk across all levels of risk for rangatahi Māori if they perceive their families as caring and supportive (Clark et al., 2013). Whanaungatanga (kinship) is developed and maintained through shared experiences involving responsibilities, obligations, and commitments that foster whānau cohesion and cooperation (Reilly, 2004). Whanaungatanga connects an individual to their kin and ancestry, providing a sense of belonging and strengthening each member of the whānau (Berryman, 2008). Many Māori health models place whānau as central to whaiora (wellness). For example, whānau represents one of four walls in the Te Whare Tapa

Whā[3] model, the head in the Te Wheke (the octopus) model, and the second of two hulls in the Meihana[4] model (Durie, 1994; Pere, 1991; Pitama et al., 2007). Among a strong cultural identity, whānau support and harmony are key protective factors against suicide (Booker et al., 2010). Whānau inclusion has been recognised as integral for Māori mental health with many services now oriented to include the family in decision making.

Suicide in Pasifika Communities

Similar to Māori, the majority of Pasifika people report high levels of overall wellbeing, however, young members (aged from 12 – 18) are three times more likely to attempt suicide than their New Zealand European peers (Ataera-Minster & Trowland, 2018; Teevale et al., 2016). Pasifika people report significantly higher mean psychological distress and depressive symptom scores than other ethnic groups, particularly for young Pasifika individuals (aged 15 – 24) (Ataera-Minster & Trowland, 2018). This is reflected in the highest rates of suicide for Pasifika occurring within this age range for nearly two decades (1996 – 2013) (Tiatia-Seath et al., 2017). Some qualitative data indicate that risk factors for suicide in the younger community include family conflict, increased familial obligations, failing to meet familial expectations, sexuality and sexual orientation, intergenerational misunderstandings and acculturative stress (Bathgate & Pulotu-Endemann, 1998). Multi-ethnic Pasifika people experience higher levels of mental distress than sole-Pasifika people, potentially due to the complexities involved in navigating multiple cultural spaces and struggling to be accepted by each ethnic group (Ataera-Minster & Trowland, 2018; Berking, 2007).

Acculturation as a risk factor for mental illness in migrated Pasifika youth has been well documented (Samu & Suaalii-Sauni, 2009; Tucker-Masters & Tiatia-Seath, 2017; Vaka et al., 2009). Aotearoa-born Pasifika individuals and those who migrated at a younger age have

[3] Māori health model based on a house with four walls (the four cornerstones of Māori health).
[4] Māori health model based on a double-hulled canoe influenced by four ocean currents and winds.

higher levels of mental illness, suicidal ideation, and suicide attempt than Island-born individuals who migrated to Aotearoa in adulthood (Foliaki et al., 2006; Kokaua et al., 2009), highlighting the impact of cultural assimilation, sociological change, as well as the importance of cultural identity on wellbeing (Tiatia, 2003). The authors of the 2006 New Zealand Mental Health Survey (NZMHS) estimated the 12-month prevalence of suicidal ideation for Pasifika people at 4.5%, with 1.2% of the Pasifika sample having attempted suicide (Foliaki et al., 2006). It was also found that those aged between 16 – 24 reported the highest rates of suicidal ideation and attempt over a 12-month period (Oakley Browne et al., 2006). The more recent 2016 NZMHS reported high levels of social connection within the Pasifika community, with half of the respondents reporting family and friends as a first point of contact in times of distress (Ataera-Minster & Trowland, 2018). However, it was also reported that compared with other ethnic groups, Pasifika respondents held more negative views towards people struggling with their mental health than other ethnicity groups (Deverick et al., 2017). Pasifika individuals may face conflict when their first points of contact for mental distress hold stigmatising views towards mental health, ultimately acting as a barrier to help seeking.

Families in Pasifika Communities

Pasifika communities are each unique. There are many shared traditional understandings of kainga[5] that encompass extended members, village, and community. Family is the core of the community and, for many, family underpins one's self and social identity (Ledoux-Taua'aletoa, 2019; Meleisea & Schoeffel, 1998). Furthermore, many Pasifika do not distinguish themselves from their kainga, as described by Efi (2009):

> I am not an individual, I am an integral part of the cosmos. I share divinity with my ancestors, the land, the seas and the skies. I am not an individual, because

[5] Meaning *family* in Tongan.

> I share a tofi (inheritance) with my family, my village and my nation, I belong to my family and my family belongs to me. I belong to my village and my village belongs to me, I belong to my nation and my nation belongs to me, this is the essence of my sense of being. (Efi, 2009, pp. 51)

Recently, Teevale et al. (2016) found that young Pasifika people with low levels of family connection (those who weren't able to talk to parents or siblings about their problems) had an almost three times higher odds of attempting suicide compared to those with higher levels of family connection. Teevale et al. (2016) also found that students with low family monitoring had twice the odds of attempting suicide compared to those with high family monitoring. Although family can be a source of conflict, their inclusion in mental health interventions and suicide prevention strategies are imperative. The importance of family inclusion was reinforced in a study where Pasifika participants who had experienced a suicide attempt and/or suicidal ideation discussed their engagement in mental health services and what Pacific strategies for suicide prevention should look like; one participant remarked that problems cannot be isolated without involving the family (Tiatia-Seath, 2014, pp. 117). The centrality of family for Pasifika people's health and wellbeing is captured by family underpinning many Pasifika health models. Families are represented collectively with the consumer in the Seitapu[6] framework, as the foundation of the Fonofale[7] model, and as the second level in the Fonua[8] model (Pulotu-Endemann, 2001; Pulotu-Endemann et al., 2007; Tu'itahi 2009). Despite experiencing high levels of mental health distress, Pasifika people (especially youth) have low rates of referral to mental health services indicating a need to identify culturally competent strategies to ensure these needs are met (Oakley Browne et al.,

[6] Pasifika mental health framework based on a flower, when placed on the head (consumers and families), the flower (framework) becomes tapu (sacred).
[7] Pasifika health model represented by a fale (house).
[8] Pasifika model of wellbeing represented by five levels and dimensions. Fonua refers to the relationship between land and the people.

2006; Tiatia-Seath, 2014). Family inclusion in suicide prevention needs to be prioritised, however, family may not necessarily be relatives but instead other community groups (e.g. church) (Samu & Suaalii-Sauni, 2009).

Rainbow Communities in Aotearoa

The rainbow community in Aotearoa encompasses all diverse gender identities and sexualities including but not limited to lesbian, gay, bisexual, transgender, intersex, queer, asexual, pansexual, takatāpui, fa'afafine, and fakaleiti. Transgender (or trans*[9]) people are those whose gender differs from sex assigned at birth, and is used as an umbrella term to include trans men (those who identify as men but were assigned female at birth), trans women (those who identify as women but were assigned male at birth), and non-binary people (who identify as neither a man or woman) (Tan et al., 2020). Intersex individuals are born with variations in sex characteristics, reproductive anatomy, or both, who do not fit into the traditional categories of male or female (Lucassen et al., 2014). *Queer*, originally defined as strange or odd, was reclaimed in the early 1990's by the rainbow community to also encompass all sexual and gender minorities (Brontsema, 2004). Asexual individuals are generally not sexually attracted to others, and do not experience interest in or desire for sex (Fraser, 2019). Pansexuality is generally defined as being attracted to others regardless of gender, and is sometimes used interchangeably with bisexuality, however, pansexuality may be explicitly used to acknowledge that there are more than two genders. Although conventional definitions for these terms have been used here, the meanings of these terms may differ across individuals. The culture-specific identities of takatāpui, fa'afafine, and fakaleiti will be discussed in subsequent sections.

[9] The asterisk denotes inclusion of all those within the gender identity spectrum.

There are identified health disparities within the rainbow community in Aotearoa New Zealand. The Christchurch Health and Development study found that non-heterosexual populations are at a higher risk for suicide and mental health problems (Fergusson et al., 1999; Fergusson et al., 2005). Similarly, in a longitudinal study based out of Dunedin, sexual orientation was associated with self-harm, suicidal ideation, and suicide attempt (Skegg et al., 2003). More recently, transgender individuals were found to have an almost nine-fold increase in psychological distress symptoms, a four-fold difference for depression, and more than a five-fold difference for anxiety disorders, compared to the general population (Tan et al., 2020). In a sample of adult Australians and New Zealanders, lifetime suicidal ideation, suicide attempts, and self-harm were more common among transgender members, with recent suicidal ideation associated with lower social support among these participants (Treharne et al., 2020). Studies in schools have shown significant mental health disparities faced by students who are transgender, or attracted to the same sex or both sexes (Clark et al., 2014; Lucassen et al., 2011). As with Māori and Pasifika populations, family support is also a protective factor for the younger rainbow (LGBTQIA+) community (McDonald, 2018). These findings highlight a need for investigation and intervention amongst young rainbow community members but also the importance of strengthening social support in this population.

Māori Rainbow Community

Prior to British colonisation, Māori accepted and embraced diverse genders and sexualities. Traditionally, Māori were open and accepting about sex and sexuality; this was evinced in carvings, waiata (songs), karakia (chants), and explicit pūrākau (stories) (Aspin, 2011). Pūrākau and carvings that have been passed on tell of ancestors with multiple partners throughout their lifetime, sex before marriage holding no stigma, and same-sex relationships as common.

Māori may identify as takatāpui instead of or as well as lesbian, gay, bisexual, or other queer identities. The Māori term *takatāpui*, originally defined as *an intimate companion of the same sex*, was reclaimed in the early 1980s to refer to all Māori with diverse genders and sexualities including whakawāhine, tangata ira tāne, lesbian, gay, bisexual, transgender, intersex, or queer (Kerekere, 2017). As the takatāpui identity connects both Māori cultural identity with gender identity, sexuality, or both, takatāpui build upon and understand their identity through whakapapa, connecting them with their tūpuna (ancestors), whānau, whenua (land), iwi (tribe), and marae (communal meeting place) (Kerekere, 2015). For some, gender and sexuality are embedded in their wairua - the soul, spirit, or essence with which that person is born - and this wairua may be different from their gender assigned at birth. Tipua were supernatural creatures who were able to change gender and form; intersex and trans* takatāpui can be seen as natural forms of tipua (Kerekere, 2015). Māori have long recognised that gender diverse identities exist, these include *whakawahine*, a person assigned male at birth who identifies as a woman, and *tangata ira tāne,* a person assigned female at birth who identifies as a man (Hutchings, 2007).

The Suicide Mortality Review Committee (2016) found that issues surrounding sexuality were significant in at least 7.2% of all deaths by suicide of rangatahi Māori (aged 15 – 24). The effects of bullying were especially significant for Takatāpui males. Takatāpui experience a unique blending of discrimination; from navigating cultural ignorance within the rainbow community to rainbow-related stigma within the whānau and extended community (Clunie, 2017). Minority stress (i.e. the cumulative effects of discrimination and exclusion) may be experienced by both Māori and Pasifika communities and research looking into what fosters wellbeing within these groups is needed to address their elevated risk of suicide (Clunie, 2018; Stevens, 2013) .

Pasifika Rainbow Community

People with diverse genders and sexualities are interwoven within Pacific and Pasifika society fulfilling important cultural functions. A variety of gender diverse identities exist among Pacific populations such as māhū in Hawai'i, vaka sa lewa lewa in Fiji, palopa in Papua New Guinea, fa'afafine in Samoa, 'akava'ine in the Cook Islands, fakaleitī in Tonga, and fafafifine in Niue (recently collectively coined as MVPFAFF) (Alexeyeff & Besnier, 2014; PrideNZ, 2011). Although these identities generally refer to those assigned male at birth who identify as women and fulfil conventional gender roles, this is an oversimplification and each identity exists independently, fulfilling different roles within their own culture. There are commonalities between the MVPFAFF and the LGBTQI+ community, some MVPFAFF may identify as trans*, or have an attraction the same or multiple genders, however, there are some unique additions. For example, fa'afafine and fakaleitī literally translate to 'in the manner of a lady', and are used to describe those assigned male at birth who transverse both the masculine and feminine worlds (Schmidt, 2016). They often partake in important labour within the household (e.g. sewing, decorating, cooking) and performances within the community. In Hawai'i, māhū held a place in traditional society for their ability to occupy both male and female spaces, heal, and perform hula (chanting) and mele (song) (Ikeda, 2014, p. 138). There are also additional responsibilities for some of these MVPFAFF, such as the expectation to take care of parents when they are older (Vaimoso, 2020a). As Pacific people, MVPFAFF are a member of the collective, however, acceptance is another issue.

Following colonisation and the spread of Christianity, these identities have been suppressed and are no longer revered like they once were, akin to the Māori rainbow community's past history (Ikeda, 2014; Schmidt, 2016). It is currently challenging to estimate the number of MVPFAFF in Aotearoa, as they are often categorised as trans* within statistics, however, it's unofficially estimated that there are around 500 fa'afafine in Aotearoa (Schmidt,

2015). Despite diverse Pacific gender and sexualities spanning previous generations, stigma still exists, with only recent moves to develop culturally appropriate frameworks to improve the wellbeing of the rainbow Pasifika community (University of Auckland, 2020).

Passive Suicidal Ideation

For every death by suicide, there is an estimated 25 suicide attempts, and for every attempt there are countless more expressing suicidal ideation (Moscicki, 2001). The interpersonal theory of suicide (ITS) proposes that death by suicide will only occur if an individual has both the desire to die and the ability to do so (Joiner, 2005). A few other ideation to action theories of suicide have emerged since 2005, meaningfully separating those who are thinking about death from those who have attempted (e.g. integrated motivational-volitional model, three-step theory, fluid vulnerability theory) (Klonsky et al., 2018). Suicidal ideation includes passive ideation (thinking one would be better off dead) and active ideation (thoughts of killing oneself) (Lutz et al., 2016). Often, passive ideation is not considered an indicator of more severe suicidal behaviour, however, this idea has been challenged by some. When assessing the clinical correlates of active versus passive suicidal ideation in geriatric patients with recurrent major depression, both groups were more alike than different, and the transition from passive to active could change during an episode of illness (Szanto et al., 1996). More recently it was found that the risk for lifetime suicide attempt was similar among those with lifetime desire for death and no suicidal ideation and those with suicidal ideation but no desire for death; those with both a desire for death and suicidal ideation having the highest risk for lifetime suicide attempts (Baca-Garcia et al., 2011). In other words, desire for death (i.e. passive ideation) had equal lifetime suicide attempt risk as (active) suicidal ideation. Those with passive suicidal ideation also score similarly to those with active suicidal ideation on measures of depression, suicidal behaviour, and hopelessness (May et al., 2015). One difference between those with passive ideation versus active ideation lies in their cognitive

flexibility; this is defined as the ability to alter decision-making behaviour to problem solve in response to external cues (Schotte & Clum, 1987). Active suicidal ideation is associated with greater cognitive inflexibility (Lai et al., 2018). Although at face value passive ideation may appear mild compared to active ideation, the centre of these thoughts houses the same notion – concluding one's life. Passive suicidal ideation should not be taken as an indicator of low suicide risk and is crucial for investigation to stop the passage to active suicidal ideation and attempt (Simon, 2014).

Overview

Suicide rates in Māori and Pasifika communities are rising within Aotearoa New Zealand. Rates peak between teenage hood and mid-20's for both populations with Māori having, overall, the highest suicide rates across the age span. This pattern indicates that the needs around fostering wellbeing for young Māori and Pasifika are not being met. Past literature has documented that risk for suicide can compound when an individual belongs to more than one minority. In exploring whether familial support was protective for Māori and Pasifika young adults against suicidal ideation, and whether differences existed between the respective rainbow and non-rainbow communities, four questions were asked. Are higher levels of familial support associated with lower risk for suicidal ideation in Māori and Pasifika young adults? Do rainbow Māori and Pasifika experience lower levels of familial support, on average, than their non-rainbow counterparts? Do rainbow Māori and Pasifika young adults experience higher levels of suicidal ideation than their non-rainbow counterparts? Lastly, does the relationship between familial support and suicidal ideation operate in the same way for rainbow and non-rainbow Māori and Pasifika young adults?

METHOD

Study Design

This project was undertaken as part of a larger collaborative investigation into wellbeing among Māori and Pasifika. Before the survey was publicly available, members of the Pasifika, Māori, and rainbow community were consulted on the appropriateness and acceptability of the survey design and measures; minor amendments were made to the original measures which are discussed further below. A quantitative, cross-sectional, online survey was utilised to measure familial support and passive suicidal ideation, and the association of these constructs within rainbow Māori and Pasifika.

Participants

Participants ($n = 160$) were recruited from among university undergraduates and members of the general public. Undergraduates were recruited from among students enrolled in introductory psychology courses. Undergraduates completing participation had opportunity to learn about the study objectives, methods, and hypotheses, and to gain course credit on the basis of assessment of that learning. Members of the general public were recruited using snowball sampling following initial advertising and promotion among Māori, Pasifika, and rainbow networks. Advertising was predominantly on social media through a Facebook Page set up for the study (Connectedness and Wellbeing in Rainbow Māori and Pasifika) as this was seen as more accessible for recruiting young rainbow Māori and Pasifika adults across Aotearoa New Zealand. The study was advertised on the researchers' personal social media profiles, through local community organisations Facebook pages (e.g. OUSA Queer* Support, Kaiāwhina Māori Humanities), Facebook groups (e.g. UniQ, University of Otago Pacific Island Centre), and direct contact with other LGBTQIA+ figures (e.g., Rainbow Inclusion Adviser at Victoria University of Wellington, LGBTQITakatāpui Network at University of Auckland). Survey invitations were also sent to colleagues, friends, and whānau who met

eligibility criteria. Those completing the survey were asked and encouraged to advertise the study through their networks or on their social media platforms. Participants were encouraged to pass on the survey to those they thought would be eligible. All participants lived in Aotearoa New Zealand, were 18- to 56-years-old, and reported identifying as Māori, Pasifika, NZ European, Chinese, Indian, Other European (English, Dutch, Scottish, Australian, etc.).

Analyses were restricted to data from participants (n = 63) who were 18- to 25-years-old, identified as Māori or Pasifika (Samoan, Niuean, Tongan, Fijian, Cook Islander, Rarotongan, Tokelauan), and were attentive during the survey. Characteristics of the sample are reported in the results section.

Procedure

All participants completed an online survey hosted on the Qualtrics platform. After initiating the survey, each volunteer had two weeks to complete the survey. The survey began with an overview of the project followed by Māori and Pasifika greetings, an introduction to the researchers, including the researchers' pepeha (way of introducing oneself in Māori that connects to ancestry, home grounds, and family) and two whakataukī (proverbs). The pepeha of the researchers were displayed to build a sense of whakawhanungatanga[10]. Additionally, the whakataukī placed participants as central to the research kaupapa (mission) and relayed their importance as partners in the research. One of the whakataukī was in Māori, *'naku te rourou nau te rourou ka ora ai te iwi',* which literally translates to 'with your food basket and my basket, the people will thrive'; its wider meaning alludes to the idea that working together has the greatest potential for progress. Similarly, the Tongan proverb, '*takanga 'etau fohe',* literally translates to 'perhaps their oars are mates', but metaphorically encapsulates the notion that working together and helping each other ensures success for the community. Following this,

[10] Māori process of making connections and relating to people through cultural linkages.

an information page and implied consent response form was shown to participants. Having continued with the survey, participants were first asked whether they lived in Aotearoa New Zealand to confirm eligibility; on the advice of a Māori academic who was consulted, the addition of 'Aotearoa' was included. This was followed by a series of other demographic questions. Participants were invited to give feedback at the end of the survey to share their experience of and suggestions for the project via an open text-box, emphasising that their input was valued. At the end of the survey, it was acknowledged that some questions on wellbeing could have been confronting or unsettling and invited participants to request information on local support services.

Measures

Demographic information was collected on region lived in, age, ethnicity, sex assigned at birth, gender, and sexual orientation. For age, participants were asked to enter their date of birth. Ethnicity was asked using seven options: Māori, New Zealand European, Pasifika, Other European (English, Dutch, Scottish, Austalian, etc.), Chinese, Indian, or Other (text box). If participants identified as Pasifika, specific ethnicity was asked using fourteen options: Samoan, Tongan, Fijian, Niuean, Ni-Vanuatu, Cook Islander, Tokelaua, Rarotongan, I-Kiribati, Tuvaluan, Papuan, Soloman Islander, New Caledonian, Tahitian. If participants identified as Māori, iwi and hapū, if known, were asked using single line text boxes. Sex was defined as "what a person is born; sex is written on your birth certificate" and was asked using three options: Male, Female, and Intersex. Gender was defined as "how a person feels or identifies" and the use of culture-specific identities such as *tangata ira wahine, fa'afafine, and fakaleitī* were encouraged; this was asked using four options: *Female, male, non-binary, and other* (text box). A single-line text box was used to ask sexual orientation and examples given included heterosexual/straight, takatāpui, and bisexual.

Familial Support was assessed using the Perceived Social Support from Family (PSS-Fa) which covers a range of feelings and experiences to measure the extent to which an individual perceives that their needs for support, information, and feedback are fulfilled by family (Procidano & Heller, 1983). PSS-Fa includes 20 declarative statements that were rated on a 7-point Likert scale (1 = *not at all true for me* to 7 = *very true for me*). Sample items include "I rely on my family for emotional support," "my family and I are very open about what we think about things," and "my family enjoys hearing what I think". Items 3, 4, 16, 19, and 20 were reverse scored. Perceived familial support scores were averaged across the 20-items to give a mean score between 1 – 7 for each participant, with higher scores indicating higher perceived support.

Following consultation, three adjustments were made to the PSS-Fa. The original response options were *yes*, *no*, and *don't know*. However, these original response options implied perceived familial support is dichotomous, whereas social support exists on a spectrum as other social support scales have reflected (Zimet et al., 1988). Second, one item ("members of my family share many of my interests") was amended to reflect the collectivistic nature of the Māori and Pasifika household rather than the implied individualistic perspective ("members of my family and I share many of the same interests"). Third, in the form viewed by those identifying themselves as Māori, *family* was substituted by *whānau*. The three studies used to validate the original PSS-Fa showed that the scale was internally consistent, with a Cronbach alpha ranging from 0.88 – 0.91, and had good concurrent validity, with scores associated with psychological distress and social competence (Procidano & Heller, 1983)The measure had a high level of internal consistency within the current sample, as determined by a Cronbach's alpha of 0.951.

Passive Suicidal Ideation was assessed using four items from the perceived burdensomeness (PB) sub-scale of the *Interpersonal Needs Questionnaire (INQ-10)*. Past

validation studies also indicate that PB consistently and significantly predicted concurrent suicidal ideation (Hill et al., 2015). The four items used included 'These days the people in my life would be better off if I were gone', 'These days, the people in my life would be happier without me', 'These days, I think my death would be a relief to the people in my life', and 'These days, I think the people in my life wish they could be rid of me'. Items are rated on a 7-point Likert scale (1 = *not at all true for me*; 4 = *somewhat true for me* =, 7 = *very true for me*) with participants' scores summed to give a total ranging from 1 – 6.99 indicating little/no passive suicidal ideation and 7 - 28 reflecting passive ideation as participants would have answered that at least one of the items was somewhat true for them. The measure had a high internal consistency, determined by a Cronbach's alpha of 0.963.

Inattention was measured using two questions telling participants to choose a particular response to show they had read the question.

Data analysis

A binomial logistic regression was used to predict the probability of a participant exhibiting suicidal ideation based on their level of perceived familial support, rainbow modality (i.e rainbow or cisgender and heterosexual), and age. This analysis was rerun excluding the non-rainbow participants. An independent sample *t*-test was used to assess the differences in familial support between rainbow and non-rainbow participants, with an additional Mann-Whitney U test conducted due to *t*-test assumption violations. Another Mann-Whitney U test was conducted to investigate the differences in suicidal ideation between rainbow and non-rainbow participants. Lastly, a hierarchical multiple regression analysis was conducted to investigate whether rainbow modality moderated the effect of familial support on suicidal ideation. Analyses were undertaken using the IBM SPSS 26 software.

RESULTS

Four hypotheses were explored in this study. It was hypothesised that higher levels of familial support would be associated with lower levels of suicidal ideation in Māori and Pasifika young adults, rainbow Māori and Pasifika young adults would experience lower levels of familial support, on average, than their non-rainbow counterparts, rainbow Māori and Pasifika would experience higher levels of suicidal ideation, and lastly, belonging to the rainbow community would not affect the relationship between familial support and suicide risk.

Descriptive Statistics

63 participants were eligible for data analysis. The sample consisted of Māori (39), NZ European (39), Pasifika (25). The majority of Pasifika participants were Samoan (13), followed by Fijian (5), Cook Islander (4), Tokelauan (3), Niuean (3), Tongan (2) and Rarotongan (2). Two Māori participants identified as takatāpui and one Samoan participant identified as fa'atama. Mean age of the sample was 21.02 with a SD of 1.65. The majority of the sample lived in the Otago region (n = 56). The breakdown of ethnicity, sexual orientation, and gender are shown in Table 1.

Table 1. Characteristics of the sample

Ethnicity	N	Sole Ethnicity	Age			Gender			Sexual Orientation	
			18 - 20	20 - 22	22 - 25	Male	Female	Non-binary	Heterosexual	Rainbow (LGBTQ+)
Māori	39	6	13	19	7	5	34	3	27	12
NZ European	39	0	15	19	5	5	32	2	25	12
Pasifika	25	10	5	11	9	7	17	2	14	12
Total	63	16	18	29	16	11	47	5	40	23

NB: N total more than 63 due to participants with multiple ethnicities.

Inferential Statistics

Hypothesis 1: Familial Support and Suicidal Ideation

A binomial logistic regression was performed to investigate the first hypothesis, namely, the effects of familial support, rainbow modality, and age on the likelihood that participants had suicidal ideation. Linearity of the continuous variable (perceived familial support) with respect to the logit of the dependent variable (passive suicidal ideation) was assessed via the Box-Tidwell procedure (Box & Tidwell, 1962). A Bonferroni correction was applied using all six terms in the model, giving $p < 0.008$ as the criterion for significance (Tabachnick & Fidell, 2014). Based on this assessment, perceived familial support and age were found to be linearly related to the logit of suicidal ideation.

The binomial logistic regression model was statistically significant, $X^2(4) = 38$, $p < .001$. The model explained 61.2% (Nagelkerke R^2) of the variance in suicidal ideation and correctly classified 85.7% of cases. Sensitivity was 84%, where the model correctly predicted passive suicidal ideation (i.e. a true positive). Specificity was 86.8%, where the model correctly predicted the absence of suicidal ideation (i.e. a true negative). The percentage of correctly predicted suicidal ideation compared to the total number predicted as having suicidal ideation (i.e., positive predictive value) was 80.8%. The percentage of correctly predicted absence of suicidal ideation cases (i.e., negative predictive value) was 89.2%. Perceived familial support was a statistically significant predictor variable; however, rainbow modality and age were not (Table 2). For each unit reduction in perceived familial support, the odds of exhibiting suicidal ideation increased by a factor of 4.76. Higher levels of familial support were associated with a lower likelihood of exhibiting suicidal ideation, whereas rainbow modality and age were not significant predictors above and beyond this.

Table 2.

Logistic Regression Predicting Likelihood of Suicidal Ideation based on Familial Support, Sexual Orientation, and Age

	SE	Wald	*df*	*p*	Odds Ratio	95% CI for Odds Ratio	
						Lower	Upper
Perceived Familial Support	.421	13.496	1	<0.001	.213	.093	.486
Rainbow Modality	.851	1.743	1	0.187	3.074	.580	16.287
Age	.246	0.031	1	0.859	.957	.591	1.551
Constant	5.087	1.606	1	0.205	629.97		

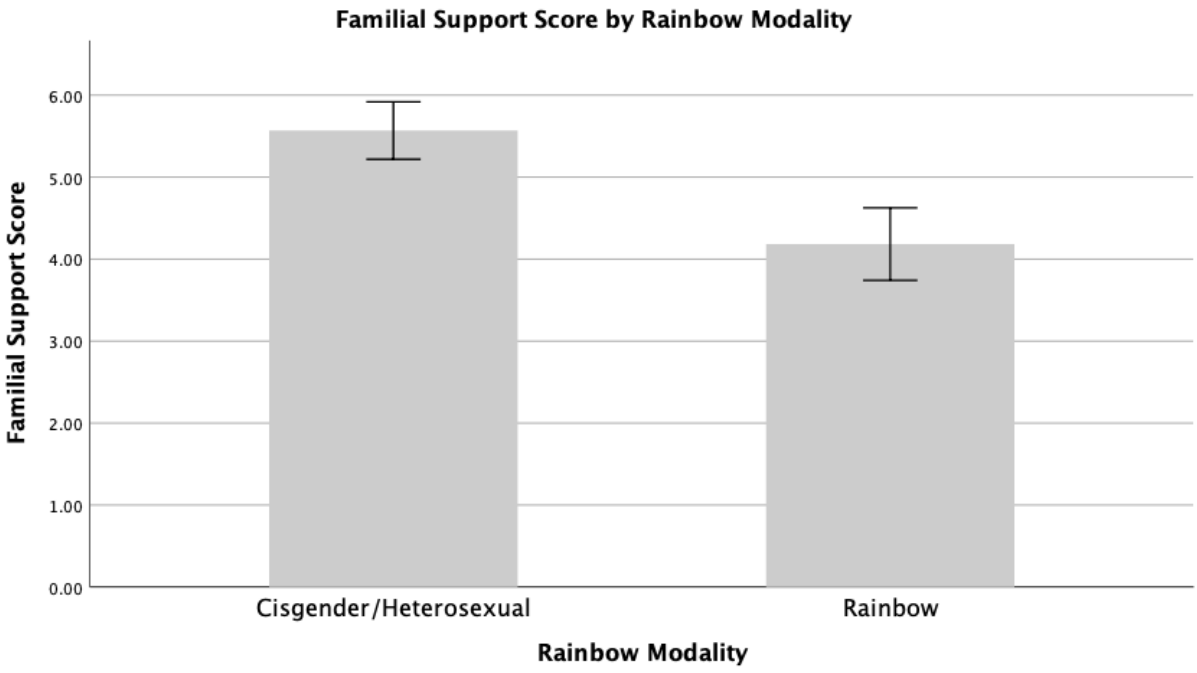
Note: Rainbow modality compares rainbow to cisgender & heterosexual individuals

This analysis was rerun with only the rainbow participants (n = 24) and the model was still statistically significant, $X^2(8) = 17.47$, $p = 0.026$. The same findings were seen where familial support was negatively associated with suicidal ideation ($p = 0.033$, $OR = 0.048$, 95% CI [0.003, 0.786]) and age had no effect ($p = 0.25$).

Hypothesis 2: Familial Support between Rainbow and Non-Rainbow

To determine whether there were differences in familial support between rainbow and cishet participants, an independent-samples t-test was run. There were three outliers in the cishet sample, as assessed by inspection of a boxplot, however, they were included in the analysis as results were similar when analysis excluded these data points. Familial support scores were normally distributed for rainbow participants but not non-rainbow participants, as assessed by Shapiro-Wil's test ($p > 0.05$), and there was homogeneity of variances, as assessed by Levene's test for equality of variances ($p = .780$). Familial support scores were slightly higher for cishet participants ($M = 5.57$, $SD = 1.08$) than rainbow participants ($M = 4.18$, $SD = 1.05$), a statistically significant difference, $M = 1.38$, 95% CI [0.83 to 1.94], $t(61) = 5$, $p < 0.001$, $d = 1.30$ (Figure 1).

Figure 1. *NB: error bars represent 95% confidence intervals*



As familial support scores were not normally distributed for non-rainbow (cf. rainbow) participants, an additional Mann-Whitney U test was run to determine if there were still differences in familial support scores between these two groups. Distributions of familial support scores were not similar, as assessed by a back-to-back bar chart. Familial support scores for cishet participants (mean rank = 39.62) were statistically significantly higher than for rainbow participants (mean rank = 19.62), $U = 171$, $z = -4.205$, $p < 0.001$. The distribution of familial support scores for rainbow and non-rainbow participants were statistically different.

Hypothesis 3: Suicidal Ideation between Rainbow and Non-Rainbow

As suicidal ideation scores were not normally distributed for rainbow and non-rainbow participants, another Mann-Whitney U test was run to determine if there was a difference in suicidal ideation scores between these two groups. Distributions of the suicidal ideation scores for rainbow and non-rainbow participants were not similar. Suicidal ideation

scores for rainbow participants (mean rank = 43.06) were statistically significantly higher than for cishet participants (mean rank = 25.19), $U = 733$, $z = 4.062$, $p < 0.001$. The distribution of suicidal ideation scores for rainbow and non-rainbow participants were statistically different.

Hypothesis 4: Rainbow Modality as a Moderator of Familial Support on Suicidal Ideation

Lastly, a hierarchical multiple regression was run to assess whether being rainbow moderated the relationship between familial support and suicidal ideation. Assumptions concerning linearity, multicollinearity, homoscedasticity, and residual normal distribution were all met. Simple slope analysis revelated that there was a statistically significant ($p < 0.001$) negative linear relationship between passive ideation and familial support in both cishet ($b = -2.446$, $SE = 0.755$) and rainbow individuals ($b = -4.154$, $SE = 1.001$). However, rainbow modality did not moderate the effect of familial support on suicidal ideation. This was evidenced by the addition of the interaction term between familial support and rainbow modality explaining only an additional 1.6% of the total variance of the model, $p < .179$. The interaction term was dropped from the model, with the new model revealing a statistically significant negative linear relationship ($b = -3.065$, $SE = 0.61$) between familial support and suicidal ideation ($p < 0.001$). Therefore, our analyses indicate that the protective efficacy of familial support against suicidal ideation is not statistically different for rainbow individuals than cishet individuals.

DISCUSSION

Main Findings and Implications

This study contributes new data on the role of familial support among Māori and Pasifika rainbow and non-rainbow young adults and the differences between these groups. In line with the hypotheses, the current study found that higher levels of familial support were associated with lower levels of passive suicidal ideation within young Māori and Pasifika populations. This parallels previous findings that family connection lowered suicide risk in both Māori and Pasifika populations. Teevale et al. (2016) illustrated that when family connection and monitoring is low in Pasifika high school populations, odds of attempting suicide are almost three times higher. Similarly, Clark et al. (2011) found that family connection worked in a protective manner against suicide attempt in high school aged Māori students. This study found that each point reduction in the familial support scale increased the odds of exhibiting suicidal ideation nearly fivefold ($OR = 0.21$, $p < 0.001$). This complements current literature that has found familial support as protective in youth to also include young adults. Māori identify first and foremost as a collective, before identifying as an individual (Robson & Reid, 2001). Whānau is at the centre of that collective and is essential for developing a sense of belonging, identity, and connection to whenua (land) and whakapapa (Berryman, 2008). It's importance for Māori health is reflected in all Māori health models (Durie, 1994; Pere, 1991; Pitama et al., 2007). As a collectivist diaspora, Pasifika view family with a similar lens; with family anchoring their place in the world, yielding a sense of identity (Ledoux-Taua'aletoa, 2019). The wellbeing of the community and the individual are intertwined, with the primary aim to achieve what's best for the collective (Tu'itahi, 2007). Akin to the Māori holistic view of health, the importance of family is also demonstrated in Pasifika health models (Pulotu-Endemann, 2001; Pulotu-Endemann et al., 2007; Tu'itahi, 2009). The negative linear relationship between familial support and passive ideation was no

different for rainbow and non-rainbow participants in the current study. This is in accordance with Māori and Pasifika research that recognises family and whānau support promotes wellbeing in rainbow populations (Ikeda, 2014; Kerekere, 2015). These findings emphasise the significance that family and whanau have on wellbeing for Māori and Pasifika communities, being at the core of the collective, and connecting and linking to whakapapa (Berryman, 2008; Ledoux-Taua'aletoa, 2019).

In the current study, age did not predict suicidal ideation above and beyond familial support. The reason there may not have been a difference detected is that all ages within this range face similar sociological changes and challenges – moving out of home, transitioning into work, and experiencing increased independence, all of which may parallel decreased social support. Rates of suicide in Māori are similar for those aged within the 15 – 19 and 20 – 24 brackets (Coronial Services of New Zealand, 2020). Age categories for Pasifika suicide rates include ages 15 – 24, so differences within this population are unclear (Ministry of Health, 2019). Although similarities of suicide rates could map on to passive ideation rates, younger populations tend to report more impulsivity, where attempts occur without prior ideation (Fortune et al., 2010). In a similar vein, those exhibiting passive ideation do not always go on to make a suicide attempt. Although individual risk factors should be considered, the uniformity of rates in younger populations indicate shared developmental and/or sociological factors. For example, the prefrontal cortex is still developing until the mid to late twenties, of which cognitive flexibility is a distinct function (Arain et al., 2013; Kim et al., 2011). Cognitive (psychological) inflexibility, responding to internal experiences in a rigid way, has been shown to predict suicidal ideation in young adults (Krafft et al., 2019; Miranda et al., 2012, 2013). Suicide risk also increases with age alongside pubertal development (Beautrais, 2019). These are just two examples of shared developmental features that may influence suicidal ideation. Another reason that differences may not have been seen is because the measures used weren't

sensitive enough to detect a difference within an age range that already collectively experiences high rates of suicide and ideation (ceiling effect).

Although rainbow modality did not predict suicidal ideation above and beyond familial support in this study, rainbow participants had higher levels of suicidal ideation compared to their non-rainbow counterparts. Elevated risk of suicide in rainbow populations have been well established globally and within Aotearoa (Beautrais, 2000; Clunie, 2017; Haas et al., 2011; Lucassen et al., 2011; Murphy & Hardaway, 2017; Treharne et al., 2020). In a diverse sample of nearly 25,000 tertiary students across the United States, regardless of race, rainbow students were more likely to exhibit passive ideation when compared to their heterosexual counterparts (Lytle et al., 2015). The current findings are also in line with two longitudinal studies in Aotearoa, where rainbow individuals were at a higher risk for mental health problems, suicidal ideation, and attempt (Fergusson et al., 1999; Fergusson et al., 2005; Skegg et al., 2003). Some reasons for these differences in passive ideation between rainbow and non-rainbow populations may include barriers to help, discrimination and stigma, or decreased familial support. Lucassen et al. (2011) found that high school students those who were attracted to the same or multiple sexes were more likely to have seen a health professional for a mental health concern but simultaneously found it harder to access help for their needs. Individuals identifying as Takatāpui made up 9.2% of suicide deaths in young Māori aged 20 – 24 from 2007 - 2011, with narratives suggesting these were caused by stigma surrounding sexual orientation (Suicide Mortality Review Committee, 2016). Suicidal ideation has also been linked to low levels of social support in young transgender adults Aotearoa and New Zealand populations (Treharne et al., 2020).

In this study, rainbow Māori and Pasifika experienced lower levels of familial support, on average, compared to their non-rainbow counterparts. Although Māori and Pasifika may face racism and cultural erasure from within the rainbow communities, they might also

experience rainbow-related stigma within the home. There is evidence that demonstrates Māori and Pasifika societies included and valued those with diverse genders and sexualities prior to colonisation and the work of missionaries (Aspin & Hutchings, 2007; Ikeda, 2014; Schmidt, 2016; Te Awekotuku, 1991, 2001). Lower familial support scores in rainbow Māori and Pasifika may be due to the presence of religious beliefs within the family. Christianity has been given a prominent place in many Pacific cultures and in many cases is synonymous with traditional values and beliefs (Robbins, 2009). This perspective was strengthened by a study exploring high school student's views on what it meant to be Samoan, all students spoke of unity in the collective, and of church being a foundation of Samoan culture (Borrero et al., 2010). Church is an important social network for Pasifika people, and a place where language and culture promoted. However, the influence of Christianity has moved the identities for many rainbow people from a place of acceptance to one of stigmatisation (Stevens, 2013). This has been recounted by rainbow Pacific individuals who have hidden their gender or sexuality from family members who hold positions in the church, been alienated from their families, or have had their identity weaponised against their families (Vaimoso, 2020a, 2020b). Some families may find it challenging understanding the rainbow identities of members when this clashes with strong traditional Christian views that underlie their cultural beliefs. Māori and Pasifika families may also undergo a process where they make sense of how having a rainbow family member transforms their collective identity. There has been little research done on the impact that religion has on Māori and Pasifika rainbow communities, let alone families. Further investigation in this area may lead to faith-based strategies so families can uphold both cultural values and the wellbeing of their rainbow kainga.

Alternatively, the lower levels of familial support seen in the current sample of rainbow participants don't necessarily equate to lower levels of familial acceptance. Instead, families may be accepting of their rainbow members, however, lack the resources to understand and

support their needs. With the visibility of rainbow identities on the rise, so has the information on rainbow-related matters for families, practitioners, and policy-makers (Clunie, 2018; Fraser, 2019; OUTLine NZ, 2019). The revival of the takatāpui identity has also led to the circulation of culturally appropriate and relevant resources for whānau (Kerekere, 2015; Kerekere et al., 2017). There is currently an opening in the Pasifika rainbow community for these kinds of resources to be developed in an accessible and culturally mindful way to empower families to support their LGBTQ+ & MVPFAFF community.

Limitations

This study extends current knowledge on the experiences of these rainbow communities; however, the limitations of the study should be addressed. Men and gender diverse individuals were under-represented, as were regions outside of Otago; therefore, these results should be considered in the context that they were undertaken. This study was a cross-sectional study, therefore the temporal relationship between, rainbow modality, familial support, and suicidal ideation cannot be inferred. Thus far discussion has centred around the importance of familial support, and in essence, familial wellbeing on individual passive ideation. However, given the interconnected nature of individual and collective wellbeing, it could be hypothesised that passive ideation and it's contributing influences impact on familial support and wellbeing. Families have expressed that when things are not going well for their children, the wellbeing of the whole whānau is affected (IHC, 2016). Future studies would benefit from utilising a longitudinal design to investigate if, and potentially why, familial support changes as a factor of suicidal ideation and vice versa. Additionally, there may be factors that affect both suicidal ideation and familial support such as sense of belonging or identity. Being rainbow is not always something that is present from birth; gender identity and sexual orientation may be fully realised over time, with adolescence and young adulthood a key period in establishing this

identity. The temporal nature of familial support, rainbow identity, and suicidal ideation should also be explored.

Differences between multi-ethnic and sole ethnic Māori and Pasifika weren't explored in this study but previous research indicates that Pasifika with multiple ethnicities experience lower levels of wellbeing (Ataera-Minster & Trowland, 2018; Manuela & Sibley, 2014). Given that the majority of the sample were of multiple ethnicities (n = 47), a replication of this study in a majority mono-ethnic sample may yield different results. Although rainbow modality and age were not significant predictors of passive ideation, given that the ideal sample to give a power of 0.8 was n = 120 and the current sample was n = 63, meeting the sample size goal may reveal significant effects.

Although the modified perceived social support from family (PSS-fa) scale and passive suicidal ideation measure (derived from the INQ) had a high level of internal consistency (alpha = 0.951 and alpha = 0.963, respectively), the current study could not assess the test-retest or interrater reliability of these measures. However, given the original PSS-Fa had high consistency and validity (Procidano & Heller, 1993), and the modifications have resulted in findings consistent with other literature on familial support, it appears that the modified PSS-Fa has construct and criterion validity. To test the scale's content validity, the modified scale should be tested in different samples in conjunction with other Māori and Pasifika familial support scales (such as the family connection scale in Teevale et al., 2016) to assess whether items can be modified to produce a culturally-appropriate familial support scale for these communities. The high internal consistency also suggests that some items might be redundant, and future participants would benefit from a scale with fewer items (Tavakol & Dennick, 2011). The original perceived burdensomeness subscale (with six questions) in the INQ has consistently predicted suicidal ideation (Hill et al., 2015). It is highly likely that the reduced subscale measuring passive ideation in this study holds the same construct, content, and

criterion validity, however, to be fully confident that this is the case, further validation studies jointly using other measures of suicidal ideation as well are warranted. On that note, where possible, future studies should aim to include measures for active suicidal ideation and suicide attempt to identify what factors influence progression for rainbow Māori and Pasifika.

Lastly, feedback from participants pointed out that some tweaks to future surveys of this nature need to be considered. These suggestions included having an "unsure" option for sexual orientation and gender, having an "other" option for Pasifika ethnicities, and giving participants the ability to select multiple ethnicities that they "most closely identified with". The last point is especially salient, as the ability to choose only one option stemmed from the ease to classify which set of questions participants received (i.e. Māori PSS-Fa version or non-Māori PSS-Fa version), however, this doesn't fully capture the way multi-ethnic people may identify. It was also pointed out that "I-Kiribati" is the correct way of referring to people from Kiribati and this was changed accordingly (from Kiribatian). There were also suggestions to allow multiple gender identities to be chosen, include romantic orientation, and look into the distinct categorisation for rainbow identities (e.g. sex, gender, and sexual orientation), which may not be perceived or experienced as distinct for some Pacific individuals.

Participants also highlighted the multiple pathways that can stem from this research, and to them I give credit for the following proposals. The rainbow Māori and Pasifika participants were happy to share their experiences, and these overall experiences should be further explored; one participant expressed that they don't see many people like themselves and often feel a need to live up to gay stereotypes and societal expectations. Another mentioned how they were not 'out' and passed as heterosexual. Additionally, the voices of the disabled rainbow Māori and Pasifika community need to be amplified as they are even less visible in rainbow resources and policy. There was also suggestion of investigating how participants placed within their family and how responsibilities may affect mental health (e.g. differences

between eldest sister, eldest brother, and only child). Further exploration of these ideas could be achieved using qualitative and ethnographic studies to capture these experiences.

Conclusion

Familial support has a significant impact on wellbeing in Māori and Pasifika young adults. High levels of familial support were associated with lower levels of passive suicidal ideation for both rainbow and non-rainbow, with rainbow participants experiencing lower levels of familial support, on average, compared to their non-rainbow counterparts. Rainbow participants also had higher levels of suicidal ideation compared to the non-rainbow participants, however, rainbow modality alone did not predict suicidal ideation when accounting for familial support. These findings are consistent with past research that has been done in adolescent Māori and Pasifika rainbow communities within Aotearoa and extends this line to include young adults. This calls attention to the interconnected nature of Māori and Pasifika families and whānau and echoes the importance of considering family inclusion in mental health interventions for these populations. Furthermore, emphasising the importance of accessible and appropriate resources for these families. There are multiple avenues for future research, however, in keeping with this study's topic, the temporal relationship between familial support, rainbow modality, and suicidal ideation should be examined to elucidate the directionality of these relationships; with the culmination of future studies ultimately uplifting the wellbeing of rainbow Māori and Pasifika individuals.

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