Psychologists' Experiences Conducting Suicide Risk Assessments

by

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Abstract

Psychologists regularly conduct suicide risk assessments (SRAs) to identify and prevent client self-harm. Although much is known about suicide risk and protective factors, little is known about psychologists' experience of the process. Filling this knowledge gap is critical, as we are currently unaware of how, why, and when psychologists conduct SRAs and how it affects them and their practice. The overarching research question is "What are psychologists' experience of conducting SRA?", with an additional focus on how psychologists perceive suicidal clients, and how psychologists are affected by SRA. An additional fourth research question emerged during analysis, that is, "How do psychologists view their SRA training?" To answer these questions, an interpretative phenomenological analysis (IPA) qualitative design was used and five registered Canadian psychologists were interviewed about the essence of their SRA experiences. Results suggest psychologists struggle to weave tenants of assessment and therapy in SRA and that they often rely on clinical intuition to conduct SRA. Additionally, psychologists invest their professional and personal lives into suicidal clients and, while they have an empathic view of suicide, they believe it is often poorly rationalized and can be addressed in psychotherapy. Psychologists often experience anxiety working with suicidal clients, where the fear of client suicide guides and motivates their SRA practices. Indeed, psychologists reported feeling pressure from peers, clients, and colleagues to conduct ethical and useful SRA, despite reporting poor SRA graduate training. These results are enlightening and important to the field of psychotherapy, as they inform psychologists' current ethical, training, and practical difficulties with SRA. With recent empirical evidence suggesting SRAs are largely ineffective, new approaches are necessary. Implications for SRA theory, research, practice, and future training are discussed.

Preface

This thesis is an original work by Jonathan Dubue. It received research ethics approval from the University of Alberta Research Ethics Board, Project Name: "Psychologists' experiences conducting suicide risk assessment", ID No. Pro00077566, February 15, 2018. No part of it has been published previously.

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Table of Contents

List of Tables

Glossary of Terms and Phenomena of Interest

Attitudes. A person's stable way of thinking about a subject.

Beliefs. What a person holds as accepted, true, or an opinion they strongly agree with.

Collaborative/Therapeutic Assessment (C/TA). Refers to a broad, overarching family of contemporary psychological assessment approaches, all of which intend to assist the client in developing new understandings of themselves in light of their assessment results (Finn, 2007).

Consensual Qualitative Research (CQR). CQR is a structured, systematic approach to developing in-depth understandings of phenomena, where researchers use open-ended questions to gather data, and a team-based analysis to formalize the findings (Hill, Thompson, & Williams, 1997).

Framework Analysis. Developed by Ritchie & Spencer (1994), this structured qualitative analysis process uses charts to help identify and define themes within the data. This model is often used for collaborative qualitative work, and for developing policy.

Information Gathering (IG) Assessment. A traditional model of assessment, the goal of which is to accurately diagnose, plan treatment, and evaluate efficacy (Finn & Tonsager, 1997).

Interpretative Phenomenological Analysis (IPA). A qualitative research approach that explores the "lived experiences" of those experiencing a particular phenomenon (Smith, Flowers, & Larkin, 2009). IPA uses hermeneutics and ideography to deeply explore emergent themes in the data and uses a step-wise procedure to complete the research analysis.

Perception. How a person understands and/or interprets a subject.

Phenomenology. A branch of qualitative research that examines the essence of what it is like to be human through the lived experience (Heidegger, 1962).

Physician-Assisted Suicide (PAS). Intentional death completed with the assistance of a physician or another health care professional. This includes providing the person with the knowledge, or means, required to die by suicide, including counselling about drug lethality and prescribing lethal doses of a drug.

Qualitative Research. An exploratory research methodology that describes data's inherent meanings, definitions, characteristics, metaphors, or symbols (Braun & Clarke, 2014)

Suicide Risk Assessment (SRA). The act of gathering data about observable and reported symptoms, behaviour, and historical factors that are associated with suicide risk and protection. (Silverman & Berman, 2014b).

Suicide Risk Formulation (SRF). The SRF is the process by which the psychologist forms a judgement about the client's foreseeable risk to harm themselves, based on the data collected through the SRA (Haney et al., 2012).

Thanatology. The scientific study of death and associated practices.

Thematic analysis. A qualitative data analysis method that clusters isolated chunks of text into meaningful patterns across the data set (Merriam, 2002).

Chapter 1

Introduction and Literature Review

Suicide is one of the most devastating and perplexing phenomena of all human behaviour. In 2012, the World Health Organisation (2012) reported a total of 804,000 suicide deaths worldwide, that is, one death every 40 seconds. In the Canadian context, suicide is the 9th overall cause of death and the 2nd leading cause in individuals aged 10-29 (Statistics Canada, 2017). In a recent national survey, 22% of Canadian teens aged 13 to 18 seriously considered suicide in 2016, where 46% further reported having a plan (Kids Help Phone, 2016). Suicide is especially devastating in some First Nations, Métis, and Inuit communities, as suicide rates range from 7-25 times higher compared to areas with a low-percentage of Indigenous communities (Kumar & Nahwegahbow, 2016). Alberta, specifically, had the second highest suicide rate across Canadian provinces, from 2000 to 2007 (Statistics Canada, 2017). Although dying by suicide is pervasive in society, it is also preventable.

Recently, the Canadian Federal government recognized suicide as a national health crisis through the passing of the *Act Respecting a Federal Framework for Suicide Prevention* in 2012 and the subsequent publication of the guiding framework in 2016 (The Government of Canada, 2016). In this report, the Canadian Government outlines prominent suicide prevention legislation, pathways and resources for municipal suicide prevention, and research regarding suicide in Canada. Bolstered by this report, the City of Edmonton commissioned barriers to be placed on their prominent High-Level bridge to prevent suicide. This step was the first of many, as the Edmonton City Council commissioned a Suicide Prevention Strategy of its own in 2015, in response to federal support and growing community awareness (Edmonton Suicide Prevention Advisory Committee, 2017). A critical, and underemphasized, piece of their prevention strategy

is the plan to help mental health workers better identify those at-risk of suicide. Indeed, most individuals who die by suicide have sought assistance from a medical health professional within the year prior to their death, with half of those accessing care within four weeks of their death (Ahmedani et al., 2014), yet most novice helpers rely on unreliable suicide assessment methods, such as relying on past SRA data (Aflague & Ferszt, 2010), or using one-time, closed question scales (Brown, Framingham, Frahm, & Wolf, 2015; Oquendo & Bernanke, 2017). The federal, provincial, and municipal effort to minimize death by suicide and its impact on society is based heavily on our ability to identify those at-risk of suicide.

Suicide risk assessment (SRA) is the act of gathering data pertinent to a person's risk of suicide (Silverman & Berman, 2014b). Psychologists typically conduct SRA through a structured interview, where the client is asked questions about their plan to suicide, their timeframe, and the means they intend to use. Risk factors, such as their history of suicidal behaviour, psychosocial environment, and level of functioning, are all used to inform the current level of risk of the client (Sánchez, 2001). Psychologists may also collect information from others in the client's life and from quantitative suicide risk scales, to further develop a suicide risk formulation (SRF). The SRF is the categorization formed based on the health professionals' judgement of the person's foreseeable risk to harm themselves, based on the data collected through the SRA (Haney et al., 2012). The SRF requires the comprehension of how the various risk factors, population demographics, base rates, and protective factors all collectively influence the person's risk of death by suicide. The resulting formulation is used to provide nuanced and, ideally, individualized treatment intervention for the person at-risk of suicide. Thus, the SRA is a precursor to SRF, and the reliability and validity of our suicide interventions relies on the robustness of the SRA.

Psychologists are taught that ethical SRA includes the identification of risk and protective factors, combined with the proper reporting of the SRF (Bolton, Gunnell, & Turecki, 2015; Truscott, 2018; Truscott & Crook, 2013). This practice is often stressed for psychologists, as expansive and detailed SRAs are highlighted as the minimum clinical responsibility of the psychologist in post-mortem suicide audits (Burgess, Pirkis, Morton, & Croke, 2000). For this reason, most psychologists, and graduate level psychologist training directors, believe that robust SRA training is principal to the practice of psychotherapy (Liebling-Boccio & Jennings, 2013). Undoubtedly, the practice of SRA is important, as 97% of psychologists will encounter a suicidal client before completing their formal training (Kleespies, Penk, & Forsyth, 1993), and nearly all psychologists list client suicide as their greatest clinical fear (Pope & Tabachnick, 1993). Although clinicians believe that SRA is important, they struggle with the practice of SRA (Waern, Kaiser, & Renberg, 2016) and identify the practice as their most challenging professional responsibility (Shea, 1999).

Considering the ethical weight and practical difficulty of SRA, several studies have examined the experiences of other mental health professionals' SRA attitudes, beliefs, and practices to inform SRA policies, best practices, and training. To date, SRA experiences have been examined in psychiatric nurses (Aflague & Ferszt, 2010), psychiatric in-patient staff (Awenat et al., 2017), general practitioners (Michail & Tait, 2016), emergency department staff (Petrik, Gutierrez, Berlin, & Saunders, 2015), social workers (Regehr et al., 2016), physicians in emergency departments (Roy et al., 2017), and psychiatrists (Waern et al., 2016). Although research has been conducted examining how psychologists interact with suicide and suicidal clients (Sommers-Flanagan & Shaw, 2016), there has been no qualitative inquiry into psychologists' SRA experience.

The purpose of this study is to understand psychologists' lived experience of SRAs. The overarching research question is: "What are psychologists' experience of conducting SRA?" Two additional qualitative questions encompass the explanatory follow-up purposes of this study: "How do psychologists view suicidal clients?" and "How are psychologists affected by SRA?" Additionally, another research question emerged during the completion of this study, that is, "How do psychologists view their SRA training?" To answer these questions, Smith, Flowers, and Larkin's (2009) interpretative phenomenological analysis (IPA) qualitative design was used to explore how participants make sense of their individual SRA experiences. I purposefully recruited a homogenous sample of five registered psychologists in Alberta, Canada, who regularly conduct SRA (more than 12 times per year). I interviewed these psychologists over the phone, using a semi-structured interview, for an average of 34 minutes. Lastly, after data analysis and thematic development, I used a synthesized member check (Birt, Scott, Cavers, Campbell, & Walter, 2016) to explore how the overall themes resonated with the individual participants' experiences.

Significance of the Study and Relevance to Counselling Psychology

This study is significant for three reasons. First, although we are aware of how psychologists are trained to practice ethical SRA (Liebling-Boccio & Jennings, 2013), we are unaware of how psychologists actually conduct the practice. This IPA study provides a brief, qualitative understanding of psychologists' SRA practices, which helps us understand how practices evolve after graduate training. This is critical, as best SRA practices have changed significantly over the last decade (Sommers-Flanagan & Shaw, 2016), and we are unaware if psychologists know of, and are integrating, these changes. Secondly, we gain a deeper understanding of how psychologists' perceptions, beliefs, and attitudes affect their SRA

experiences. With the recent rise of client-centered, collaborative SRA practices (Schembari, Jobes, & Horgan, 2016), and the growing concern over the validity of information-focused SRA checklists and scales (Chan et al., 2016; Large et al., 2016; Sommers-Flanagan, 2018), understanding psychologists' attitudes towards suicide helps our understanding of why, and how, they practice certain models of SRA. Lastly, although we know psychologists find SRA stressful and difficult (Pope & Tabachnick, 1993; Shea, 1999), we have no empirical understanding of what specific factors make the SRA experience more difficult compared to other professional psychologist responsibilities. Through IPA, we will be able to nuance the psychologists' lived experience of conducting SRA and will generate a stronger understanding of how they make sense of these experiences. Understanding how these attitudes form and how they are precipitated will give us further insight into why SRA is considered the most anxiety-laden practice of psychologists (Reeves & Mintz, 2001). Ultimately, the present study informs how we train future psychologists, provide psychological service to our clients, and improve our understanding of how to best treat, and view, clients struggling with suicidal ideation.

This study fits within the roles, functions, and core values of Counselling Psychology. Specifically, this study promotes the scientist-practitioner model underlying the practice of psychology in Canada, as it examines the integration of SRA research into daily practice (CPA, 2017). As counselling psychology scholars argue, the function of Counselling Psychology in the field of health is to continuously modify psychological practices and training programs to better reflect empirical understandings of well-being and treatment (Bedi, Sinacore, & Christiani, 2016; Sinacore & Ginsberg, 2015). This study extends past the expectation of researching best practices and, instead, examines how those best practices affect the practitioners. This completes

a necessary component of the scientist-practitioner model, as the results of this research can be used as feedback for future research and training in SRA.

Furthermore, as the field of Counselling Psychology becomes increasingly individualized from other health fields, counselling psychologists are poised to become experts in suicide and SRA. Counselling Psychology, as defined by the Canadian Psychological Association (CPA, 2017), specializes in the treating individuals as their own change agents, where assessment is approached as holistic, culturally-sensitive, and client-centered. Considering that recently validated SRA methods, such as the Collaborative Assessment and Management of Suicide (Jobes, 2012) and the Cultural Assessment of Risk for Suicide (Chu et al., 2018), prioritize client-centered and culturally-informed values, counselling psychologists may become leaders in adapting these new SRA models in their individual practices, and in influencing its adaptation in interdisciplinary settings and the health care system.

Next, I review research related to SRAs and the present study.

Empirical Foundations

To date, there are an innumerable amount of empirical studies of SRA, most of which are quantitative scale development and risk factor analysis. Virtually nothing has been written about psychologists' experience of conducting SRAs. Here, in this section, I review 30 studies that relate most closely to my research questions and psychologists' experiences of SRAs. Five topical themes were noted: (a) Mental Health Professionals' Experiences and Practices of SRA, (b) Effect of Client Suicide on Psychologists, (c) Psychologists' Attitudes and Beliefs Towards Suicide, (d) Clinical Utility of Suicide Risk Assessment, and (e) Therapeutic Assessment and Other Collaborative Suicide Risk Assessment Models.

This section provides readers with a comprehensive understanding how SRA and suicide is currently viewed, experienced, and practiced. I begin with seven studies related to mental health professionals' experiences and practices of SRA.

Mental Health Professionals' Experiences and Practices of SRA

Although we lack any knowledge of psychologists' experiences in conducting SRA, we have limited research on other mental health professionals' experiences conducting SRA. In this this section of the literature review, I identified seven qualitative studies that examine how health care providers, across a variety of mental health and emergency contexts, experience SRA. A summary of these studies can be found in Table 1.

Waern et al. (2016) conducted a cross-sectional qualitative study on psychiatrists' experiences of SRA. Here, researchers explored 15 Swedish psychiatrists' behaviours, emotions, preferences, and attitudes regarding SRA through semi-structured face-to-face interviews. Using Braun and Clarke's (2006) inductive thematic analysis, researchers identified three main themes: (a) understanding the patient in a precarious situation, (b) understanding and coping with one's own feelings, and, (c) understanding the influence of the patient-doctor interaction. Researchers reported that low emotional contact and clinical reputation were recurrent themes throughout each interview, and only a few psychiatrists reported using a checklist or rating scale when conducting SRAs. When specifically asked about SRA scales and checklists, most psychiatrists reported such instruments were unhelpful, or, in the event of low client rapport, harmful. Researchers also reported that psychiatrists commonly felt worried, uncertain, frustrated, and lonely when assessing suicide risk, ultimately affecting their ability to care for their client. Overall, participating psychiatrists noted collaborative SRAs, which included dyadic discussion of their suicidal thoughts, were more effective in assessing a patient's risk of suicide, increased

clinician and patient vulnerability, and increased the breadth of their patient's responses. They identified some limitations of their results, however, as all three authors on the study identified personal connections and biases towards collaborative suicide and SRA practices, which may have biased their analysis and conclusions.

Although outpatient psychiatrists are the primary health care providers for suicide treatment, roughly 10-20% of individuals who die by suicide sought assistance at a hospital emergency department (ED) one to two months prior to their death (Ahmedani et al., 2014; Skeem, Silver, Aippelbaum, & Tiemann, 2006). To understand how EDs handle suicidal patients, Petrik, Gutierrez, Berlin, and Saunders (2015) explored how ED service providers viewed the practice of SRA, looking specifically at processes that help or harm the quality of SRA. The authors used a qualitative online survey design to collect responses from 92 ED providers from two Colorado-based EDs, where they answered open-ended questions on barriers to SRA, preferences on assessment methods, and facilitating factors in SRA. Participants were mostly registered nurses (69.5%), whereas the remainder were emergency medicine residents or fellows (9.8%), attending physicians (9.8%), and social workers (4.4%), all with an average 10 years of clinical experience. In exploring barriers to ethical SRA in ED, participants discussed how lacking time prevented meaningful assessment, privacy lacks in EDs, patients rarely have therapeutic SRA experiences, self-harm language is inconsistent across professionals, and protocols are often too general to specifically assess client experiences. Regarding facilitating factors, ED providers identified having more time with the patient to discuss their suicide, by directing patients to attending social workers and security officers, increased rapport and helped ease clients into treatment. They further identified collaborating with other health professionals and with patients to develop personalized assessment and treatment decreased the rate of

readmission. Although a formative study regarding SRA use in EDs, researchers identified the online nature of the surveys prevented the collection of emotional and non-verbal factors in their SRA questionnaire, limiting the quality of the data. Additionally, it is an unorthodox qualitative study, as it used a large number of participants and survey-based data collection, which sometimes compromises in-depth understanding of homogenous groups.

Narrowing on specific ED service providers, Roy et al. (2017) explored how physicians in EDs understood and perceived SRA use in a large urban EDs. Authors of this study recruited 16 ED physicians and residents through convenience sampling to participate in focus groups that examined the personal practices, attitudes towards, and systemic barriers of SRAs. Researchers identified eight themes affecting how ED physicians assess for suicide, ranging from how physicians pull from their experience in ED to nuance the assessment, to the anxiety they feel when conducting a SRA. Overall, physicians reported mechanistic, or checklist-based, SRAs were problematic, given they do not appropriately reflect their patient's circumstance, nor do they help inform ED treatment options. Furthermore, physicians reported they are too busy to adequately connect with their patient, and they would prefer having psychiatrists or social workers present to help with treatment. Participating physicians reflected the uncertainty in suicide prediction caused fear and anxiety in their practice, and they deeply worried missing a serious suicide risk would impact their ability to continue their medical practice. Physicians further recognized that collaborating with psychiatric colleagues is optimal for creating strong treatment plans and decisions. Authors identified their primary limitation to this study is the non-representative sample size, as the low sample number limits the generalizability of their results.

The experience of ED physicians also appears consistent with those of general practitioners (GP) working in youth and primary care. Michail and Tait (2016), using qualitative

focus groups, asked United Kingdom-based GPs from five inner city general practices about their experiences assessing, communicating, and managing young suicidal patients. Twenty-eight GPs, nine of which were male, were recruited through convenience sampling. Using framework analysis (Ritchie & Spencer, 1994), three key themes emerged from the focus groups: (a) lack of formalized or practical SRA training, (b) belief that suicide is inevitable and therefore untreatable, and (c) that better education and SRA tools may mitigate youth suicide. Indeed, GPs reported a lack of sufficient SRA training, preventing them from adequately dealing with complex patient barriers, such as hopelessness, treatment-resistance, and client malingering. In worrying about the inevitability of their patient's suicide, some GPs reported needing to justify their clinical judgement when working with a suicidal patient, leading to SRA practices that heavily rely on validated screening tools. Others perceived the opposite, as they argued the multifactorial nature of suicide risk supported their decision to use more holistic and client-guided assessment measures. Given the GPs in this study believe suicide is impulsive, unpredictable, and difficult to assess, they reported feeling limited in their capacity to aid their patients, as organizational barriers and heavy workloads prevented the assessment of the emotional, psychological, and social factors that influence suicide risk. The researchers imply these results promote the need for collaborative SRA practices, as therapeutic engagement and communication were factors that GPs desired, but could not practice, in conducting SRA. The authors recognize that their results are limited by their convenience sample, and that the GPs who participated in the study likely have an implicit interest in mental health and suicide treatment.

These recurrent themes of organizational barriers, negative beliefs towards suicide prognosis, and mixed practices of SRA, appear consistent across most health care professionals

in hospital settings. In another recent study, Awenat et al. (2017) investigated experiences of an eclectic mix of hospital staff who work with psychiatric in-patients who are suicidal. Using purposeful sampling, a mix of nurses (n=10), psychiatrists (n=4), and allied health professionals (psychologists, social workers, occupational therapists; n=6) were recruited from community- and ward-based clinical teams, where they were asked about their experience, training, and understanding of suicidality and therapeutic approaches through semi-structured interviews. Participants reported being highly emotional as they recounted their experiences of treating, and losing, suicidal patients. They expressed that, after a patient suicide, the ward had to continue its function, implicitly ignoring the loss. This led to severe and enduring effects, where staff felt unsupported and were fearful of being blamed for the client's death. Staff were also divergent on their beliefs about the ontology of suicide, struggling between identifying it as a symptom of illness or a means of escape. Despite this conflict, most staff saw suicide as inevitable and untreatable, given that, regardless of prior treatment, suicide did not discriminate between patients. This resulted in staff hopelessness, frustration, and fear of additional uncontrollable in-patient suicides. Lastly, most staff recognized suicide as a delicate topic, fearing the use of direct suicide questions, and avoiding responsibility for asking their patients about suicide risk. Overall, staff working with suicidal in-patients felt unprepared, stressed, and deeply impacted regarding suicide and suicide assessment. The authors conclude that additional training, in the way of collaboratively working with the client, instead of using SRA scales, would help decrease SRA apathy, and would increase the likelihood of preventing suicide death.

Additional allied health professionals in hospital settings, appear to have consistent views and practices of SRA as their colleagues. Interviewing psychiatric nurses, Aflague and Ferszt (2010) used a phenomenographic approach to answer the following research questions: (a) what

conceptualizations of suicide are held by psychiatric nurses, and (b) what strategies do psychiatric nurses use when conducting a SRA? Using a convenience sampling approach, the researchers recruited six participants from two United States psychiatric hospitals, one specializing in emergency medicine, the other in locked intake. One of the authors, a nurse themselves, observed *in-vivo* how the participants conducted SRAs with a real patient, followed by a semi-structured interview asking about their conceptualizations of SRA and strategies used during SRA. All participants perceived suicide as the patient's manifestations of hopelessness, worthlessness, and their desire to eliminate emotional pain and suffering. The authors reported that all participants incorporated risk-factor assessments in their SRA, but none of them were systemic in practice. They all asked about their patient's plan, supportive resources in their life, and generally assessed for correlative mental illness diagnoses that could explain their suicidal thoughts. However, not all participants explored past suicidal thoughts, nor did they assess for other risk factors like bipolar disorders, schizophrenia, or anxiety. In assessing methods, all participants used supportive listening to assess their patients. It is notable that none of them used SRA checklists or guidelines. However, all participants reported wanting to collaborate with other health professionals to provide nuanced treatment for their patient. Overall, the researchers conclude that when psychiatric nurses spend enough time to conduct a full SRA with their patients, the quality of their SRF, their assessment confidence, and the belief that suicidal patients can be treated, all increase.

Indeed, a practitioners' confidence in their clinical judgement when conducting SRAs is paramount to the patients' experience. Regehr et al. (2016) recruited 71 social workers from Canadian mental health facilities and the University of Toronto to explore how their professional judgement was mediated by their confidence in their SRA. The participants in this study assessed

two simulated patients who presented with suicidal ideation, specifically, an adolescent in acute crisis and a middle-aged woman with depression. The participants were subsequently asked to make a SRF based on their assessment, which included three SRA scales, and, at the end of the role-play, had to determine if the client required hospitalization. Furthermore, participants completed a battery of questionnaires aimed at assessing their own emotional state, vocational background, and confidence in their SRF. Following these quantitative measures, participants with high confidence (4.5 or 5 out of 5) and low confidence (1 or 2 out of 5) participated in an interview, where they were asked to discuss their performance. The researchers found social workers had vastly divergent SRFs, as most believed the first client should be hospitalized (70%), and that the second client should not be hospitalized (62.9%). The social workers' confidence and decision to hospitalize were not associated (t = -1.367, p = 0.176), nor was confidence associated with scores on any of the standardized SRA scales (t = -.788, p = .043). Social workers with higher levels of burnout were significantly less confident in their assessment of the adolescent in acute crisis, but not with the middle-aged woman with depression. In contrast, experience working with suicidal clients was associated with higher confidence in assessing the middle-aged client, but not the adolescent. Overall, participating social workers were equally confident in recommending either hospitalization or other treatments, and workers with high confidence were more strongly associated with less experienced workers. Ultimately, the researchers suggest that clinician confidence is not a good indicator of ethical practice, and, given SRA scales do not reliably predict suicide, consultation and collaboration with other professionals should be required for such high-risk decisions.

These seven qualitative studies explored how mental health professionals, other than psychologists, experience the process of conducting SRA. Table 1 summarizes characteristics of these studies. Next, I review four studies related to the effects of client suicide on psychologists.

Effect of Client Suicide on Psychologists

For most psychologists, the fear of losing a client to suicide guides their SRA practices, beliefs, and experiences (Pope & Tabachnick, 1993). Regardless of training experience, clinicians often report feelings of being overwhelmed and unprepared to handle the experience. Unfortunately, over 22% of practicing psychologists and 51% of psychiatrists reported experiencing a client suicide during their career, prompting practitioners to understand the phenomenon as an occupational hazard (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989). Indeed, out of the 30,000 clients who die by suicide in the United States, 10,000 of those had received mental health services within the past year (Luoma, Martin, & Pearson, 2002), suggesting that psychologists, and other mental health workers, are often exposed to client suicide. Although common, client suicide never appears to become familiar, as clinicians experience a diverse range of negative symptoms and problematic self-attributions, often impacting their practice.

Ellis and Patel (2012) reviewed literature on the impact of client suicide on mental health clinicians and discussed notable coping responses. Common reactions to client suicide, according to a heterogenous sample of psychologists, psychiatrists, and mental health workers, include feelings of guilt, self-blame, shame, inferiority, and withdrawal. These reactions suggest that clinicians often believe they are at fault for the client's death, which creates a sense of incompetence when a client dies by suicide. These feelings are typically followed by experiences of depression, anxiety, worry, and betrayal. Most clinicians, after internalizing their grief, begin

to fear the reviewal process of their client's suicide, which typically manifests itself as avoidance, fear, anger, or a combination of the three. Ellis and Patel (2012) also found that, across studies, clinicians with less psychotherapy experience relied on their natural helping qualities to assist clients, which made them more susceptible to self-blame after a client's suicide. They further uncovered that the length of therapy is commonly associated with increased grief responses. Similarly, contexts where the client and the therapist work together often, or closely, such as in-patient or individual therapy settings, are often linked to deleterious emotional reactions, comparative to out-patient or brief therapeutic contexts. Ellis and Patel (2012) further identified that the literature is bare on how clinicians make sense of these experiences, and how different SRA methods influence their grief reactions. As future directions, the authors argue that clinicians receive little, to any, training on how to handle a client suicide. Given its high clinical prevalence, psychologists should be better trained and prepared for the inevitability of a client's intentional death.

These feelings of anxiety, fear, anger, and professional incompetence have their origin well before client suicide, rather, they appear to manifest at the onset of working with a suicidal client. Reeves and Mintz (2001), in an exploratory qualitative study, recruited a homogenous sample of four practicing counsellors who regularly work and interact with clients experiencing suicidal thoughts. In their semi-structured one-on-one interviews, the researchers asked the counsellors about their experiences and the impact of working with suicidal clients. They found that counsellors reported ranges of distressful emotions, as they doubted their competence and feared the impending mortality review process. Counsellors reported using coping strategies to emotionally distance themselves from the client, such as writing in-depth case notes and discussing the case with their supervisor. They further reported wanting certainty in their

practice, as they wanted to know that their interventions would reliably prevent their client's suicide. Across all four participants, they all agreed that they were not adequately trained to assess and work with their suicidal clients, as they lacked continued training and theoretical knowledge on treating a suicidal client. Without any SRA knowledge, the participants saw the assessment process as informal, where they were guided by their gut reactions. The authors identify that their small sample size, compounded with the fact that their participants were all 40-50-year-old Caucasian person-centered counsellors, makes the results of this study difficult to generalize. Nonetheless, these results are consistent with those reviewed by Ellis and Patel (2012), where counsellors express a range of negative emotions, and often feel unprepared to handle their suicidal clients.

Similar experiences were reported in Skodlar and Welz's (2013) case study of a therapist who lost two patients to suicide within a year of practice. Here, Skoldar discusses his experiences treating and grieving the loss of his patients with Welz, who, as a co-constructor of Skoldar's narrative, reframed and highlighted notable reflections. In this discussion, Skodlar expresses that feelings of groundlessness overtook him after hearing of his clients' suicide death. He explains groundlessness as a dissociative state where he felt unbalanced and isolated, unable to reconcile his swirl of discomfort that shattered his psychotherapeutic confidence. He further analogizes the experience as becoming mute. In voicing his concerns to colleagues, he felt as if his words could not reach them, increasing his isolation and shaking his confidence in the talking cure. Having "turned to something beyond" himself (Skodlar & Welz, 2013, p. 244), Skodlar noted that his experience of losing clients to suicide emboldened his ability to connect with other suicidal clients. Finding refuge and knowledge in philosophical texts, Skodlar lastly argues that

offering insights to new clients regarding human existence, through existential psychotherapy, may help widen their scope of pain, despair, and protect them from suicide.

The process of connecting with suicidal clients, to reduce feelings of groundlessness, is examined further in a qualitative inquiry by Hagen, Hjelmeland, and Knizek (2017). Here, the authors investigated how therapists view and experience treatment for suicidal patients in a psychiatric ward. The authors recruited a purposeful sample of four psychiatrists and four psychologists who regularly treated suicidal patients, where six of the participants reported working over 10 years in the area. In analyzing the semi-structured interviews through thematic analysis, the authors uncovered that their experiences revolved around the tension between categorizing their patient's suicidal risk and establishing a meaningful connection. In one reflection, one of the participants noted that patients often report feeling violated by these risk categorizations, especially if they were kept as a secret from the patient. The health care professional also felt pressure to intervene and protect their patient, even if they actively refused treatment, ultimately causing more distress on both the patient's and the psychotherapist. Other participants corroborate this experience as they discussed patients that they had lost to suicide, seemingly due to the negative experiences incurred through psychiatric hospitalization. The participants identified that these nosocomial suicides are the cost of in-patient SRA that prioritizes system requirements over patient connection, ultimately leaving the professional with the feelings of guilt, powerlessness, and dissociation from the patient. The authors identified that future studies should identify how specific therapist and patient characteristics impact the patient-clinician connection.

In this section, four studies on the impact of client suicide on psychologists were reviewed using a variety of research methods, such as a literature review, a case study, and two

phenomenological qualitative inquiries. In each study, themes of clinician helplessness, fear, inadequate training, and isolation all described the psychologists' experience of losing a client to suicide. Evidently, the loss of a client to suicide produced deep self-reflection, where experiences of negative self-attributions or existential self-awareness impacted the psychologists' future suicide and SRA practices.

Psychologists' Attitudes and Beliefs Towards Suicide

Underlying the psychologists' experiences of loss to client suicide and SRA is their attitudes and beliefs towards suicide. The way psychologists conceptualize and understand the phenomenon of self-intended death implicitly guides their therapeutic and assessment decisions, including their choice of using checklist or interview-based SRA, hospitalization of suicidal clients, and recommended treatments (McKinlay, Couston, & Cowan, 2001). Therefore, it is critical to understand how psychologists believe and perceive suicide before understanding how they practice and are impacted by SRA.

One such study examined the attitudes of 81 Australian psychologists towards suicide and self-harm. Gagnon and Hasking (2012) sought to specifically examine how the effects of age, gender, professional experience, and conceptualization of suicide impacted SRA attitudes. The authors administered the Knowledge of Self-Harm scale (Warm, Murray, & Fox, 2003), the Attitudes Towards Deliberate Self-Harm Questionnaire (McAllister, Creedy, Moyle, & Farrugia, 2002), and the Suicide Opinion Questionnaire (Domino, Moore, Westlake, & Gibson, 1982) through an online survey to a representative sample of Australian psychologists. The authors found that less experienced psychologists held higher self-confidence in working with a self-harming patient, and more empathically viewed a person's right to die. Those with more clinical experience in the area showed more empathy towards suicidal clients and had higher confidence

in the overall treatment of suicide and self-harm. All the psychologists held generally positive attitudes towards suicide and self-harm and displayed high levels of knowledge in the field, as they agreed with an individual's right to die and understood the psychosocial equifinality of the phenomenon. Several limitations of this study exist, as the authors identified that their small sample size impact the generalizability of their results, and that, since psychologists self-selected their participation, response bias may explain the overwhelmingly positive attitudes towards suicide.

However, Gagnon and Hasking's (2012) findings on psychologists' positive and humanistic attitudes towards suicide is consistent across the literature. Exploring the attitudinal differences across mental health professionals, Hammond and Deluty (1992) randomly selected 115 clinical psychologists, 81 psychiatrists, and 167 oncologists to complete a mailed questionnaire assessing their attitudes towards suicide. In their questionnaire, the authors assessed how health care providers felt about situation-specific suicides, the morality and rationality of suicide, and the role of mental illness in suicide. All the participants saw suicide as acceptable in the face of chronic psychiatric pain, and that, even though some clinicians experienced suicidal ideation themselves, the positivity of their attitudes did not appear to change. Most respondents (90%) agreed that suicide can be rational, with a strong majority of participants (82%) agreeing that suicide is wrong due to the consequential grief on the survivors. Those who have experienced a loss to suicide felt significantly more responsible for their patient's care and well-being. The key difference between the health care professionals surveyed in this study lies in their overall positive attitudes towards suicide, as psychologists were more accepting of suicide, even in the absence of chronic illness, compared to psychiatrists and oncologists who were less accepting. The authors hypothesize that these attitudinal differences

exist due to the exposure and knowledge psychologists have towards clinical depression and suicide-related behaviours. Indeed, familiarity with deviance tends to increase the acceptability of the behaviour (Bereska, 2014).

In unfamiliar territory, psychologists rely on their inherent beliefs to guide their practices. Examining the controversial practice of physician-assisted suicide (PAS), DiPasquale and Gluck (2001) explored how psychologists' and psychiatrists' beliefs about PAS differ based on their underlying beliefs of suicide and death, and how those beliefs modify their assessment and treatment practices. The authors mailed a survey to 485 psychologists and 148 psychiatrists and received 202 and 59 returned surveys (44% response rate). Of those that responded, most clinicians (70%) reported having counselled at least one patient considering PAS, while 3% wrote a prescription for ending their patient's life. Regarding their views towards PAS, 75% of respondents agreed that the practice should be legalized, and 55% of them would be willing to assist in the process. Those unwilling to participate in PAS, even if legal, cited arguments that asserted the externalization of the patient's life, such as their life belonging to God (39%), or a strong adherence to the Hippocratic oath (30%). Participants who believed in the benefits of PAS, that suicide can be rational, and who endorsed lower levels of religious conviction were more willing to aid in PAS. In assessing their patient for mental capacity, 60% of participants reported that they would conduct the assessment, while others would refer externally (26%) or refuse the assessment (14%). Overall, participants reported a tendency to act in accordance with their own values and attitudes, even if they contrast with their patients'. Indeed, when faced with the decision of assisting in another's death, psychologists adhere closely to their personal attitudes and beliefs, which, depending on the client's context and rationale, may change their treatment course.

Another example of how attitudes towards suicide influence clinical practice is the use of the no-suicide contract (Range et al., 2002), a practice where the client agrees to contact the clinician or emergency services prior to attempting suicide. Used to deter their clients from suicide, clinicians often ask their clients to verbally repeat the contract to promote their compliance, giving the practitioner a sense of due diligence. Although the validity and clinical utility of using no-suicide contracts has since been brought into question (Rudd, Mandrusiak, & Joiner, 2006), psychologists' attitudes influence how, and if, the contract is part of their SRA toolkit. Davidson, Wagner, and Range (1995) recruited 46 licensed American psychologists to complete a mailed questionnaire evaluating the frequency and appropriateness of no-suicide contract use for different age groups, followed by questions about their attitudes towards these practices. The participants all reported that they felt no-suicide contracts helped more with adolescents and adults (12-18+) compared to children (6-11). Most participants believe that this practice helps communicate their care to their client, and that it helps postpone their suicidality. However, in this group of registered psychologists, most believed no-suicide contracts were not effective in reducing legal liability. Furthermore, in this study, most clinicians believed that these practices were effective in building client rapport and ultimately benefited their safety. Indeed, clinicians who believed their clients can control their own fate rated the no-suicide contract as more effective, and those who rated the therapeutic alliance as a priority in their therapy stressed how no-suicide contracts could assist client-therapist rapport. The authors recognize that this study is limited by a low response rate (35%), and that, although the results of this study are useful for developing clinical practice, the effectiveness of no-suicide contracts had yet to be unequivocally empirically supported.

Overall, psychologists view suicide empathically, compared to other mental health professionals such as psychiatrists and physicians. Given that psychologists spend the bulk of their clinical work understanding their client's rationale, history, and psychosocial experiences, it is no surprise that psychologists are familiar, and therefore more comfortable, with suicide. Indeed, these empathic attitudes manifest themselves in beliefs that individuals with suicidal thoughts can be helped, that suicide can be rationale, that suicidal ideation is normal, and that suicide is a personal right (Cwik et al., 2017). However, a lacking component in this area of research, as noted by Gagnon and Hasking (2012), is that we are relatively unaware of how attitudes towards death and suicide influence a psychologists' practice with suicidal clients. Although some evidence exists about attitudes and beliefs towards specific suicide-related practices, such as PAS and no-suicide contracts, we lack any evidence relating beliefs about death and suicide towards clinical behaviours.

Clinical Utility of SRA

Although attitudes towards suicide may influence the use of SRA, a more pressing issue in the area is the clinical utility of SRA, as the practice has recently been brought into question by several research groups (Bolton et al., 2015; Chu et al., 2015; Connor, Gaynes, Burda, Soh, & Whitlock, 2013; Fowler, 2012; Silverman & Berman, 2014a). Specifically, three components of SRA are being examined: (1) the differences in SRA tools and measures, (2) the positive and negative impact of SRA on clients, and (3) the predictive validity of suicide risk factors.

Differences in SRA measures. One problematic aspect of SRAs is their lack of empirical and theoretical validity. Indeed, clinicians often use SRA tools, such as the Suicide Assessment Checklist (Rogers, Lewis, & Subich, 2002), the Mini International Neuropsychiatric Interview (Lecrubier et al., 1997), the Columbia-Suicide Severity Rating Scale (Posner et al.,

2011), the P4 suicide screener (Dube, Kroenke, Bair, Theobald, & Williams, 2010) and the Scale of Suicide Ideation (Beck, Kovacs, & Weissman, 1979) to assess their client's risk of suicide. Within these measures are a wealth of variability, such as response format (dichotomous or continuous), focus on suicide behaviour (suicide plan or past attempts), and other salient suicide risk factors (previous health history, substance use, demographics). To best compare the utility of these measures, Harris, Lello, and Willcox (2017) collected survey data from 2079 Australians and Singaporeans across three independent samples, who were recruited through Google, Facebook, and snowballing to complete an online suicide questionnaire. Using item response theory (van der Linden & Hambleton, 2013), general linear modeling, and linear regression, the authors measured how much variance of current suicidality was explained by a range of suicide behaviours and response formats. Here, the authors found that participants with suicide plans correlated with higher current suicide intent compared to past suicide behaviours. Furthermore, the severity of past suicide attempts and dichotomizing suicidal risk (yes/no), did not significantly explain the variance in current suicide risk. Conversely, continuous response scales measuring suicide risk explained 47-61% of the suicidality variance. The authors conclude that, among most SRA scales, those that emphasize cut-off scores based on dichotomous response variables, and those that do not prompt the clinician to ask about the psychosocial aspects behind their suicidal intent will ultimately fail to adequately predict suicidal risk. Although this was the first study to empirically assess suicide models through statistical methods, the authors recognize that their convenience sampling approach may impact the generalizability of their results.

In addition to the response format, the number of items and the method of presentation is important to effective SRA scale administration. Hom, Joiner, and Bernert (2015) explored the measurement of suicide attempt history across single-item self-report scales, multi-item self-

report scales with follow-up questions, and semi-structured face-to-face clinical interviews. The authors recruited 100 undergraduates from an American university who endorsed a history of suicide attempts during a prescreening survey. The authors presented participants with a single item assessing suicide history (0, 1, 2, 3, or more attempts) during a pre-screening department-wide survey: "Have you ever attempted suicide, where you attempted to kill yourself?" Participants who endorsed at least one prior suicide attempt completed a follow-up self-report survey that asked them to elaborate on their suicide attempt(s) through open-ended written questions. Following the completion of the second open-ended survey, participants completed an in-person clinical interview to assess timing, nature, and circumstances of the prior suicide attempts, where risk was categorized by standards set by the Centers for Disease Control and Prevention (CDC; Crosby, Ortega, & Melanson, 2011). Indeed, the authors clarified each attempt into one of five categories: suicide attempt, interrupted suicide attempt, aborted suicide attempt, suicidal ideation, and non-suicidal self-injury. Although all participants (100%) endorsed a prior suicide attempt in the single-item assessment, only 67% of the responses qualified as a past suicide attempt in the multi-item assessment. In the clinal interview, only 60% of participants qualified for a past suicide attempt, where those unqualified reported interrupted suicide attempts (3%), aborted suicide attempts (7%), and no suicide attempts (30%). Although the data was not compared to external, objective observations of suicide attempts, the discrepancies between the assessment methods suggests that the validity of SRA is based on the process used to conduct SRA. Notably, the clinical interview did not provide additional suicide attempt history information compared to the multi-item self-report, suggesting low incremental validity after the multi-item, open-ended self-report scale. The authors recognize that this study is limited in its conclusions, as those who reported a history of suicide attempts may have denied its presence in

the multi-item self-reports and clinical interview due to compromised anonymity. Overall, the authors conclude that research and clinical practice that uniquely involve single-item SRAs should be revised to ensure that appropriate SRFs are made.

Impact of SRA on clients. Another key question that surrounds the utility of SRA is the impact SRA and SRF have on the client. Although the SRA may provide clinicians with useful data about their client's current functioning and their level of safety, the process of asking the client about their suicidal ideation and behaviour may be stressful.

One such study examined the question: are SRAs harmful to participants? Harris and Goh (2017) assessed the personal distress of survey participants when they were presented with suicide-related questions. Using a randomized double-blind controlled trial design, the authors recruited 259 Singapore community members and university students who ranged from having no suicidal ideation, to being at high-risk for suicide. The authors randomly assigned participants to an experimental and control condition, where those in the experimental condition completed the Suicidal Affect-Behaviour-Cognition scale (Harris et al., 2015) and answered intense death-related questions, while those in the control group completed the World Health Organization Quality of Life Questionnaire (WHOQOL group, 1998). Both groups completed a measure of emotionality (PANAS; Watson, Clark, & Tellegen, 1988) before and after their trial, while also completing depression, loneliness, and perceived social support scales, all assessed through an in-lab computer. Lastly, participants provided open-ended feedback to the researchers after the completion of their measures through a semi-structured interview and written response, where researchers later coded positive and negative feedback responses. The authors found that, despite experimental manipulation, asking individual about suicide-related questions did not lead to significant increases in emotional distress, and further conclude that suicide questions are no

more distressing then asking participants other psychosocial questions. Participants in the qualitative interview identified that, among all the steps in this study, questions about social support produced the most displeasure. The authors recognize that their results are limited by their research context, as most (90%) of their participants indicated that their survey experience was positive in the open-ended written response. Given that research participants struggle to report negative reactions in feedback (Booth-Kewley, Larson, & Miyoshi, 2007), the design of this study may have not been powerful enough to detect iatrogenic effects in using SRA.

How, and who, conducts the SRA may also impact the client's response accuracy. A study from Hom, Stanley, Podlogar, and Joiner (2017) examined how prior experience of being asked about suicidal ideation, intent, and behaviours, impacted their response accuracy. The authors surveyed 306 undergraduate students who self-reported a history of suicidal ideation and asked them to complete questionnaires assessing their experiences of being probed about suicidal ideation and to identify the factors that influenced their response accuracy. The majority (63.1%) of participants reported being asked about their thoughts of suicide in the past, where probes mostly came from a friend (27.5%), psychologist/counsellor (26.8%), or family member (24.5%). Participants reported that they were more accurate in their descriptions when asked by mental health professionals compared to family and friends. Participants, when disclosing their suicidal ideation or intent, were concerned about being embarrassed (62.2%), judged (55.4%), or having others find out (54.7%). Across all probes, participants reported that they sought empathy and emotional understanding when disclosing their thoughts of suicide, suggesting that they were more comfortable with those who were specifically trained with supportive listening skills.

Although the evidence is limited in determining how clients are affected by SRA, the literature demonstrates that using SRA is not innocuous in counselling. Indeed, clients appear to

be, in some way, impacted by the use of SRA, where experiences may differ depending on who, and how, the assessment is conducted. However, asking suicide-specific questions do not appear to negatively impact clients, suggesting that SRA is, overall, a safe practice. For these reasons, it is important to ensure that SRAs are not dissociated from the client or the intended therapeutic outcomes of psychotherapy, and that the decision to use SRA is informed by its potential impact on the client.

Predictive validity of suicide risk factors. Complicating the decision of using SRA, recent evidence has brought into question the validity of the practice. Large et al. (2016) conducted a meta-analysis of longitudinal cohort studies, where psychiatric patients or people who had made suicide attempts were classified as either high or low risk, to measure the statistical power of SRA in predicting suicide mortality. After filtering through 11,776 studies, Large and colleagues included 37 longitudinal studies that used more than two variables to define a high suicide risk group, measured patient risk factors prior to intervention, and reported subsequent deaths by suicide as a dependent variable. Assessing a total of 53 samples, the authors found that the pooled odds of suicide mortality was 4.84 times higher in the high-risk groups compared to the lower risk group, suggesting that the SRA, overall, was an effective predictor of suicide risk. However, they also found high between study heterogeneity, with the lowest odds ratio at 1.023, and the highest at 37.27 ($I^2 = 93.3$, Q-value 773, $p<0.001$), suggesting that studies widely varied in their ability to assess risk appropriately. Importantly, they further found that the effect size of SRA did not change across the 40-year time-span, and that the rate of suicide for those in the high-risk categorization was 5.5%, whereas the rate of suicide of suicide in the lower-risk group was 0.9%. They additionally report that, although the rate is increased in high-risk categorizations, out of those who do lose their life to suicide, over half of

them were assessed as low-risk. From these results, Large et al. (2016) conclude that the psychometric properties of SRA cannot be used in isolation, as they are not robust enough to appropriately predict suicide mortality. Additionally, they caution the interpretation of these results cannot be generalized, given the very high between-study heterogeneity of the effect size suggests there are too many differences across studies for the pooled estimate to be reliable.

Investigating more specific predictors of suicide, Chan et al. (2016) investigated how well suicide risk factors and SRA scales could predict suicide in individuals who were admitted to hospital following self-harm. Through a meta-analysis of 12 studies on risk factors, Chan and colleagues found that hazard ratios were elevated for previous episodes of self-harm (HR = 1.68), reported suicidal intent (HR = 2.7), physical health problems (HR = 1.99), and identifying as male (HR = 2.05). Aggregating the data on the Beck Hopelessness Scale (BHS; Beck, Steer, Kovacs, & Garrison, 1985) and Suicide Intent Scale (SIS; Harriss & Hawton, 2005), positive predictive values ranged from 1.3 to 16.7%, with moderate sensitivity (.80) and low specificity (.46). From these data, Chan et al. (2016) suggest that, although the hazard ratio for these risk factors are robust, they are too common in clinical practice to helpfully differentiate between a high or lower-risk suicidal client. Coupled with the significant and pernicious rate of false positives in risk assessment scales, the authors concluded that SRA tools, scales, and checklists fail to address the needs of suicidal clients.

Both groups, after completing their meta-analyses, argued that SRA lacks the clinical and empirical validity necessary to be commonly practices in counselling and psychiatric settings. They argue that use of SRA scales, or an over-reliance on identification of risk factors, may provide false reassurance of completing suicide due diligence, leading to poor client attunement and client self-harm. Supporting their claim, they identify that even if there was strong statistical

discrimination between high and lower-risk categories, there are currently no interventions that should be differentially provided to high or lower-risk groups. Indeed, most high-risk suicide interventions rely heavily on emergency services, such as overnight hospitalization, which has poor outcomes for suicidal clients (Hagen et al., 2017). Thus, Large et al. (2016) and Chan et al. (2016) agree that collaborative, or non-checklist emphasized SRA models will be more predictive of suicide mortality, and will promote stronger client outcomes that extend beyond client risk categorization.

Therapeutic Assessment and Other Collaborative SRA Models

Large et al. (2016) and Chan et al. (2016) were not the first to make these conclusions, as the debate around effective and proper counselling assessment has waged for decades prior. Within the past fifty years, clinicians and researchers have begun to understand that the process of assessment can be therapeutic for clients. Dressel and Matteson (1950) originally presented the argument that test administration and interpretation are typically practiced as authoritarian and directive, where proponents of the practice assert that unequivocal compliance to the directions of the clinician will result in therapeutic gains. Indeed, Dressel and Matteson (1950) argue that client growth and the therapeutic relationship is stifled through this authoritarian process, as the completion of the assessment is prioritized over how the client can benefit or utilize the results of the assessment.

Indeed, in a large-scale review of psychological assessment, Meyer et al. (2001) further argue that distinct assessment methods provide unique sources of data, yet the reliance on one data source leads to incomplete understandings of clients. The researchers suggest that multimethod assessment methods affords more sophisticated information integration that deepen client-clinician understanding and, as a result, therapeutic gains. Reviewing two key assessment

practices, Finn and Tonsager (1997) contrasted traditional models of assessment, termed the Information Gathering (IG), with more collaborative models, like Therapeutic Assessment (TA). Their article summarized the extensive theoretical understanding of TA and IG, comparing their goals, processes, underlying rationales, focuses, assessor roles, and consequences of failure. Table 2 summarizes these comparisons.

Finn (2007) argues that, within the field of psychological assessment, the IG model of assessment is over-represented, which limits the clinician's ability to engage in collaborative, client-centered practice. The same idea can be extended towards SRA, given that self-report and clinician-administered scales have dominated clinical SRA practice for the past five decades (Brown, 2001; Sommers-Flanagan & Shaw, 2016). Scholars argue that the introduction of multivariate analyses and the ability to analyze large sets of risk factors, combined with the serious threat of loss of life, helped solidify close-ended SRA scales as best practice. Fears of clinical litigation further support the use of these scales, as, when processing a mortality review, quantitative measures of SRA are one of the first examined criteria that assess for clinical negligence (Reeves & Mintz, 2001). Thus, the use of these clinical scales often ease the clinician's worries about professional competence and appropriate SRA practice (Reeves & Mintz, 2001).

These SRA scales lack what Jobes & Drozd (2004) describes as a fundamental component to being suicidal, the investigation into the patient's intra-subjective phenomenological experience, which cannot be assessed quantitatively. Jobes (2000) argues that the presence and absence of key relationships is the fundamental variable that prevents or causes suicide, leading him to conclude that the therapeutic relationship is disproportionally privileged with a suicidal client. In the therapeutic dyad, the clinician entreats the client to share

vulnerabilities in exchange for an empathic, listening ear. However, this relationship loses its simplicity when self-harm or suicide is introduced; it is understood that, due to ethical and legal obligations, the clinician must subvert their clients' trust and break confidentiality to appropriately conduct their suicide safety strategy, often including reporting personal client details to professionals outside the therapeutic relationship. This authoritative, clinician-centered approach prevents clients from making personal choices, a skill that, ironically, clinicians wish to embolden. Ultimately, as the clinician worries about professional liability, the client may begin lying to avoid unnecessary hospitalization. Indeed, this is the primary limitation of checklist and quantitative SRA, where ethical reporting supersedes the opportunity for collaborative, client-centered approaches.

One such collaborative SRA method, namely, the Suicide Status Form (SSF; Jobes, 2016; Jobes et al., 2004) uses a mix of ranked scale response and open-ended written questions to stimulate suicide-related conversations between the clinician and the client. Jobes (2016) described the SSF as a multi-purpose engagement tool which helps with treatment planning, tracking, updating, and connecting with a client's suicidal ideation. Specifically, clients are assessed on the interaction between their psychological pain, pressure, perturbation, hopelessness, and self-hate, both quantitatively and qualitatively. The primary focus of the SSF is to develop the client's awareness of their suicidality through clinician-feedback and skill building.

In validating the qualitative component of the SSF, Jobes et al. (2004) evaluated the written responses from previously completed SSFs from mid-Atlantic Counselling Centers (n = 119) and active duty U.S Air Force personnel (n = 33) using Consensual Qualitative Research (CQR; Hill, Thompson, & Williams, 1997). The authors found that, in the written reflections,

participants reported developing interoceptive skills, dealing with situation specific stressors, and weighing personal responsibilities, all factors that were not represented in quantitative SRA scales. Furthermore, themes of relationships, helplessness, unpleasant internal states, and role responsibility pressure captured the bulk (66%) of responses, suggesting that, although accounted for quantitatively, the addition of a qualitative inquiry helped nuance the participants responses. This is more obviously demonstrated when comparing the results from both samples, as the proportion of codes differed depending on the sample. For example, the university counselling center sample had a higher proportion of relational difficulties, whereas the air force sample reported more external descriptors that pertained uniquely to military experiences. Although the authors recognize that they were limited by the analysis of qualitative responses that were completed within the specific SSF framework, they safely conclude that the addition of a qualitative component to their SSF provided nuanced information that humanized and personalized the SRA.

With the SSF in its fourth revision (SSF-4), Jobes (2016) considers the assessment a foundational component of his larger treatment model: the Collaborative Assessment and Management of Suicide (CAMS; Jobes & Drozd, 2004) therapeutic framework. CAMS is a structured, cooperative framework for rapport building, SRA, case formulation, treatment planning, and risk management. The approach is rooted in remediating client-defined drivers, which are the specific problems that have led them to consider suicide as an option, while developing the clients' skills and techniques. The underlying philosophy of CAMS is one of collaboration between the clinician and the client, where the primary focus and outcomes of assessment and intervention are co-authored with the client. This contrasts with IG approaches, such as Dialectical Behaviour Therapy (Linehan, 1993), Cognitive Therapy for Suicide

Prevention (Wenzel, Brown, & Beck, 2009), Brief Cognitive Behaviour Therapy (Rudd et al., 2015), and mentalization-based therapy (Bateman & Fonagy, 2008), which emphasize the client as the problem and the clinician as the expert. Indeed, the two main therapeutic philosophies in CAMS, collaboration and focusing on factors related to suicide, directly support a TA-approach to SRA, as the process of assessment is client-centered, promotes clinician reflection and feedback, and aims to develop a suicide treatment plan to is co-developed and specific to the client's situation (Jobes, Lento, & Brazaitis, 2012).

For assessing suicidal risk, the CAMS approach concludes that clinicians must understand that every suicidal person is suicidal for legitimate reasons, and acceptance of their rationality increases pathways to collaboration (Jobes, 2012). It is for similar reasons that, when conducting a SRA within the CAMS approach, clinicians are recommended to sit beside their client, to exemplify the collaborative and supportive philosophy embedded in the CAMS approach. Using the SSF, clinicians and clients co-author responses to the SRA, with the client focusing on identifying their suicide "drivers" and the clinician helping refocus and reframe the client's understanding of their suicidality. Ultimately, the CAMS framework provides the client with access to a therapeutic alliance, a personalized and clinician-approved stabilization and treatment plan, and quantitative self-rating scales for future use. Negotiating the termination of therapy in CAMS continues as a collaborative process, ensuring that the client can rely on non-suicidal coping options, or can eliminate the issues that caused their suicidal ideation originally.

The practice of CAMS is supported by several studies, as the framework has been associated with reductions in suicidal behaviour in a college student population (Jobes & Jennings, 2011), outpatient community mental health settings (Comtois et al., 2011), and in military contexts (Jobes et al., 2012). A recent randomized controlled trial study examined the

impact of the CAMS approach on SRA validity and post-discharge treatment outcomes. Ellis, Rufino, and Allen (2017) recruited 104 participants from an extended-stay psychiatric hospital in Texas, all of whom reported some form of suicidality within the first two months prior to admission. Most participants (43.3%) reported multiple suicide attempts and the average length of stay in the hospital for this sample was 59.5 days. The authors separated the participants into two groups, CAMS-treated and treatment as usual (TAU), through nonrandomized, naturalistic comparisons, which were based on the patients' treatment team's requests and availability of a CAMS-trained therapist. All participants received intensive inpatient treatment, including two 50-minute individual psychotherapy sessions per week. Those in the CAMS condition received their individual therapy from a CAMS-certified therapist, who received training from CAMS creator David Jobes, whereas the other participants received TAU. Groups were matched on age, sex, hospital units, suicide severity, and number of prior suicide attempts during analysis to help control for confounding outcome comparisons. The authors found that, regardless of the condition, suicidal in-patients improved significantly across measures of health and wellbeing during their stay. The therapeutic gains remained 6-months post-discharge, but those treated by CAMS therapists, compared to those treated by another psychotherapist, improved significantly faster, and the effects were greater after discharge. However, after 6-months post-discharge, the differences were no longer significantly different. The authors conclude that interventions that emphasize collaboration and that are specifically tailored to suicidal client have advantages compared to TAU, as they address psychological vulnerabilities specific to the population and the client. The authors assert that their results are limited by the high, yet statistically insignificant, rate of attrition (65-66% loss at 6-months post-discharge).

Narrowing specifically on the SRA component, Schembari et al. (2016) explored patients' experiences of being assessed and treated for suicide through CAMS. Specifically, the authors coded previously recorded written comments on the participants' perceptions of the helpful aspects of their treatment (Q1), and what they learned from their clinical care (Q2). The authors analyzed the responses, using CQR (Hill, Thompson, & Williams, 1997), from 49 (Q1) and 52 (Q2) formerly suicidal patients from medical centers in Seattle, Houston, and Denmark who participated in a standardized suicide treatment. Notably, almost all (96%) of the participants endorsed something helpful about their treatment, with the most identified theme being therapy (30.6%). Participants reported learning that actively seeking help (23.1%) and developing stronger introspective coping methods (23.1%) were among the most common factors they took away from their therapy. Indeed, 88.5% of participants identified that the techniques they learned in therapy would be useful to mitigate future suicidal ideations and attempts. It is notable that, a primary component of SRA, identifying the suicide plan, was rated the lowest in terms of utility for participants (9.6%), suggesting that this practice was not emphasized during treatment, or patients did not find it as useful as other techniques. The authors recognize valid interpretations of their results is minimized by their small, heterogenous sample, but bolstered by cross-cultural participant representations from Denmark and the United States.

The CAMS approach is the specific product of a broader movement to include the client in assessment. The profession of psychology promotes the maintenance of competence across practical domains, and SRA is no different. Contemporary psychologists should incorporate evidence-based SRA strategies into their assessment protocols, which, given the current literature, includes establishing a collaborative therapeutic relationship and recognizing suicide as an expression of distress instead of a symptom of pathology. Similarly, the identification of

risk and protective factors can be deepened to help the client understand their psychological pain, rather than inform our clinician-centered, and problematic, SRFs. By embracing new theoretical advancements, such as the CAMS and SSF approach, the stress of working with a recurrently suicidal client may be lessened, which increases the likelihood of successful suicide treatment.

Summary of Research

Given the literature discussing psychologists' experiences conducting SRA is limited, the reviewed research is intended to contextualize the present study in our current understanding of SRA and how it affects health professionals. To accomplish this goal, this section was divided into five thematic areas. In the first area, Mental Health Professionals' Experiences and Practices of SRA, I reviewed qualitative studies that explored the SRA phenomenon through other professionals' experiences of SRA (Table 1). A recurrent experience that emerged from this search was that of fear and lacking resources, as other mental health professionals found SRA to be a stressful and time-consuming process. In the second area, Impact of Client Suicide on Psychologists, I reviewed a mix of qualitative and quantitative studies that examined how psychologists reel from experiencing a client suicide. Here, psychologists often reported crippling functional impairments that preceded a client suicide, beginning with excessive anxiety at the onset of working with an openly suicidal client. In the third section, Psychologists' Attitudes and Beliefs Towards Suicide, I reviewed qualitative research that examined how psychologists view suicide, which illustrated an overall positive and empathic disposition towards suicide compared to other health professionals and the public. These positive attitudes help explain why psychologists are a unique population to study SRA experiences, as their attitudinal valence, combined with the incomparable length of time spent with clients, suggest that the psychologists' experience of SRA is structurally different compared to other health

professionals. In the fourth section, the Clinical Utility of Suicide Risk Assessment, I reviewed recent literature that draws the clinical validity and utility of SRA into question. Here, meta-analyses and other quantitative studies suggested that SRA scales are poor predictors of suicidal death and warn about the impersonal and cold nature of using SRA checklists in clinical practice. Lastly, I reviewed Therapeutic Assessment and Other Collaborative Suicide Risk Assessment Models to contextualize how SRA might be evolving. The most prominent collaborative SRA model, CAMS, asserts that risk assessments should be completed with the input of the client, where direct feedback and collaborative co-constructions of therapy help both parties better understand, and treat, suicidal ideation.

Overall, this literature review demonstrates that the pervasive field of SRA is evolving, yet, the experiences of psychologists, some of the most prominent users of SRA, are being left behind. Although we understand that psychologists are detrimentally impacted by their clients' suicide, and that they have specific positive beliefs about suicide, there exists little other evidence that speaks directly to the experience of psychologists in their use of SRA. The studies reviewed here also point to an impending paradigm shift in the way mental health professionals may use SRA, or how they might conceptualize their suicidal clients. Given that psychologists have an ethical imperative to minimize harm and maximize benefits, how they make sense of their SRA experience is foundational for future suicide training and research.

The Present Study

The purpose of this exploratory qualitative study is to examine the lived experience of psychologists conducting SRA. This was accomplished by interviewing practicing psychologists in Alberta, Canada, with questions exploring how they understand the use of their SRAs, how they view suicidal clients, and how they are affected by SRA. Given that there is currently no

literature on the experiences of psychologists conducting SRA, an exploratory study of this nature is foundational in beginning this line of empirical inquiry. Indeed, the significance of this study is threefold: to obtain a nuanced and experiential understanding of how psychologists conduct and experience SRA, to elucidate the effect of suicide attitudes and beliefs on SRA practice, and to inform training programs by exploring how SRA affects psychologists. Highlighting the significance of SRA may be a new experience for psychologists, given that the practice of SRA is often experienced within busy contexts. As the experience itself may be flooded by other professional responsibilities, using an exploratory approach to initially gather these foundational data allows psychologists to reflect on their experiences and derive meaning from them. Indeed, an exploratory qualitative study helps develop an essence of the SRA experience without intentionally occluding potential significant understandings of the experience.

Research Questions

1) How do psychologists experience SRA? (overarching RQ)
2) How do psychologists view suicidal clients?
3) How are psychologists affected by suicide risk assessment?

An unexpected fourth question emerged during data analysis, namely:

4) How do psychologists view their SRA training?

To address these questions, I used an exploratory qualitative methodology and interpretative phenomenological design. Qualitative methodologies are characterized by a social constructivist philosophy, where multiple realities are co-constructed between researcher and the participant (Creswell & Poth, 2017). As a methodology, qualitative research is further characterized through the recognition of researcher bias, emphasis on ascertaining meaning in

participant interviews, inductive and emergent approaches to textual data analysis, and conclusions that represent a holistic account of the central phenomenon. The qualitative philosophy and methodology is appropriate for this study, given that the subjective and experiential nature matches that of the unstudied and personal phenomenon of psychologists' SRA experiences. Indeed, by leveraging the inductive approaches of qualitative research, we may develop an understanding of the phenomenon that is reflexive, rich, and foundational to our understanding of psychologists' SRA experiences (Braun & Clarke, 2014).

Phenomenological Design

For the present study, I used interpretative phenomenological analysis (IPA), a qualitative constructivist approach to understanding how individuals make sense of their lived experiences. IPA was selected because it allows for the exploration and description of how people understand and interpret phenomena in the world around them. Specifically, phenomenology, in IPA, is the examination of what it is like to be human, or, the examination of how people make sense of their lived experiences (Smith et al., 2009). The underlying philosophical nature of IPA is that experiences are often taken for granted, unexamined by our conscious awareness. The act of being phenomenological is to disengage from routinized behaviours and attend to the experience itself. In this study, psychologists often experience SRA as implicit behaviours, such that they are unaware of how, or why, they use the practice. In IPA, the researcher establishes intentional and conscious reflection of their experience as significant, lending itself well to meaning-making and the development of the "essence" of the phenomenon. Similarly, IPA is further characterized by hermeneutics and idiography, where the former describes the act of constantly comparing details to the whole in a recursive and circular fashion. Idiography interacts harmoniously with these philosophical assumptions, as IPA researchers are often concerned with the particular, that

is, the details and depth of the experiences and their subsequent analysis. Blended together, IPA designs allow researchers to explore the essence of a collective phenomenon across multiple participants, such as psychologists' experiences of conducting SRA.

Chapter 2

Methods

Participants

The sample consisted of two males and three females, with the average age being 37 (*SD* = 6.96) and the average years of practice being 4.5 (*SD* = 3.32). Participants practiced in a variety of settings, with two practicing in a private setting. Similarly, participants have a variety of theoretical orientations guiding their practice, with two practicing primarily from a Cognitive-Behavioural framework. Participants were relatively split on their highest educational achievement, with two practicing with a PhD, and the other three practicing with an M.Ed, M.A/M.S, or M.Sc. All the participants identified as European-Canadian/White. Table 3 summarizes participant demographics.

Procedure

Participants were initially recruited through a research notice board on the Psychologists' Association of Alberta's (PAA) website, the fraternal body of psychological practice in Alberta. Here, a brief description of the study and contact information of the principal investigator (Jonathan Dubue) were published on their website for three months (Appendix A). Additional participants were recruited through e-flyers sent to various practice sites in Alberta, which included the same study information from the PAA website.

A typical participant number for IPA studies, such as this one, is three to six (Creswell & Poth, 2017; Smith et al., 2009), with the primary criteria being that participants bring clarity and

refinement regarding an experience of perception of the studied phenomenon (Braun & Clarke, 2014). To achieve this clarity, I recruited a homogenous sample of five registered psychologists in Alberta through purposeful sampling. Homogeneity is important in this sampling strategy, as it allows an in-depth idiographic description of this subgroup's experiences. Indeed, the closer participants are in characteristics, the greater the significance of their experiential differences (Smith et al., 2009). These participants were homogenous because they shared the following criteria: (a) registered psychologist practicing in Alberta, Canada and (b) reported conducting twelve or more SRAs with clients per year. All registered psychologists practicing in Alberta must be registered under the College of Alberta Psychologists, the regulatory body for the practice of psychology in the province. To become registered, individuals must have at least attained a recognized masters' or doctorate degree in psychology that has relevant practical coursework, completed a national competency exam, completed an ethics oral exam, and have completed 1600 hours of supervised psychological practice above masters degree requirements. Provisional psychologists or students in psychotherapy programs were not included in this study.

Once the participants expressed interest in the study, I sent them an email screener that ensured they fit the inclusion criteria of the study while briefing them on the consent form, the purpose of the study, the audio recording procedure, and confidentiality. Once they electronically returned to me the consent (Appendix B) and demographics form (Appendix C), we scheduled a 25-30 minute phone interview, where, prior to the interview, I instructed participants to take the call in a quiet and confidential space free of distractions and to reflect on a specific SRA experience that is summative of their experience, or significant to their practice.

I used a semi-structured interview protocol (Appendix D) to guide the phone interviews, where a list of predetermined questions facilitated discussion, and follow-up questions were

spontaneously generated to better reflect and deepen their experiences. I also used supportive listening techniques, such as paraphrases, reflections, and validations to support the participants throughout the interview. Interviews lasted for an average of 34 minutes and 29 seconds, with most participants expressing an interest in continuing the conversation. Theoretical saturation was reached with these five participants, as no new information was obtained after the last interview (Braun & Clarke, 2014; Smith et al., 2009). No compensation was provided to the participants.

Once the interview was completed, I informed the participants their interview would be transcribed, where I develop themes and categories, subsequently comparing them to the other interviews. I further informed participants I would email them within two months following their interview with a document that has aggregated themes from each participant, and I will ask for their written feedback about how it fits with their own experiences (Appendix E). I used this synthesized member check to evaluate how the themes, and their descriptions, describe the essence of psychologists' SRA experiences (Birt et al., 2016). Specifically, I asked participants three questions in this member check: (a) do these themes represent your experiences? (b) what would you change about these themes? and (c) what would you add to these themes? Three out of five of the participants responded to the request, all of which agreed, without corrections, with the developed categories and descriptions.

Researcher-as-Instrument and Bracketing

A primary, and essential, component of qualitative analysis is the bracketing of the researchers' own experiences and biases. Indeed, bracketing our own experiences helps the qualitative researcher concentrate on the participant's perceptions of the world (Heidegger, 1962). Prior experiences, assumptions, and preconceptions of the central phenomenon irrefutably

influence how we look at new experiences. Heidegger (1962), in reference to bracketing, suggests that researchers should "make scientific themes secure by working out the fore-structures in terms of the things themselves" (p. 195). Thus, to best ensure I bracketed my own preconceptions and fore-structures prior to data collection and analysis, I wrote about my professional upbringing and reflected on my own experiences and conceptualizations of SRA.

I, Jonathan Dubue, am the principal investigator and primary analyst of the study. My academic history is founded on quantitative methodologies and epistemologies, as I have completed my undergraduate degree in Honours Psychology and have published two quantitative journal articles prior to engaging in this study. Thus, my reigning ontological views for the better part of my academic career have been post-positivist, that there exists a singular truth and that proper research methods help elucidate that truth. Since my foray into my Master of Education in Counselling Psychology, I have developed a personal understanding that truth is co-created within social structures, and my conceptualizations of research have consequently evolved to include, and value, qualitative methodologies. Indeed, the completion of graduate level coursework in basic and qualitative research methods have solidified this constructivist worldview and has primed me for a study of this nature.

I also have an extended history with SRAs. When I was 18, I worked at the Edmonton Distress Line, where, per requirements of the organization, I was mandated to complete a standardized SRA if I heard any semblance of a suicide clue. I often struggled to assess suicide clues, as, much to the organizations' discontent, I opted instead to empathize with the client and endeavored to use our limited time to establish a connection. Given that I had no other comparisons for best practices, I understood these, often innocuous and repetitive, SRAs to be foundational to the practice of counselling. I continued with these highly prescriptive practices

during my four years volunteering at the University of Alberta's Peer Support Center, where I continued to hound my clients on their suicidal ideation, history, current plan/timeframe, and other salient risk and protective factors. These experiences made me skilled at completing typical SRAs, although, they consequently made me aware of their dissociating and reductionist features. During a practicum in my Masters of Education in Counselling Psychology, I further conducted these SRAs, but, given that I had a long-term relationship with my clients, I probed their beliefs about the utility of the practice. Nearly all my clients spoke about how the SRA felt overly prescriptive, and that they failed to understand how the practice helped them become better. Conferring with peers and supervisors, I began developing a harsh opinion on SRA practices, reading about their inefficiencies, hearing stories about the fear they cause psychologists, and recognizing the ethical pressures that are inoculated in counselling students to commit to checklist-based SRA.

Although I reflect harshly on SRA practices, I do not believe they are unequivocally worthless. I instead see opportunity for a paradigm shift in how we practice and view SRA, in the way that we reframe SRA as a collaborative, client-centered approach instead of the current zeitgeist of clinician-focused, information-gathering method. In this way, I believe SRA will directly benefit the client's understanding of their own suicidality, effectively completing our perceived ethical requirements of minimizing the suicide risk while maximizing benefits for the client. Furthermore, training counselling students on collaborative SRA models may help prospective and future psychologists reflect on the existential and deepened nature of SRA, which may assist in the crucial connection-building skill that is necessary in counselling a suicidal client.

Growing up, I was keenly aware of the realities of depression and suicide, as my two closest family members suffered from depression and grappled with suicidal ideation. Being an informal, and sometimes primary, source of support for my family, I grew familiar with talking and thinking about suicide. For the better part of my life, during moments of familial crisis and psychosocial instability, preventing my family members' suicide remained at the forefront of my thoughts and actions. Because I am, to my family, more than just a counselling psychology student, I found that leveraging my relationship often decreased the perceived suicide risk, rewarding my continued use of humanistic and collaborative SRA methods with family, friends, and clients. Because I continue to live with the possibility of losing a loved one to suicide, the success and results of this study are linked to my professional and personal identities.

Considering my personal background with suicide and SRA, I expected the results of this study to reveal that psychologists, just like me, prefer conducting collaborative, humanistic SRAs over mechanistic and close-ended SRAs. I also expected participants to reveal the SRA process to be the most stressful component of their practice, due to the difficulties in predicting and preventing suicide. Ultimately, to bracket these assumptions and endeavor to remain neutral in my interviewing and analysis, I completed memos about these reflections, connected with like- and other-minded peers, and grounded my thinking less as Jonathan Dubue and more as an investigator trying to understand and enter the participant's world.

Despite the attempts at initial bracketing, the process is implicitly reflexive and only ever partially accomplished. The use of triangulation and the synthesized member check assisted in keeping my analysis the best representation of the participants' lived experiences.

Data Analysis

Prior to data analysis, I transcribed phone interviews verbatim and scrubbed any identifying information from the final transcriptions. Once transcribed, I began the standard protocol for data analysis as identified through IPA (Moustakas, 1994; Smith et al., 2009). Although IPA does not endorse a single method for data analysis, IPA offers a set of common stepwise processes and principles to help achieve an iterative, inductive, and meaning-focused analysis of the textual interview data. While the analytic process endeavors to explore the essence of the phenomenon and the lived experiences of the participants, invariably, the resulting analysis will be the account of how I, the analyst, conceptualize the participants' thinking. This double hermeneutic, a key component of IPA, helps identify truth claims as subjective and tentative, although the process used to reach these claims are systematic, rigorous, and dialogical. Thus, to ensure the analysis of this qualitative study remains manageable, IPA provides a step-by-step guideline for novice qualitative researchers, such as myself, to facilitate the analytic process.

The first step in IPA analysis is reading and re-reading the transcript. Here, I listened to the audio of the interview while following along with the transcript, recording my own reflections about the participant's experiences through memoing. The intention of this step is to situate myself in the participant's world, and engage deeply with the data, ultimately slowing down my own processes and focus uniquely on theirs.

The second step involved initial noting of the participants' semantic content and language. This open and reflective process helped me make detailed notes about the participant's unique lived experiences and began my investigation into how they understand the use of SRA. Here, my comments were divided into three categories: (a) descriptive comments, (b) linguistic comments, and (c) conceptual comments. Descriptive comments focused on what the participant

was saying, linguistic comments explore the specific use of language in their experiences, and conceptual comments engaged the underlying phenomenon that guided their experiences. As each case was analyzed, additional cross-case comments were made, looking at similarities and differences between experiences.

The third step involved the development of emergent themes. By this step, I have a clear and comprehensive understanding of the interview, enough that I can aggregate the large data set into salient emergent themes. Compared to the second step, instead of expanding the data, the identification of emergent themes aims to reduce the volume of detail, while maintaining its complexity. Here, chunks of the transcript are separated from its context, where salient and concise descriptors help summarize the essence of this experiential piece of the data. On a conceptual level, I am distancing myself from the participant and looking broadly at how what they have said can be reduced into understandable and decontextualized understandings of the phenomenon.

The fourth step seeks to establish connections across emergent themes. Here, the emergent themes are charted and mapped, as I aggregated similar themes with the intent of forming superordinate categories that describe the case. During this analytic step, some themes were merged with other themes where conceptual overlap existed. To better examine the connections between the emergent themes, I digitally laid out each theme on a movable grid in Atlas.ti (Scientific Software, 2012). Using aggregation strategies such as abstraction, subsumption, and contextualization, I organized the themes into superordinate categories, promoted themes to superordinate categories, and developed categories based on the context the theme was described, respectively.

The fifth step brings me further away from one participant's experience to begin examining another case. Initially, prior to moving to the new case, I wrote down my thoughts on the previous case to bracket and dissociate my conceptualizations from the first case, prior to analyzing the next case. This helps promote the idiographic nature of IPA, as the details of each case should be examined in depth. Inevitably, despite my attempts at bracketing, I was influenced by prior assessment, although I endeavored to develop new themes and categories.

The sixth step seeks to establish patterns across cases. Here, I have finished reviewing and analyzing each individual case for their emergent themes and superordinate categories. Now, I am refining previously established themes and categories as I investigate the parallels and differences between the cases. Here, I merged convergent themes, refined their wording, and examined the overlap between concepts across participants. Specifically, I re-examined each transcript and converged themes that were semantically similar, adding and refining comments for each theme. This was followed by mapping all the themes into their own superordinate categories, which stretched across all five cases. The result was nine superordinate themes that describe the overall experience of a psychologist conducting SRA.

To increase the reliability and validity of these developed superordinate themes, in addition to collecting synthesized member checks from participants, I also compared the resulting themes with my own memos, reflecting on how my own thinking developed these superordinate themes. This comparative process, known as triangulation (Creswell & Poth, 2017), was the last step in completing the analysis.

Chapter 3

Results

The analysis of the participants' transcripts revealed nine superordinate themes: (a) Weaving Assessment and Therapy, (b) Relying on Clinical Intuition, (c) Investing in the Suicidal Client, (d) Empathic View of Suicidal Clients, (e) Suicide is a Choice, But Not a Good One, (f) Fear of Client Suicide Drives SRA, (g) The Pressure of Perfection, (h) SRA is Setting-Dependent, and (i) Graduate SRA Training is Inefficient and Insufficient. See Appendix E for a summary of the findings.

Weaving Assessment and Therapy

The most common experience conducting SRA by participating psychologists was feeling torn between practicing two allegedly ontologically divergent skills, assessment and therapy, into one holistic SRA. The imagery of weaving was used by participant two, as they said: "I would weave techniques or tools that I thought might be helpful to build the relationship into the risk assessment, so I was kind of integrating them" (F, 37, M.A/M.S). Participant three, when discussing this dilemma, contextualized the integration of assessment and therapy as the "art of therapy" (F, 27, M.Sc), noting how therapeutic skills could be used to nuance the SRA, as it encourages clients to be more vulnerable and honest. Participant four went as far as to say that SRA cannot be ethically conducted without the integration of assessment and therapy, which they "firmly believe are two different roles" (M, 46, Ph.D). Participant four goes onto to explain these differing roles:

> The experience is in part stressful, because I'm popping back and forth between being an assessor which is a gatherer of information, a formulator of a plan, a deliverer of a plan, making sure the plan occurs if the client is so distressed that they're going to imminently harm themselves. I have to be ready to assess, decide, and act. And that's not the role of a

> therapist. A therapist, in my orientation, is very much more of a non-directive, following, allow the client to discover their next steps. (M, 46, Ph.D)

All participants identified their SRA experience as a perceived conflict between assessment and therapy. To further qualify these experiences, this superordinate theme was dissected into two subordinate themes: (a) Prioritizing Client Safety and (b) Building Rapport and Connection.

Prioritizing Client Safety. A key validation for integrating assessment into SRA is that psychologists often feel a need to prioritize their client's safety, thus, they emphasize information-gathering approaches to SRA, such as using risk-factor based practices, discrete checklists, and direct questions, to urgently assess the client's safety. Participant two mentions this as, when asked about the main reason for conducting SRA, they said: "for client safety" (F, 37, M.A/M.S), and participant three discusses the biggest piece about SRA being: "developing the safety plan" (F, 27, M.Sc). Psychologists experience this part of SRA through an authoritative identity, as any delays in gathering this information is perceived as a health, and ethical, risk. Participant five speaks to this, as they speak to prioritizing "the [SRA] steps that will keep [the client] safe" (M, 43, Ph.D) because they perceive it as "their duty to protect" (M, 43, Ph.D). Indeed, being emotionally distant from the client, although contraindicated to the development of client rapport, helps narrow the psychologists' efforts on ensuring their client's safety. Participant two discusses the experience of prioritizing the risk assessment, and, only after collecting the information, refocusing on client rapport:

> The thing about risk assessment in how I do them is, I'm trying to get more information. And, part of it is asking questions in a caring way like, what are you thinking of doing. The risk assessment is really helpful to get more information, and then I can show that

> I'm interested, that I care. And when I get that information I also add, to build the relationship, I add parts of myself. (F, 37, M.A/M.S)

In this context, suicide mitigation techniques, such as contracting and action planning are emphasized as discrete and concrete ways to prevent and decrease suicide risk.

Building Rapport and Connection. In contrast, psychologists also feel a need to establish connection with their client when conducting SRA. Psychologists rationalize this approach by asserting that a strong therapeutic relationship will tether their client to the living world and help them deal with common underlying factors in suicide, such as disconnection and hopelessness. Participant four explains their fear and rationale with prioritizing empathy:

> The real part [of SRA] is trying to find that that human hook with the person. And if I can't find that then I'm really in trouble, because all that assessment stuff and safety planning stuff goes straight out the window; they've already seen it before and they've already tried it before. (M, 46, Ph.D)

In this approach, information about the suicidal risk is still gathered, but with less urgency and directedness, allowing the client to explore their suicidal ideations collaboratively with the client. All the participants argued that rapport supports stronger SRA, and that connecting with the client decreases suicidal risk. Participant four, in recalling a SRA with a client, said: "you could feel the difference when the client started to lock in. And that's when everything kind of deescalated" (M, 46, Ph.D). Indeed, by building rapport with the client, psychologists experienced more trust with their client, found it easier to get them to stay in therapy, and developed a collaborative relationship with their client, normalizing and remediating the suicidal risk together. Participant one speaks to this experience:

> I think that having enough therapeutic rapport with someone, and having a strong enough alliance, really, in my experience, contributes significantly to bring suicidality out on the table as something that we can talk about. (F, 32, M.Ed)

It is important to note that, although prioritizing client safety and prioritizing client rapport in SRA were reported as discordant practices, all the participants endorsed both approaches as integral to their SRA experience, with some psychologists prioritizing certain approaches depending on their clinical setting, their current client relationship, and their progress in therapy.

Relying on Clinical Intuition

All the participants referenced a gut feeling in their SRA practices where, although they used scales and measures to predict suicide risk, they also relied heavily on how they felt about the seriousness of the risk. The word *seriousness* was used by each participant as an analogue to level of risk, where seriousness described the *feeling* psychologists had about their client's suicidal risk, regardless of their psychometrically-assessed risk score. Participant one provides an example of this, where, although SRA scales and other colleagues determined that the client was no longer suicidal, that "it was [their] clinical intuition that [the client] wasn't just *not* suicidal anymore" (F, 32, M.Ed). Indeed, participant five expands on this concept by discussing how they need face-to-face interactions to facilitate this clinical intuition:

> I never see the people on the other side of the phone, I don't know their kind of seriousness… I think the sincerity of that reporting is a little easier to gauge with the face-to-face contact. And my clinical judgement can be probably a bit more accurate with the therapeutic engagement. (M, 43, Ph.D)

Indeed, all the participants weighted their own intuition as more valuable than their SRA scales and used their gut feelings to guide the client's therapy and subsequent action plan. Participant four recalls a time they observed a supervisor conduct a SRA with a suicidal client, where, despite SRA scales and protocols suggesting that the client was fit to leave, the participant and their colleagues felt otherwise:

> None of us were *morally* comfortable with just sort of saying, well, good luck with all that. Not even at an *ethical* level, like at a *moral* level, like at a core value level. None of us felt good about her leaving. Not even the junior students. They all were like, this doesn't feel safe. (M, 46, Ph.D)

This theme, in summary, describes how psychologists rely heavily on their own visceral assessment of their clients to guide their SRAs.

Investing in the Suicidal Client

It was common to hear participants speak about deeply investing in their suicidal clients. Worrying about them after session, scheduling emergency meetings, or working overtime to write detailed case notes and follow-ups, were experiences endorsed by all participants. With this investment came a feeling or urgency and depth. Participant three speaks to the pressure felt after hearing a suicide clue:

> …even just like an inkling that they might not want to be here, automatically I feel this pull to be like, okay, I need to explore this further and see if there's risk. Obviously, that sense of urgency as well, too. (F, 27, M.Sc)

Indeed, participant three noted that they feel like "springing into action" (F, 27, M.Sc), as they differentiated themselves from a previous state of therapeutic calm and adopted a stance of

assessment-focused haste. Participant four mirrors this feeling during their formative training at a supportive listening call center:

> You can't just be a passive, kind of active listener, always being, oh that's too bad, or always being anxious, so there was this feeling of ramping up every time that the phone rang. (M, 46, Ph.D)

This sudden resource investment in the client is often followed by a feeling that participant one refers to as "going down the rabbit hole" (F, 32, M.Ed). This is the feeling where, once a SRA has begun, there's a well-trained fixed action pattern that is followed to complete the assessment. Participant three speaks to their process of going down the rabbit hole:

> But if they say there has been [suicidal ideation], that's when I ask more of those more pointed questions and do somewhat of an informal risk assessment to figure out, okay, so they've had suicidal thoughts, what is the frequency of those thoughts, how often are they having them… And then, I look at, has there been a plan put in place. Is this something that they've taken further… Whether it's more of a general thought or a pointed plan… So, if they have a plan I do want to recognize when is this going to happen, have you set a date at this point, or, if things don't get better by this point, then maybe acting on those thoughts. (F, 27, M.Sc)

Participant four nuances this innate urgency and pressure for depth by explaining the grounding features of stress:

> [SRA] gives them something to frame their experience around, because the experience is overwhelming. And it gives me a frame of how much risk there is. So I get a lot of *really* important data around the assessment. (M, 46, Ph.D)

Overall, participants experience a feeling of investing themselves deeply in the client, often initiated through the suicide clue, they spring into action and dive deep into their SRA. Participants further endorsed that, in addition to this investment, they felt that once it had started, they felt committed to completing the SRA, often developing an agitation around assessing future risk, and felt, overall, exhausted by the process.

Empathic View of Suicidal Clients

Psychologists often spoke about their clients through an empathic lens, supporting beliefs that suicide can be justified, that there are underlying psychosocial concerns causing suicide, and that experiencing suicidal ideation was normal. This empathic view was differentiated into two subordinate themes: (a) Clinical View and (b) Humanistic View.

Clinical View. Typically, the first way psychologists spoke about their client was through a clinical lens. Using clinical language, such as low affect, dysregulation, and distress, psychologists viewed their suicidal clients as struggling to speak about suicide, being lost in despair, feeling ambivalent, being isolated, and experiencing shame. Participant five described one of their clients as a "man in a great deal of pain and confusion" (M, 43, Ph.D), and participant two recounted their client as having "sounded kind of depressive and in a low mood" (F, 37, M.A/M.S).

Humanistic View. Conversely, psychologists also endorsed a view of their suicidal clients through a more humanistic lens, as they explored the psychosocial nature of their client's suicidal ideation, discussed its complexities, and noticed the lack of hope in their lives. Participant one recounted an empathic moment in conceptualizing their client: "I'll admit I have parallel process of people where they tell me horrific things, the tortures, the abuses they lived through, and I think, *no shit*, I'd probably want to kill myself too" (F, 32, M.Ed). Participant

three further supports this view when they mentioned: "And I think that anyone can get to a point in their life where they feel like life has become unbearable and they can no longer cope with it" (F, 27, M.Sc).

It was also the case that participants molded both views into distinct descriptions of their clients, where clinical language was used to describe humanistic perspectives of their clients. Participant four speaks about how they see the risk factors plaguing the client, in addition to understanding the deep psychosocial issues that formed the despair: "Their loss, the isolation and loneliness, and that's like the super catalyst on top of the already legitimately existing pain that they feel" (M, 46, Ph.D). This empathic perception of their clients helped participants initiate conversations about suicide, affording them greater opportunity to support their clients and engage in them in SRAs.

Suicide is a Choice, But Not a Good One

When asked about their views on suicide, participating psychologists were clear in endorsing the idea that suicide can be a rational choice. Indeed, participant one succinctly said "suicide makes sense" (F, 32, M.Ed), participant two endorsed the idea that "[suicide] is something that people can choose" (F, 37, M.A/M.S), and participant three asserted that "suicide is definitely a valid experience for someone to want to consider" (F, 27, M.Sc). However, this belief was quickly addended to include the belief that suicide is reactionary. The underlying belief of the participants is that suicide is the result of deep distress and despair, where the client only sees suicide as their remaining option to end their pain. Participant four wrestles with this belief:

> Let's say, if I deescalate them and they're totally deescalated and their like, okay, I'm calm now, and now I very *very* calmly decided and consulted and everything else, and I

> know I'm going to end my life on this day for these reasons, that becomes different for me. The client's autonomy becomes important to me at that point." (M, 46, Ph.D)

Participant five echoes these issues as they say "I will do what I reasonably can do to prevent someone from acting on thoughts of suicide, but, I recognize that it's that person's choice" (M, 43, Ph.D). Participant two echoed a similar opinion, saying: "I think that [suicide] is something that people can choose, even though, as a professional, I would intervene" (F, 37, M.A/M.S). Indeed, participating psychologists believe that suicide is not the solution to their clients' problems, and that, through psychotherapy, they may find alternatives to ending that pain. In the same way, psychologists also believe that suicidal clients do not fully think it through, in regards to their suicide plan, its lethality, or its consequences. Participant one reflects this perspective, saying: "I think that people don't necessarily think through all the repercussions of the ripple effect that can happen with suicide" (F, 32, M.Ed), and participant three, speaking about how a client came close to killing themselves: "kind of questioning whether they realised that, hey, if you had taken all those pills, what do you think would have happened?" (F, 27, M.Sc). Indeed, participant four argues that this lack of fully thinking it through is a by-product of being in unending stress and despair:

> By the very nature of being in distress, their ability to form cognitions are kind of limited, right? When people are in really high distress, they can't make good decisions, even if they try to. They've been lots of studies that show that if you stress someone they can't even make simple mathematical calculations. So, this idea of being of, that the client always knows what's best for them, isn't true when they're in that level of distress, and it's not true for many of us. It's biologically not true. It's *provably* not true.

Fear of Client Suicide Underlies SRA

Psychologists in this study often feared SRA as a practice, given that they felt uncertain about how to best practice it, and because of the potential consequences of poor SRA. Participant two grounds their SRA through fear, saying: "I always try to mentally prepare myself for the fact that I might lose a client to suicide" (F, 37, M.A/M.S), whereas participant three situates current and future SRAs in reflections of the past:

> I'm going into a lot of my risk assessments like, I feel like I'm even more cognizant or on edge, maybe a bit more prone to having more of a thorough risk assessment, because that fear of your client passed away has actually come true." (F, 27, M.Sc)

This fear and uncertainty that underlies the SRA experience can be better understood through two subordinate themes: (a) Lacking Autonomy and Control and (b) Wrestling with an Authoritative Identity.

Lacking Autonomy and Control. The most prevalent explanatory piece to the fear induced by SRA is that psychologists feel a deep lack of control over their client's behaviours. Although the fear fluctuates depending on the setting of practice, being unable to control what happens to their client after they leave the session causes deep fear of client suicide for the psychologist. Participant one speaks to this feeling: "I don't really have any control over when people are discharged…and it can feel really powerless" (F, 32, M.Ed), and participant five expands by saying:

> I recognize fully, that by the time a person, an hour after they walk out of my office, something might have happened that would have changed their risk level. You know, there's only so much a therapist can do. (M, 43, Ph.D)

This lack of autonomy and feeling of powerlessness is often the driver for a steadfast SRA practice that is polished, rapid, and ethically acceptable, as the consequences are too steep

for anything less than perfect. Building fast rapport, keeping close distance with the client, and contracting, all help the psychologist decrease their fear, as the client is often more likely to stay in therapy.

Wrestling with an Authoritative Identity. In stark contrast to feeling powerless, participants also felt like the SRA positions them as a figure of authority, who is viewed as the prime decision-maker and expert in the room. Participant two understands this position, saying that their clients are: "putting their trust in [them]. [They're] the professional" (F, 37, M.A/M.S). This position of power is sometimes foreign to the psychologist, as some brands of therapy emphasize the client as the expert, and the psychologist as a reflective mirror or holding hand that guides them towards self-actualization. Participant four knows this about themselves, saying:

> …there are times when the therapist has to be turned off. Like, the client is in so much distress that they actually need a hard plan, and that they are actually are in so much distress that they cannot contract them. (M, 46, Ph.D)

Indeed, being an authority means making choices, which, in the eyes of the client and the public, must be the right ones. Deciding to intervene is at the center of this fear, as external involvement in the client's therapy is often confrontational, conflictory with some ethical principles, and adds several personal and professional layers of complexity to the therapeutic dyad. Participant two speaks to this concern: "my fear of what if I have that happen, my worst fear, where the client doesn't want me to report it, so I have to call the police and then it turns into this big [deep breath in], conflict" (F, 37, M.A/M.S).

The Pressure of Perfection

A consequence of fearing SRA is that, to mitigate these negative emotions, psychologists adopt and welcome pressures of perfection to their SRA practices. Because they cannot control their client's behaviour, are grappling with a complex novel authoritative power, and lack the knowledge of clear best SRA practices, psychologists mitigate their dissonance and fear by asserting that their SRA practice needs to be the best it can be. This is well represented throughout the study, as participant one comments on their SRA practices: "I just, do the best I can" (F, 32, M.Ed), participant two speaks to the limits to their SRA practice: "as long as you do the best you can, then that *has* to be enough" (F, 37, M.A/M.S), and participant four reflects on why there is this need: "something serious is happening and I've got to be the best therapist I can be right now" (M, 46, Ph.D). The risks of failure and client suicide promote these thoughts, and this pressure is exuded both (a) In the Therapy Room and (b) Outside the Room.

In the Therapy Room. Part of practicing the best SRAs means feeling pressure to be helpful to the client, despite the clinician-motivated goal of gathering the necessary information to complete the SRA. Participant two recalls one client where, while completing the SRA, they remarked: "I feel pressure from my client to actually be helpful" (F, 37, M.A/M.S), while participant three tries to mitigate the pressure by collaborating with their client: "I'm asking these [SRA questions] because I want to be able to help them" (F, 27, M.Sc). Consequently, attempting to assess and help their clients requires strong emotional regulation capacities. Participant three recognizes this, saying that the SRA is "not going to be very productive, if you as a therapist, are a nervous wreck and are exhibiting really nervous behaviour in front of [the client]" (F, 27, M.Sc). Indeed, the psychologist feels pressure from both the client and the self, as they try to navigate their SRAs.

Outside the Room. Although pressure inside the room informs the psychologists' SRA practices, outside the room, psychologists are buffeted by their supervisors, colleagues, and their ethics board to assert that their SRA practices are ethical and justified. Indeed, in managing these outside pressures, participant one views their client notes as protective factors to their practice: "I'll document like crazy because, you know, *cover your ass* doctoring at this point" (F, 32, M.Ed), and does this because of their fear of not practicing ethically: "I'm always conscious of, did I ask the right questions, did I ask them in the right way" (F, 32, M.Ed). Indeed, psychologists feel a resounding pressure to be ethically attuned to the SRA process, given the belief that SRA is an ethical obligation. Participant two recognizes these ethical pressures as absolutes, saying: "there is definitely a pressure to our profession and my ethics, you know, we have the CPA guidelines and then we have CAP. I have a professional responsibility" (F, 37, M.A/M.S). Failing to conduct SRA is viewed harshly, as participant five notes: "I think I'm somewhat negligent if I'm not assessing for suicide in some form or fashion" (M, 43, Ph.D), and participant three understands the consequences of negligence, saying: "if we catch any sort of wind of a client having the impending threat that's something you could be held liable for as a psychologist" (F, 27, M.Sc). Given that psychologists are taught that SRA protects them from litigation, the practice is naturally supported and stanchly defended, creating a definitive pressure outside the room by colleagues to conduct best SRA practices.

SRA is Setting-Dependent

Across the five participants, four primary practice settings were endorsed, all influencing how SRA was viewed and conducted. For example, in hospital/in-patient settings, psychologists appeared less worried about client suicide, given that they have more inherent control and authority over their client's behaviour. Participant one reflects this:

> …they go back to the unit and they're checked on every 15 minutes, or if I'm really concerned I just talk to the nursing staff and we get them on constant observation and someone follows them around 24/7. And they take their shoe laces, and they don't have access to medication so they don't overdose. So management wise, that way, it's easier in this kind of setting. (F, 32, M.Ed)

Similarly, clients in these settings are exhausted and saturated with SRAs, and psychologists leveraged that saturation by being more honest with their clients about the use of SRA to get them to adhere to therapy. Participant one notes: "I'll even make deals with patients where I'm like, I know that you're still suicidal. I know that you get asked about it every five seconds. I'm not going to ask about it anymore" (F, 32, M.Ed). Participant four adds: "some of these young adults have seen more suicide risk assessments than I've done. They've seen it and have been through it so many times. What am I going to add that's going to be any better, right?" (M, 46, Ph.D). Seeing that clients are oversaturated with SRAs, and that they have adopted negative views of the practice, psychologists adapt their practice to their clients.

Similarly, previous client behaviours in specific settings may guide the psychologists beliefs and predictions about their client's risk. Participant three discussed: "one of the places I work at, we see a lot of really compromised clients and a lot of highly suicidal clients, and, unfortunately, I had the unpleasant experience of loosing a client to suicide" (F, 27, M.Sc). Some psychologists assert that some settings are more or less appropriate for their clients, with participant five noting: "I didn't know if my private practice would be a kind of appropriate venue for him, given the potential severity of his circumstance" (M, 43, Ph.D). Ultimately, the type of SRA is deeply dependent on the practice setting, as that informs how psychologists view and conduct SRAs.

Graduate SRA Training is Inefficient and Insufficient

A reflection endorsed by most psychologists, graduate level SRA training was deemed more theoretical and, at times, an after-thought to their training. In reviewing their experiences, most psychologists commented on how disproportionate their SRA training was, in comparison to how often they use it in therapy. When prompted about their SRA training, participant two said: "oh it's terrible" (F, 37, M.A/M.S), participant one commented: "I think I could get more training" (F, 32, M.Ed), and participant three mentioned that: "My [SRA training] wasn't great" (F, 27, M.Sc). Participant four further asserted that SRA training simply was not emphasized: "I got the sense that everybody sort of assumed that we all knew how to do suicide risk assessment" (M, 46, Ph.D).

In addition to being insufficient, participants also endorsed the idea that SRA training should be experiential, focused on developing a practical sense of conducting SRAs rather than a theoretical understanding. Participant three summarizes these reflections:

> I personally think there needs to be more emphasis in the schools and more practice, because it's one of those skills where you can't really look on a lecture slide and know how to do them. You actually have to be able to practice it and feel comfortable asking those questions because they're awkward to ask unless you have training in it. (F, 27, M.Sc)

Indeed, knowing how and where, psychologists are trained is paramount to changing how SRAs are conducted, as nearly all the interviewed psychologists point to their first exposure to SRA training as their preferred method of practice. Participant two notes: "I really feel that a lot of the knowledge I've gotten is from what supervisors do… I obviously trust it because I use them" (F, 37, M.A/M.S). Indeed, one of the participants who has had a practice for over a

decade, continues to reference their SRA training at a volunteer call center as their primary method of SRA practice. Notably, the participants did not speak about novel learnings regarding their SRA practices over their professional careers, suggesting that there is little pressure, or emphasis, to update their standard of care in this area.

Chapter 4

Discussion

The purpose of this exploratory qualitative study was to obtain a deeper understanding of the lived experiences of psychologists conducting SRA. This is accomplished through the phenomenological analysis of semi-structured interviews with five practicing Albertan psychologists. Results addressed the overarching research question: "What are psychologists' experiences of conducting SRA?" and provided exploratory information on two other research questions: "How do psychologists view suicidal clients?" and "How are psychologists affected by SRA?". The data also answered an additional emergent question not originally proposed in the methods, that is: "How do psychologists view their SRA training?"

Research Question 1: What are Psychologists' Experiences in Conducting SRA?

Results of this study have elucidated two key understandings of psychologists' SRA experience. Firstly, psychologists differ uniquely in their SRA experiences compared to other mental health professionals. And secondly, psychologists struggle with balancing the worldviews and practices of traditional information-gathering and contemporary collaborative/therapeutic assessment models in SRA.

Psychologists' SRA Experiences Differ from Other Health Professionals.

Psychologists, as health professionals, differ from other professional colleagues largely due to training programs focusing on biopsychosocial understandings of health (Fitzpatrick & River,

2018; Hill & O'Brien, 2004). Indeed, psychologists are taught to examine the intersection of the client's social, biological, and psychological health to determine therapeutic course, whereas other health professionals typically treat patients through a biomedical framework emphasizing a post-positivist solution to discrete biological problems (Engel, 1980). In emphasizing the biopsychosocial approach, psychotherapy values a strong therapeutic relationship as a primary factor that emboldens client change, a process that takes several one-hour sessions across multiple weeks. In contrast, other mental health professionals may have as little as 15 minutes to complete their assessments and recommend treatments (Delgado et al., 2011). The differences in the time spent with clients, in addition to the divergent views on health, make psychologists a unique population of study in the health field, specifically for practicing SRA.

Some of the most prominent complaints regarding SRA from other mental health practitioners revolved around lacking time. Nurses and emergency department staff (Petrik et al., 2015), physicians (Roy et al., 2017), and psychiatrists (Waern et al., 2016), all reported being too busy to adequately conduct SRAs. Indeed, due to a lack of time, these mental health professionals often diverted the task of SRA to those whom, they believed, had the capacity to properly invest a full SRA. Off-setting the duty of SRA to psychiatric nurses, social workers, or other allied health professionals, such as psychologists, does assist in providing patients with attuned care (Ward-Ciesielski, Wielgus, & Jones, 2015), although it increases the risk of the client falling through the cracks of the health care system. This may open up health practitioners to litigation and client reviews in the event of a client suit or suicide, which is a common and overwhelming fear of most health care workers (Awenat et al., 2017). In comparison, none of the participants in this study reported difficulties in time management during SRA, even those in fast-paced hospital settings that might promote more efficient SRA. Evidently, SRA requires

more time than most health professionals can afford, as the SRA, and suicide treatment, may be better conducted through a strong therapeutic alliance.

An additional difference lies in how practitioners attend to their clients during SRA. A common thread throughout this study was the desire to develop client connection, regardless of SRA methods or ontological worldviews regarding death and suicide. All participants noted how connecting to the client was seemingly a key deterrent in their client's suicide, which consequently increased the reliability and fidelity of their SRA and SRF. These views are consistent with the literature on contemporary suicide treatment, as a strong therapeutic alliance decreases overall suicidality and self-harming behaviours (Dunster-Page, Haddock, Wainwright, & Berry, 2017). Participants in this study seldom reported feeling disconnected to their clients during SRA experiences, suggesting there was sufficient time in clinical practice to develop and maintain a meaningful therapeutic alliance with clients. In comparison, however, other health professionals found themselves starved for similar connection, reporting low emotional contact (Waern et al., 2016), feelings of detachment after assessment (Michail & Tait, 2016), and hopelessness throughout the process (Awenat et al., 2017). Other mental health professionals are not, it appears, afforded opportunities to develop a similar connection, as a result of the time-limited structures in which they work. Given that psychotherapy is normed on 50-minute sessions spanning several weeks, the results of these data suggest psychologists are perhaps better equipped to conduct SRA and treat suicidal clients.

Although these differences are pronounced, there are similarities between health professionals and psychologists regarding SRA experiences. Across all professions, feelings of uncertainty plagued the use of SRA, as health professionals consistently report lacking confidence in their SRA practices and resulting SRFs (Petrik et al., 2015; Regehr et al., 2016;

Roy et al., 2017). Participants in this study extend these findings by highlighting how there is no unequivocally agreed-upon SRA practice, which may be a primary cause for the ambiguous feelings present in SRA. This uncertainty extends implicitly into clinician fear of client suicide, which is consistent with findings in the literature (Pope & Tabachnick, 1993; Truscott, 2018). The experience of SRA-induced fear, and fear-based SRA, is unsurprising, given traditional risk-factor-based SRAs themselves are poor predictors of suicide (Large et al., 2016; Nock, Kessler, & Franklin, 2016). Many clients with chronic suicidal ideation never make a suicide attempt, or die by suicide, yet, clinicians often experience an overwhelming fear of getting SRAs wrong.

In mitigating this worry, health professionals conducting SRA often referenced the necessity of consulting other allied professionals to increase certainty in their SRA practice (Awenat et al., 2017; Waern et al., 2016). Participants in this study similarly emphasized supervision and colleague consultation as a way to increase the certainty in their SRA practices, thereby decreasing anxiety and fear responses. Participants in this study extended this experience by endorsing the personal therapeutic benefits of collaborating with their clients on conducting SRA, as they reported it decreased their own anxiety of conducting SRA, while increasing the validity in the SRA/SRF. Given there is a perception that no singular best SRA practice exists, clinicians practicing SRAs require external validation, either from their client or colleagues, to mitigate the anxiogenic effects of SRA.

Balancing Information-Gathering and Collaborative SRA. The primary theme endorsed by psychologists was the struggle of being both an assessor and a therapist while they conducted SRAs. Participants said prioritizing risk factors and quickly gathering salient determinants of health, while enabling client trust and leveraging the therapeutic relationship to enact client change, was demanding and bewildering. As uncovered in this study, these two roles

are both complimentary and adversarial in SRA, as assessing the client's risk factors often decreases trust and diminishes the therapeutic alliance, yet, gathering client information increases the likelihood of a strong safety plan (Schembari et al., 2016). Conversely, approaches that uniquely emphasize client connection and the therapeutic alliance fail to prioritize the assessment of suicide, which may impact the quality and likelihood of a successful safety plan. Some participants saw the practices as integrative, where they used client connection as the basis for gathering their assessment information, a practice which is more reliably decreases suicide risk (Dunster-Page et al., 2017). The struggle between these two roles describes part of the essence of practicing SRA as a psychologist, and while this data is recent, the alleged ontological struggle between information-gathering (IG) assessments and collaborative/therapeutic assessments (C/TA) has been misperceived for decades (Finn & Tonsager, 1997).

Traditional SRA, borne by the IG model of assessment, has over-focused on gathering risk factor information (Nock et al., 2016). Factors such as demographics, previous suicide attempts, mental health concerns, or substance use, are all prioritized as inquiries to the client, as a way to swiftly assess the client's level of imminence, despite being poor predictors of suicide (Chan et al., 2016). No method of traditional SRA has been empirically tested for reliability and validity, nor has any method boasted sufficient sensitivity of specificity to be effective (Simon, 2012). This is likely due to the low base rate of suicide, estimated at 0.0115% in Canada (Statistics Canada, 2017). For example, even if the presence of a previous suicide attempt increased the risk of suicide by 30 times, effectively changing the base rate to 0.35%, that still equates to about 1 suicide in every 286 clients who have endorsed previous suicide attempts. With such a minute base rate, and no reasonable differences in treating someone at low or high-risk suicide, traditional SRAs are unhelpful to both client and therapist.

It is understandable therapists in this study struggled to weave the facets of assessment and therapy into one cohesive SRA practice, given therapists are often trained to complete these practices divergently. Participants in this study all endorsed the concept that, in SRA, information must precede the relationship due to ethical and safety obligations, and that assessment is often dissociated from the client. This is the framework typically adopted by counsellors who are often lacking in SRA training, or feel incompetent in the practice (Brown et al., 2015; Jacobson, Hanson, & Zhou, 2015). By training psychologists to practice IG-centric SRA that separates assessment and therapy, a precedent is set to view them as incongruent, increasing the cognitive difficulty of the practice, denouncing other non-IG SRA practices as unethical, and decreasing the likelihood of client collaboration and, consequently, remedial therapeutic outcomes.

As participants in this study further reflected, honest SRAs prioritizing client connection and self-understanding are often defaulted to after ensuring the client's immediate safety. Participants in this study argued that this paradigm shift away from the IG model of SRA often increased their stress of ethical perfection and of best SRA practices. These reflections match those of Finn and Tonsager (1997), as they identified that the process of assessment and psychotherapy are becoming increasingly blurred, and that the C/TA and IG approaches can be theoretically and practically complementary. Although our understanding of weaving therapy and assessment together in SRA is fairly new, these ontological shifts of providing feedback and collaborating with the client during assessment are well-established (Finn, 2007). For example, researchers and practitioners, such as Jobes (2016) and Mohammadi (2015), have already developed C/TA models of SRA, which integrate the IG approach to ensure client safety, while emphasizing client collaboration as the primary therapeutic factor steering clients away from

suicide. In-line with participant reflections, future SRAs are likely to be weighted more heavily towards client connection, and that the pressure of ensuring immediate client safety through reductionist IG methods will inevitably decrease.

Research Question 2: How do Psychologists' View Suicidal Clients?

As noted in the results, participants have a relatively empathic and highly supportive view of suicidal clients. This view, where psychologists endorsed empathic responses to suicide rather than stigmatizing their clients, was wholly consistent across all five participants, and it is also consistent with the literature (Gagnon & Hasking, 2012; Hammond & Deluty, 1992). However, additional data were uncovered suggesting psychologists view suicidal clients through two lenses: a clinical lens and a humanistic lens. When prompted to discuss how they viewed suicidal clients during SRA, participants almost always led with a clinical description of their client, suggesting that a clinical approach is prioritized over an humanistic one. The inherent response to view and conceptualize suicidal clients through a clinical lens fits with how psychologists also struggled to weave IG and C/TA approaches, often favoring and prioritizing IG SRAs. By seeing clients clinically first, psychologists may begin conducting an informal SRA, as they develop a sense of the client's risk factors through observation and dialogue. However, once participants exhausted their clinical reflections of the client, they commented on the more personal and humanistic characteristics of their clients. This clearly mimics the priority between IG and C/TA methods of assessment, suggesting some resonance with previous data.

Beliefs about Suicide. Consistent with the literature, participants endorsed empathic beliefs about suicide (Cwik et al., 2017), yet nuanced their beliefs with the caveat that, although rationale and acceptable, suicide is not the right answer. This belief is a reflection of the pervasive worldview of psychologists, as believing clients are capable of change is paramount to

believing in, and effecting, therapy (Hill & O'Brien, 2004). Although psychologists understand the rationality of suicide, and, in certain cases endorse the act, believing clients cannot be healed through psychotherapy would counter the foundation of the profession. Instead, participants argued most suicides stem from deep psychosocial stress, and that the stress occludes their options to relieve their pain. In holding this complex belief, psychologists in this study agreed most clients can be treated through psychotherapy and see opportunities in their practice with suicidal clients to help them see choices other than suicide.

It is critical that, in addition to understanding the essence of how psychologists experience SRA, we further attune to suicide beliefs of psychologists and psychotherapists-in-training. Suicide beliefs invariably affect psychotherapy practice, where, in some cases, a negative or neutral belief leads to biased and stigmatizing SRA (McCabe, Sterno, Priebe, Barnes, & Byng, 2017). It is no surprise that recent guidelines and trainings include a dissection of psychotherapists' suicide beliefs as part of their SRA training (Schmitz et al., 2012), yet suicide beliefs are not prioritized in graduate-level SRA training (Liebling-Boccio & Jennings, 2013). Given participants in this study endorsed humanistic and empathic beliefs about suicide, our current account of how SRA practices are affected by beliefs are narrow. It is increasingly vital we develop a stronger understanding of how beliefs influence SRA practices, and that we survey psychologists on their suicide beliefs.

Research Question 3: How are Psychologists' Affected by SRA?

Participants in this study, when queried about how SRA affects them, endorsed feelings of agitation, exhausting emotional and physical arousal, and debilitating neuroticism. As a way of preventing client suicide, participants deeply invested time and effort into suicidal clients, disproportionately to other clients. Given the common understanding that client suicide, at some

point in the psychologists' career, is inevitable (Chemtob et al., 1989), and that the reactions from said client suicide are resoundingly negative (Ellis & Patel, 2012), it is understandable psychologists seek to prevent those experiences. Unfortunately, two of the five participants reported they had lost a client to suicide, and, when discussing their experiences, they expressed similar sentiments to other psychologists who have lost a client to suicide, such as guilt, betrayal, anxiety, and withdrawal (Skodlar & Welz, 2013). It is the fear of client suicide that participants endorsed as one of the main components of conducting SRA, creating an internal locus of control towards client suicide (Rotter, 1966) and ultimately fostering a culture of self-efficacy in the face of an unpredictable phenomenon. The belief psychologists can prevent suicide is aspirational and potentially damaging to their psyche yet, consequently, believing nothing can be done is likely more harmful (Truscott, 2018). It is therefore critical to educate psychologists and other mental health professionals about the predictability and the known treatments to suicide, to increase the understanding that, although there is hope to prevent client suicide, there is sometimes little that can be done to prevent it.

Setting Determines How Psychologists are Affected. How SRA affects psychologists is deeply related to practice settings. Participants who primarily practice in inpatient clinical settings endorsed less anxiogenic experiences, as their clients have little to no access to lethal means of suicide. In this way, participants felt less responsible for their client's immediate safety, thereby allowing them to divide their attention evenly across their case load. Conversely, participants who worked in outpatient or community clinics, endorsed feelings of sole responsibility to prevent client suicide. In these settings, SRA became less of an opportunity to connect with the client's existential pain, and more about ensuring they would not die by suicide, often prioritizing IG methods over C/TA methods. Given that setting-specific variance was not a

primary research question in this study, there is additional opportunity to investigate how clinical settings influence SRA types and experiences.

Emergent Research Question 4: How do Psychologists' View their SRA Training?

The semi-structured nature of the interviews used afforded the opportunity for participants to deeply explore their SRA experiences. One such facet was reflecting on their SRA training, which nearly all participants resoundingly agree was inadequate. Four of the five participants reported their SRA training was inordinate to the frequency of suicide in their practice, and that the training itself remained theoretical, rather than experiential. Only one of the participants reported a reasonable SRA training experience.

Being disappointed by graduate-level SRA training is not new to the field, as only half of pre-doctoral psychology interns report any formal training in the area (Dexter-Mazza & Freeman, 2003). Although SRA training is endorsed by graduate-level programs (Liebling-Boccio & Jennings, 2013), there is no expectation from colleagues or ethics boards to maintaining SRA competency through additional post-graduate training (Silverman & Berman, 2014a), despite significant and recent research that brings traditional SRA into question (Sommers-Flanagan & Shaw, 2016). As our primary health concerns transition towards psychosocial understandings of care, psychologists must be prepared to provide ethical, updated, and effective SRA.

Limitations

This study was limited by at least three factors: the heterogeneity of the sample, biased interpretation of the data, and recruitment methods.

The heterogeneity of the sample may have decreased the idiographic nature of the results. Participants came from a large age (27 – 46 years) and years practicing range (0.5 – 10 years),

from diverse academic backgrounds, practice settings, and theoretical orientations. The only criteria that was homogenous in this sample was all participants practice psychology in Alberta, Canada, and they identify as European Canadians. Due to diversity in the sample, results of this study may have lacked an idiographic depth, ultimately limiting the certainty in our results.

An additional limitation is the biased interpretation of the data analysis and results. Although I conducted a synthesized member check (Birt et al., 2016) and used triangulation (Creswell & Poth, 2017), I remained the sole analyst of the transcripts. In this way, I may have biased the quote selection and analysis, ultimately influencing how themes were developed and how research questions were answered.

This study is also limited in how the members of the study were recruited. As is the case in most studies of this nature, participants were self-selected, potential biasing the results to be more suicide-informed than the average sample of psychologists. This may have specifically affected the humanistic understanding and support shown towards suicidal clients, or how participants endorsed feelings of deep investment in their clients, given these participants were engaged and knowledgeable of suicide and SRA prior to the study.

Directions for Future Research

As an exploratory qualitative study, the results provide a foundation for future empirical inquiry in how psychologists experience SRA. The national and provincial sample of psychologists in Canada varied significantly from the sample in this study (Psychologists' Association of Alberta, 2017; Ronson, Cohen, & Hunsley, 2011), suggesting an opportunity to generalize and replicate this study on a larger, and more diverse, scale. Metrics of age, gender, ethnicity, theoretical orientation, years of practice, and personal experiences with suicide are all critical variables to incorporate when generalizing these results. In this way, future directions of

this research could include a national survey of psychologists' experiences of SRA, where mixed methods are used to nuance the quantitative survey data with qualitative anecdotal experiencing. This survey, in addition to investigating and reporting on the psychologists' experience of SRA, may also provide actuarial data on how psychologists experience SRA training, how they currently practice SRA, and how their beliefs on suicide influence their practice.

Another future direction is the replication of this study across different cultural backgrounds. The cultural background of this study's participants was European-Canadian and, although the Canadian Psychological Association nor the Psychologists' Association of Alberta publishes demographics statistics on the ethnicity of their registered members, it is evident that a culturally homogenous sample is not representative of the field. Indeed, this is a reflection of a larger problem in the study of thanatology, as 81.9% of suicide research published between 2010 and 2014 has been conducted in North America and Europe, and only 6% has been conducted in China and India, despite claiming near half of the world's suicides (Lopez-Castroman, Blasco-Fontecilla, Courtet, Baca-Garcia, & Oquendo, 2015). The translation of suicide research into practice has likely been framed through a Western-centric lens, which explains the preference for deterministic SRA, the adherence to perceiving suicide as pathology, and for viewing suicide as the ultimate end to meaning (Ma-Kellams & Blascovich, 2012). Comparatively, Eastern, or primarily collectivist cultures, emphasize collaborative models of healing, promote ideals of selflessness, and view death with less anxiety, given that their identities are strongly linked to communal in-groups (Hofstede, 1980; Peng & Nisbett, 1999). Evidently, the experiences accrued in this study were primarily from a western, individualist background, and may not be representative of all SRA experiences in Alberta, Canada, or globally.

Lastly, future qualitative studies can refine the data collected in this study, particularly regarding the intricacies of weaving assessment and therapy, the differences between practice settings, or how volunteer experiences prior to graduate training influence SRA practices. Although IPA was used for this study due to the phenomenological nature of the research questions, future studies could also examine SRA experiences through a naturalized setting as an ethnography, such as Aflague and Ferszt (2010), through an in-depth case study analysis, such as Skodlar and Welz (2013), or using a grounded theory approach to conceptualizing SRA (Glaser & Strauss, 2009).

Implications for Practice and Training

The results of this study have significant implications for practice and training of SRA. Based on these results, the following recommendations are made:

1. Explore the practice of collaborative and client-centered SRA that emphasizes client connection, as it may be a better therapeutic fit for both your client and you as a practitioner. A C/TA SRA practice of this nature may also decrease the disparity between suicide assessment and treatment, empower the client to better understand their suicidality, decrease the cognitive load and difficulty of SRA, and create SRFs that are of a higher fidelity than traditional IG SRA (Sommers-Flanagan, 2018).
2. Develop and revise graduate-level psychologist training to include experiential SRA as a foundational component to the competencies needed for effective psychotherapeutic practice. By prioritizing experiential learning over theoretical learning, such as including role-plays and *in-vivo* observation of SRA, new psychologists may feel less anxiety towards practicing SRA outside of a training

setting, while developing a culture of seeing SRA as a longstanding competency that requires consistent follow-up.

3. Integrate the appraisal of suicide beliefs as part of SRA training and concurrent psychotherapy practice. A missing piece from most SRA training is the investigation of suicide beliefs, and, given their influence on practice, psychologists may avoid developing stigmatizing practices by addressing these existential and moral queries early in training.
4. Increase clarity in SRA practices across ethical guidelines and requirements. It is common to understand SRA as a necessity to treating suicide, yet, according to the Canadian Psychological Association, sufficient due diligence is the only recommended practice, rather than the misconception of needing to complete specific SRA scales. C/TA SRA, such as the CAMS (Jobes & Jennings, 2011) are equally effective, sufficiently standardized for litigation defense, and have shown superior outcomes to treating client suicide. Furthermore, the use of SRA scales, such as the Beck Depression Inventory (Beck, Steer, Ball, & Ranieri, 1996), may still be used for assessment purposes, but they must be followed with a personalized interview.
5. Develop specific knowledge about treating a suicidal client. A common mistake is to view suicidal ideation as pathological, which is natural given pervasive negativity typically experienced by a suicidal client. This may lead psychologists towards encouraging, but not empathic, responses. Saying things like: "this too shall pass", or "let's focus on what's going well," prevent empathic connections. Instead, sitting with the client in their despair, and reflecting a willingness to explore the suicidal ideation together, may be more beneficial: "right now, I hear that you're miserable

and hopeless" or, "I'm hearing some heavy thoughts. Tell me more about how you're experiencing your thoughts of suicide." Table 4 summarizes key factors in having a therapeutic conversation about suicide.

Conclusion

Suicide is multifaceted, morally vexing, and a low base-rate phenomenon. Predicting such an event has shown promise in controlled research settings, yet fails during clinical trials (Sommers-Flanagan, 2018). Our failure to effectively predict suicide has led to SRA practices guided by fear, often prioritizing a standardized method that is ethically sanctioned to diminish litigation anxiety. In our efforts to keep clients safe, psychologists have overvalued SRAs as a tool, and have forgotten that a desire for connection and to communicate their distress are the true reasons a client discloses suicidal ideation.

Prior to this study, we knew very little about how psychologists experience SRA. We know a little more now. And, although this qualitative exploratory study has helped elucidate notable experiences, such as weaving assessment and therapy, investing in the client, and feeling collegial pressures, the psychologists' experience remains to be fully understood. Aspects of the experience, such as the actuarial usage of SRA scales versus verbal assessments, the effects of suicidal beliefs affecting SRA practice, or in-depth analyses on how SRA training informs SRA practices, all remain unanswered. As one of the first inquiries into this area, this study provides a potentially useful framework from which to expand, critique, and better understand how psychologists experiences the process of conducting SRA. As the rate of suicide is expected to rise to one death every twenty seconds by 2020 (World Health Organisation, 2018), it is paramount psychologists recognize the weight, consequences, and therapeutic opportunities of SRA.

Tables and Figures

Table 1

Characteristics of the studies exploring other mental health professionals' suicide risk assessment experiences

Study	Population	N	Location	Research Design	Data Collection Method	Data Analysis Method
Waern et al. (2016)	Psychiatrists	15	Sweden	Cross-sectional qualitative	Face-to-face semi-structured qualitative interviews	Inductive thematic analysis (Braun & Clarke, 2006)
Petrik, Gutierrez, Berlin, and Saunders (2015)	Emergency Department Providers	92	Colorado, U.S.	Phenomenology	Qualitative online survey	Inductive thematic analysis (Braun & Clarke, 2006)
Roy et al. (2017)	Emergency Department Physicians and Residents	16	South-West U.S.	Phenomenology	Focus Groups	Thematic analysis (Braun & Clarke, 2006)
Michail and Tait	Inner City General	28	United Kingdom	Phenomenology	Qualitative Focus Groups	Framework Analysis

(2016)	Practitioners				and one in-depth interview	(Ritchie & Spencer, 1994)
Awenat et al. (2017)	Hospital Staff working with Suicidal Psychiatric in-patients.	20	Northern England	Phenomenology	Semi-structured interviews until theoretical saturation	Thematic analysis (Braun & Clarke, 2006)
Aflague and Ferszt (2010)	Psychiatric Nurses	6	United States	Phenomenographic	Observation, vignettes, and semi-structured interviews	Phenomeno-graphic data analysis (Marton, 1986)
Regehr et al. (2016)	Social Workers	71	Canada	Mixed-Method	Observation of simulated patients, quantitative self-report scales, semi-structured interviews	Thematic analysis (Braun & Clarke, 2006)

Table 2

Comparing the information-gathering and therapeutic models of assessment from Finn Tonsager (1997)

Criteria	Information-Gathering	Therapeutic Assessment
Assessment Goals	Describe the client using empirical measures	Help the client explore new understandings of themselves
Assessment Process	Unilateral, deductive test interpretation	Iteratively collaborate with the client to define assessment goals and check for client understanding
Assessment Rationale	Standardize clients' behaviours to predict behaviour outside of assessment setting	Open dialogue for clients to examine usual responses to their environment
Assessor Role	Objective observer	Participant-Observer
Consequences of Failed Assessment	Biased or inaccurate information is collected, and the wrong treatment decision is made	Client does not feel respected or understood, and they do not acquire new understandings about themselves

Table 3

Participant Demographics

Participant	Age	Sex	Highest Degree Earned	Years Practiced	Ethnicity	Primary Practice Setting	Theoretical Orientation
1	32	F	M.Ed	6	European Canadian	Psychiatric Unit / Hospital	Psychodynamic and Cognitive Behavioural
2	37	F	M.A/M.S	0.5	European Canadian	Private Practice	Integrative
3	27	F	M.Sc	2	European Canadian	Private Practice	Cognitive Behavioural
4	46	M	Ph.D	4	European Canadian	Community Mental Health Center	Process-Experiential
5	43	M	Ph.D.	10	European Canadian	University / College Counselling Center	Cognitive Behavioural

Table 4

Summative guide to a therapeutic discussion about suicide. Adapted from Sommers-Flanagan (2018).

Behaviour	Rationale
Be clear and direct when addressing suicide.	Demonstrates a comfort with discussing suicide, which increases the likelihood of honest disclosures.
Express empathy for the client's suicidal thoughts.	Increases connection to the client, which reduces suicide risk and increases client comfort.
Normalize the pervasiveness of suicide.	Decreases stigma of having suicidal thoughts, and increases client's comfort with suicide disclosure.
Use a scaling question to investigate the suicidal thoughts.	Placing suicide, and suicidal thoughts, on a scale shows the malleability of the thoughts, which increases the likelihood of building hope.
Identify the pain underlying the suicidal thoughts as separate from the client.	Client does not feel respected or understood, and they do not acquire new understandings about themselves
Initiate collaborative safety planning and reframe hospitalization.	Personalizing the safety plan to the client is paramount to successful enactment. When the risk exceeds collaborative capacities, reframe hospitalization as a temporary solution that is meant only to de-escalate.

References

Aflague, J. M., & Ferszt, G. G. (2010). Suicide assessment by psychiatric nurses: A phenomenographic study. *Issues in Mental Health Nursing*, *31*(4), 248–256. https://doi.org/10.3109/01612840903267612

Ahmedani, B. K., Simon, G. E., Stewart, C., Beck, A., Waitzfelder, B. E., Rossom, R., … Solberg, L. I. (2014). Health care contacts in the year before suicide death. *Journal of General Internal Medicine*, *29*(6), 870–877. https://doi.org/10.1007/s11606-014-2767-3

Awenat, Y., Peters, S., Shaw-Nunez, E., Gooding, P., Pratt, D., & Haddock, G. (2017). Staff experiences and perceptions of working with in-patients who are suicidal: Qualitative analysis. *British Journal of Psychiatry*, *211*(2), 103–108. https://doi.org/10.1192/bjp.bp.116.191817

Bateman, A., & Fonagy, P. (2008). 8-Year follow-up of patients treated for borderline personality disorder: Mentalization-based treatment versus treatment as usual. *American Journal of Psychiatry*, *165*(5), 631–638. https://doi.org/10.1176/appi.ajp.2007.07040636

Beck, A., Kovacs, M., & Weissman, A. (1979). Assessment of suicidal intent: The scale for suicide ideation. *Jornual of Consulting and Clinical Psychology*, *47*(2), 343–352. Retrieved from https://www.researchgate.net/publication/22673360_Assessment_of_suicidal_ideation_The_Scale_for_Suicide_Ideation

Beck, A. T., Steer, R. A., Ball, R., & Ranieri, W. (1996). Comparison of Beck Depression Inventories -IA and -II in psychiatric outpatients. *Journal of Personality Assessment*, *67*(3), 588–97. https://doi.org/10.1207/s15327752jpa6703_13

Beck, A. T., Steer, R. A., Kovacs, M., & Garrison, B. (1985). Hopelessness and eventual suicide:

a 10-year prospective study of patients hospitalized with suicidal ideation. *American Journal of Psychiatry*, *142*(5), 559–563. https://doi.org/10.1176/ajp.142.5.559

Bedi, R. P., Sinacore, A., & Christiani, K. D. (2016). Counselling Psychology in Canada. *Counselling Psychology Quarterly*, *29*(2), 150–162. https://doi.org/10.1080/09515070.2015.1128398

Bereska, T. M. (2014). *Deviance, Conformity, and Social Control in Canada* (4th ed.). Ottawa, Ontario: Pearson Education Canada.

Birt, L., Scott, S., Cavers, D., Campbell, C., & Walter, F. (2016). Member Checking: A Tool to Enhance Trustworthiness or Merely a Nod to Validation? *Qualitative Health Research*, *26*(13), 1802–1811. https://doi.org/10.1177/1049732316654870

Bolton, J. M., Gunnell, D., & Turecki, G. (2015). Suicide risk assessment and intervention in people with mental illness. *British Medical Journal (Online)*, *351*. https://doi.org/10.1136/bmj.h4978

Booth-Kewley, S., Larson, G. E., & Miyoshi, D. K. (2007). Social desirability effects on computerized and paper-and-pencil questionnaires. *Computers in Human Behavior*, *23*(1), 463–477. https://doi.org/10.1016/j.chb.2004.10.020

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Braun, V., & Clarke, V. (2014). *Successful Qualitative Research: A Practical Guide for Beginners*. London, UK: Sage.

Brown, G. K. (2000). *A review of suicide Assessment mesaures for intervention research with adults and older adults*. *National Institute of Mental Health*. Bethesda, MD.

Brown, L. M., Framingham, J. L., Frahm, K. A., & Wolf, L. D. (2015). Crisis counselors' perceptions and assessment of suicidal behavior among hurricane survivors receiving crisis counseling services. *Disaster Medicine and Public Health Preparedness*, *9*(3), 291–300. https://doi.org/10.1017/dmp.2015.41

Burgess, P., Pirkis, J., Morton, J., & Croke, E. (2000). Lessons from a comprehensive clinical audit of users of psychiatric services who committed suicide. *Psychiatric Services*, *51*(12), 1555–1560. https://doi.org/10.1176/appi.ps.51.12.1555

Chan, M. K. Y. Y., Bhatti, H., Meader, N., Stockton, S., Evans, J., O'Connor, R. C., … Kendall, T. (2016). Predicting suicide following self-harm: Systematic review of risk factors and risk scales. *British Journal of Psychiatry*, *209*(4), 277–283. https://doi.org/10.1192/bjp.bp.115.170050

Chemtob, C. M., Bauer, G. B., Hamada, R. S., Pelowski, S. R., & Muraoka, M. Y. (1989). Patient suicide: Occupational hazard for psychologists and psychiatrists. *Professional Psychology: Research and Practice*, *20*(5), 294–300. https://doi.org/10.1037/0735-7028.20.5.294

Chu, C., Klein, K. M., Buchman-Schmitt, J. M., Hom, M. A., Hagan, C. R., & Joiner, T. E. (2015). Routinized Assessment of Suicide Risk in Clinical Practice: An Empirically Informed Update. *Journal of Clinical Psychology*, *71*(12), 1186–1200. https://doi.org/10.1002/jclp.22210

Chu, J., Hoeflein, B., Goldblum, P., Espelage, D., Davis, J., & Bongar, B. (2018). A Shortened Screener Version of the Cultural Assessment of Risk for Suicide. *Archives of Suicide Research*, 0, 1–9. https://doi.org/10.1080/13811118.2017.1413469

Comtois, K. A., Jobes, D. A., S. O'Connor, S., Atkins, D. C., Janis, K., E. Chessen, C., …

Yuodelis-Flores, C. (2011). Collaborative assessment and management of suicidality (CAMS): Feasibility trial for next-day appointment services. *Depression and Anxiety*, *28*(11), 963–972. https://doi.org/10.1002/da.20895

Connor, E. O., Gaynes, B. N., Burda, B. U., Soh, C., & Whitlock, E. P. (2013). Screening for and Treatment of Suicide Risk Relevant to Primary Care: A Systematic Review for the U.S. Preventive Services Task Force. *Annals of Internal Medicine*, *158*(10), 741–754.

Canadian Psychological Association (CPA). (2017). *Canadian Code of Ethics for Psychologists*. *Canadian Psychology/Psychologie canadienne*. Ottawa, Ontario. https://doi.org/10.1037/h0086812

Creswell, J. W., & Poth, C. N. (2017). *Qualitative inquiry and research design: Choosing among five approaches*. Sage publications.

Crosby, A. E., Ortega, L., & Melanson, C. (2011). *Self-directed violence surveillance: Uniform definitions and recommended data elements*. Atlanta, GA.

Cwik, J. C., Till, B., Bieda, A., Blackwell, S. E., Walter, C., & Teismann, T. (2017). Measuring attitudes towards suicide: Preliminary evaluation of an attitude towards suicide scale. *Comprehensive Psychiatry*, *72*(10), 56–65. https://doi.org/10.1016/j.comppsych.2016.09.008

Davidson, M., Wagner, W., & Range, L. (1995). Clinician attitudes towards no-suicide agreements. *Suicide and Life-Threatening Behavior*, *25*(3), 410–414.

Delgado, M. K., Acosta, C. D., Ginde, A. A., Wang, N. E., Strehlow, M. C., Khandwala, Y. S., & Camargo, C. A. (2011). National Survey of Preventive Health Services in US Emergency Departments. *Annals of Emergency Medicine*, *57*(2), 104–108.e2. https://doi.org/10.1016/j.annemergmed.2010.07.015

Dexter-Mazza, E. T., & Freeman, K. A. (2003). Graduate Training and the Treatment of Suicidal Clients: The Students' Perspective. *Suicide and Life-Threatening Behavior*, *33*(2), 211–218. https://doi.org/10.1521/suli.33.2.211.22769

DiPasquale, T., & Gluck, J. P. (2001). Psychologists, psychiatrists, and physician-assisted suicide: The relationship between underlying beliefs and professional behavior. *Professional Psychology: Research and Practice*, *32*(5), 501–506. https://doi.org/10.1037/0735-7028.32.5.501

Domino, G., Moore, D., Westlake, L., & Gibson, L. (1982). Attitudes toward suicide: A factor analytic approach. *Journal of Clinical Psychology*, *38*(2), 257–262. https://doi.org/10.1002/1097-4679(198204)38:2<257::AID-JCLP2270380205>3.0.CO;2-I

Dressel, P. L., & Matteson, R. W. (1950). The effect of client participation in test interpretation. *Educational and Psychological Measurement*, *10*(4), 693–706.

Dube, P., Kroenke, K., Bair, M. J., Theobald, D., & Williams, L. S. (2010). The P4 Screener: Evaluation of a Brief Measure for Assessing Potential Suicide Risk in 2 Randomized Effectiveness Trials of Primary Care and Oncology Patients. *Journal Clinical Psychiatry*, *12*(6), 1–8.

Dunster-Page, C., Haddock, G., Wainwright, L., & Berry, K. (2017). The relationship between therapeutic alliance and patient's suicidal thoughts, self-harming behaviours and suicide attempts: A systematic review. *Journal of Affective Disorders*, *223*, 165–174. https://doi.org/10.1016/j.jad.2017.07.040

Edmonton Suicide Prevention Advisory Committee. (2017). *Edmonton Suicide Prevention Strategy*. Edmonton, Alberta.

Ellis, T. E., & Patel, A. B. (2012). Client Suicide: What Now? *Cognitive and Behavioral*

Practice, *19*(2), 277–287. https://doi.org/10.1016/j.cbpra.2010.12.004

Ellis, T. E., Rufino, K. A., & Allen, J. G. (2017). A controlled comparison trial of the Collaborative Assessment and Management of Suicidality (CAMS) in an inpatient setting: Outcomes at discharge and six-month follow-up. *Psychiatry Research*, *249*, 252–260. https://doi.org/10.1016/j.psychres.2017.01.032

Engel, G. L. (1980). The clinical application of the biopsychosocial model. *The American Journal of Psychiatry*, *137*(5), 535–544. https://doi.org/10.1176/ajp.137.5.535

Finn, S. E. (2007). *In our clients' shoes: Theory and techniques of therapeutic assessment*. New York, NY: Psychology Press.

Finn, S. E., & Tonsager, M. E. (1997). Information-gathering and therapeutic models of assessment: Complementary paradigms. *Psychological Assessment*, *9*(4), 374–385. https://doi.org/10.1037/1040-3590.9.4.374

Fitzpatrick, S. J., & River, J. (2018). Beyond the Medical Model: Future Directions for Suicide Intervention Services. *International Journal of Health Services*, *48*(1), 189–203. https://doi.org/10.1177/0020731417716086

Fowler, J. C. (2012). Suicide risk assessment in clinical practice: pragmatic guidelines for imperfect assessments. *Psychotherapy*, *49*(1), 81–90. https://doi.org/10.1037/a0026148

Gagnon, J., & Hasking, P. A. (2012). Australian psychologists' attitudes towards suicide and self-harm. *Australian Journal of Psychology*, *64*(2), 75–82. https://doi.org/10.1111/j.1742-9536.2011.00030.x

Glaser, B. G., & Strauss, A. L. (2009). *The discovery of grounded theory: Strategies for qualitative research*. Transaction publishers.

Hagen, J., Hjelmeland, H., & Knizek, B. L. (2017). Connecting with suicidal patients in

psychiatric wards: Therapist challenges. *Death Studies*, *41*(6), 360–367. https://doi.org/10.1080/07481187.2017.1284955

Hammond, L., & Deluty, R. (1992). Attitudes of clinical psychologists, psychiatrists, and oncologists toward suicide. *Social Behavior and Personality*, *20*(4), 289–293. https://doi.org/10.2224/sbp.1992.20.4.289

Haney, E., O'Neil, M., Carson, S., Low, A., Peterson, K., Denneson, L., … Kansagara, D. (2012). *Suicide Risk Factors and Risk Assessment Tools: A Systematic Review*. *VA-ESP Project #05-225*. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22574340

Harris, K. M., & Goh, M. T.-T. (2017). Is suicide assessment harmful to participants? Findings from a randomized controlled trial. *International Journal of Mental Health Nursing*, *26*(2), 181–190. https://doi.org/10.1111/inm.12223

Harris, K. M., Lello, O. D., & Willcox, C. H. (2017). Reevaluating Suicidal Behaviors: Comparing Assessment Methods to Improve Risk Evaluations. *Journal of Psychopathology and Behavioral Assessment*, *39*(1), 128–139. https://doi.org/10.1007/s10862-016-9566-6

Harris, K. M., Syu, J. J., Lello, O. D., Chew, Y. L. E., Willcox, C. H., & Ho, R. H. M. (2015). The ABC's of suicide risk assessment: Applying a tripartite approach to individual evaluations. *PLoS ONE*, *10*(6), 1–21. https://doi.org/10.1371/journal.pone.0127442

Harriss, L., & Hawton, K. (2005). Suicidal intent in deliberate self-harm and the risk of suicide: The predictive power of the Suicide Intent Scale. *Journal of Affective Disorders*, *86*(2–3), 225–233. https://doi.org/10.1016/j.jad.2005.02.009

Heidegger, M. (1962). *Being and Time*. (J. Macquarrie & E. Robinson, Eds.), *SCM Press*. United Kingdom.

Hill, C. E., & O'Brien, K. M. (2004). *Helping skills: Facilitating exploration, insight, and*

action. American Psychological Association Washington, DC.

Hill, C. E., Thompson, B. J., & Williams, E. N. (1997). A Guide to Conducting Consensual Qualitative Research. *The Counseling Psychologist*, *25*(4), 517–572.

Hofstede, G. (1980). *Culture's consequences: International differences in work-related values* (5th ed.). SAGE Publications.

Hom, M. A., Joiner, T. E., & Bernert, R. A. (2015). Limitations of a single-item assessment of suicide attempt history: implications for standardized suicide risk assessment. *Psychological Assessment*, *28*(8), 1026. https://doi.org/10.1037/pas0000241

Hom, M. A., Stanley, I. H., Podlogar, M. C., & Joiner, T. E. (2017). "Are You Having Thoughts of Suicide?" Examining Experiences With Disclosing and Denying Suicidal Ideation. *Journal of Clinical Psychology*, *73*(10), 1382–1392. https://doi.org/10.1002/jclp.22440

Jacobson, R. M., Hanson, W. E., & Zhou, H. (2015). Canadian Psychologists' Test Feedback Training and Practice : A National Survey. *Canadian Psychology/Psychologie Canadienne*, *56*(4), 394–404. https://doi.org/http://dx.doi.org/10.1037/cap0000037

Jobes, D. A. (2000). Collaborating to Prevent Suicide: A Clinical-Research Perspective. *Suicide and Life-Threatening Behaviour*, *30*(1), 8–17. https://doi.org/10.1023/B

Jobes, D. A. (2012a). The collaborative assessment and management of suicidality (cams): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, *42*(6), 640–653. https://doi.org/10.1111/j.1943-278X.2012.00119.x

Jobes, D. A. (2012b). The collaborative assessment and management of suicidality (CAMS): An evolving evidence-based clinical approach to suicidal risk. *Suicide and Life-Threatening Behavior*, *42*(6), 640–653. https://doi.org/10.1111/j.1943-278X.2012.00119.x

Jobes, D. A. (2016). *Managing suicidal risk: A collaborative approach* (2nd ed.). New York,

NY: Guilford Publications.

Jobes, D. A., & Drozd, J. F. (2004). The CAMS Approach to Working with Suicidal Patients. *Journal of Contemporary Psychotherapy*, *34*(1), 73–85. https://doi.org/JOCP.0000010914.98781.6a

Jobes, D. A., & Jennings, K. W. (2011). The Collaborative Assessment and Management of Suicidality (CAMS) with suicidal college students. *Understanding and Preventing College Student Suicide*, 236–254.

Jobes, D. A., Lento, R., & Brazaitis, K. (2012). An Evidence-Based Clinical Approach to Suicide Prevention in the Department of Defense: The Collaborative Assessment and Management of Suicidality (CAMS). *Military Psychology*, *24*(6), 604–623. https://doi.org/10.1080/08995605.2012.736327

Jobes, D. A., Nelson, K. N., Peterson, E. M., Pentiuc, D., Downing, V., Francini, K., & Kiernan, A. (2004). Describing suicidality: an investigation of qualitative SSF responses. *Suicide & Life-Threatening Behavior*, *34*(2), 99–112. https://doi.org/10.1521/suli.34.2.99.32788

Kids Help Phone. (2016). Teens Talk 2016, 1–8. Retrieved from https://kidshelpphone.ca/sites/default/files/2017-04/Kids-Help-Phone-Teens-Talk-2016-English.pdf

Kleespies, P. M., Penk, W. E., & Forsyth, J. P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice*, *24*(3), 293–303. https://doi.org/10.1037/0735-7028.24.3.293

Kumar, M. B., & Nahwegahbow, A. (2016). Past-year suicidal thoughts among off-reserve First Nations, Métis and Inuit adults aged 18 to 25: Prevalence and associated characteristics. Retrieved September 20, 2017, from http://www.statcan.gc.ca/pub/89-653-x/89-653-

x2016011-eng.htm

Large, M., Kaneson, M., Myles, N., Myles, H., Gunaratne, P., & Ryan, C. (2016). Meta-analysis of longitudinal cohort studies of suicide risk assessment among psychiatric patients: Heterogeneity in results and lack of improvement over time. *PLoS ONE*, *11*(6), 1–17. https://doi.org/10.1371/journal.pone.0156322

Lecrubier, Y., Sheehan, D. V., Weiller, E., Amorim, P., Bonora, I., Sheehan, K. H., … Dunbar, G. C. (1997). The Mini International Neuropsychiatric Interview (MINI). A short diagnostic structured interview: Reliability and validity according to the CIDI. *European Psychiatry*, *12*(5), 224–231. https://doi.org/10.1016/S0924-9338(97)83296-8

Liebling-Boccio, D. E., & Jennings, H. R. (2013). The Current Status of Graduate Training in Suicide Risk Assessment. *Psychology in the Schools*, *50*(1), 72–86. https://doi.org/10.1002/pits.21661

Linehan, M. (1993). *Cognitive-behavioral treatment of borderline personality disorder*. New York, NY: Guilford Publications

Lopez-Castroman, J., Blasco-Fontecilla, H., Courtet, P., Baca-Garcia, E., & Oquendo, M. A. (2015). Are we studying the right populations to understand suicide? *World Psychiatry*, *14*(3), 368–369. https://doi.org/10.1002/wps.20261

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*, *159*(6), 909–916. https://doi.org/10.1176/appi.ajp.159.6.909

Ma-Kellams, C., & Blascovich, J. (2012). Enjoying life in the face of death: East-West differences in responses to mortality salience. *Journal of Personality and Social Psychology*, *103*(5), 773–786. https://doi.org/10.1037/a0029366

Marton, F. (1986). Phenomenography: A Research Approach to Investigating Different Understandings of Reality. *Journal of Thought*, *21*(3), 28–49. https://doi.org/10.2307/42589189

McAllister, M., Creedy, D., Moyle, W., & Farrugia, C. (2002). Nurses' attitudes towards clients who self-harm. *Journal of Advanced Nursing*, *40*(5), 578–586. https://doi.org/10.1046/j.1365-2648.2002.02412.x

McCabe, R., Sterno, I., Priebe, S., Barnes, R., & Byng, R. (2017). How do healthcare professionals interview patients to assess suicide risk? *BMC Psychiatry*, *17*(1), 122. https://doi.org/10.1186/s12888-017-1212-7

McKinlay, A., Couston, M., & Cowan, S. (2001). Nurses' behavioural intentions towards self-poisoning patients: a theory of reasoned action, comparison of attitudes and subjective norms as predictive variables. *Journal of Advanced Nursing*, *34*(1), 107–16. https://doi.org/doi:10.1046/j.1365-2648.2001.3411728.x

Merriam, S. B. (2002). *Qualitative Research in Practice: Examples for Discussion and Analysis*. San Francisco: Jossey-Bass.

Meyer, G. J., Finn, S. E., Eyde, L. D., Kay, G. G., Moreland, K. L., Dies, R. R., … Reed, G. M. (2001). Psychological testing and psychological assessment. A review of evidence and issues. *The American Psychologist*.

Michail, M., & Tait, L. (2016). Exploring general practitioners' views and experiences on suicide risk assessment and management of young people in primary care: A qualitative study in the UK. *BMJ Open*, *6*(1), 11–13. https://doi.org/10.1136/bmjopen-2015-009654

Mohammadi, D. (2015). Under the Maytree. *The Lancet. Psychiatry*, *2*(6), 494–495. https://doi.org/10.1016/S2215-0366(15)00244-8

Moustakas, C. (1994). *Phenomenological research methods*. Thousand Oaks, California: Sage.

Nock, M. K., Kessler, R. C., & Franklin, J. C. (2016). Risk Factors for Suicide Ideation Differ From Those for the Transition to Suicide Attempt: The Importance of Creativity, Rigor, and Urgency in Suicide Research. *Clinical Psychology: Science and Practice*, *23*(1), 31–34. https://doi.org/10.1111/cpsp.12133

Oquendo, M. A., & Bernanke, J. A. (2017). Suicide risk assessment: tools and challenges. *World Psychiatry*, *16*(1), 28–29. https://doi.org/10.1002/wps.20399

Peng, K., & Nisbett, R. E. (1999). Culture, Dialectics, and Reasoning About Contradiction. *American Psychologist*, *54*(9), 741–754.

Petrik, M. L., Gutierrez, P. M., Berlin, J. S., & Saunders, S. M. (2015). Barriers and facilitators of suicide risk assessment in emergency departments: A qualitative study of provider perspectives. *General Hospital Psychiatry*, *37*(6), 581–586. https://doi.org/10.1016/j.genhosppsych.2015.06.018

Pope, K. S., & Tabachnick, B. G. (1993). Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice*, *24*(2), 142–152. https://doi.org/10.1037/0735-7028.24.2.142

Posner, K., Brown, G. K., Stanley, B., Brent, D. A., Yershova, K. V., Oquendo, M. A., … Mann, J. J. (2011). The Columbia-suicide severity rating scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry*, *168*(12), 1266–1277. https://doi.org/10.1176/appi.ajp.2011.10111704

Psychologists' Association of Alberta. (2017). *Annual Report*. Edmonton. Retrieved from https://www.psychologistsassociation.ab.ca/ieadmin/files/PAA_2016-

2017_Annual_Report.pdf

Range, L. M., Campbell, C., Kovac, S. H., Marion-Jones, M., Aldridge, H., Kogos, S., & Crump, Y. (2002). No-suicide contracts: An overview and recommendations. *Death Studies*, *26*(1), 51–74. https://doi.org/10.1080/07481180210147

Reeves, A., & Mintz, R. (2001). Counsellors' experiences of working with suicidal clients: an exploratory study. *Counselling & Psychotherapy Research*, *1*(3), 172–176. https://doi.org/10.1080/14733140112331385030

Regehr, C., Bogo, M., LeBlanc, V. R., Baird, S., Paterson, J., & Birze, A. (2016). Suicide risk assessment: Clinicians' confidence in their professional judgment. *Journal of Loss and Trauma*, *21*(1), 30–46. https://doi.org/10.1080/15325024.2015.1072012

Ritchie, J., & Spencer, L. (1994). Qualitative data analysis for applied policy research. In *Analysing qualitative data* (pp. 305–329). London: Routledge.

Rogers, J. R., Lewis, M. M., & Subich, L. M. (2002). Validity of the Suicide Assessment Checklist in an Emergency Crisis Center. *Assessment and Diagnosis*, *80*(3), 493–502.

Ronson, A., Cohen, K., & Hunsley, J. (2011). *Implementation, evaluation, and application of an electronic practice network for mental health surveillance in Canada*. *Public Health Agency of Canada*. Ottawa. Retrieved from https://www.cpa.ca/docs/File/MHSP/Final_Report(1).pdf

Rotter, J. B. (1966). Generalized expectancies for internal versus external control of reinforcement. *Psychological Monographs: General and Applied*, *80*(1), 1–28. https://doi.org/10.1037/h0092976

Roy, W., Roaten, K., Downs, D., Khan, F., Pollio, D. E., & North, C. S. (2017). Suicide Risk Assessment and Management: Real-World Experience and Perceptions of Emergency

Medicine Physicians. *Archives of Suicide Research*, *21*(3), 365–378. https://doi.org/10.1080/13811118.2016.1199987

Rudd, D. M., Mandrusiak, M., & Joiner, T. E. (2006). The Case Against No-Suicide Contracts: The Commitment to Treatment Statement as a Practice Alternative. *Journal of Clinical Psychology*, *62*(2), 243–251. https://doi.org/10.1002/jclp

Rudd, M. D., Bryan, C. J., Wertenberger, E. G., Peterson, A. L., Young-McCaughan, S., Mintz, J., … Bruce, T. O. (2015). Brief cognitive-behavioral therapy effects on post-treatment suicide attempts in a military sample: Results of a randomized clinical trial with 2-year follow-up. *American Journal of Psychiatry*, *172*(5), 441–449. https://doi.org/10.1176/appi.ajp.2014.14070843

Sánchez, H. G. (2001). Risk factor model for suicide assessment and intervention. *Professional Psychology: Research and Practice*, *32*(4), 351–358. https://doi.org/10.1037//0735-7028.32.4.351

Schembari, B. C., Jobes, D. A., & Horgan, R. J. (2016). Successful treatment of suicidal risk: What helped and what was internalized? *Crisis*, *37*(3), 218–223. https://doi.org/10.1027/0227-5910/a000370

Schmitz, W. M., Allen, M. H., Feldman, B. N., Gutin, N. J., Jahn, D. R., Kleespies, P. M., … Simpson, S. (2012). Preventing suicide through improved training in suicide risk assessment and care: An american association of suicidology task force report addressing serious gaps in U.S. mental health training. *Suicide and Life-Threatening Behavior*, *42*(3), 292–304. https://doi.org/10.1111/j.1943-278X.2012.00090.x

Scientific Software. (2012). Atlas.ti Qualitative Analysis Software. Berlin: Scientific Software Development GmbH.

Shea, S. C. (1999). *The practical art of suicide assessment: A guide for mental health professionals and substance abuse counselors.* Hoboken, NJ: John Wiley. Retrieved from http://psycnet.apa.org.login.ezproxy.library.ualberta.ca/record/1999-04067-000

Silverman, M. M., & Berman, A. L. (2014a). Suicide risk assessment and risk formulation part I: A focus on suicide ideation in assessing suicide risk. *Suicide and Life-Threatening Behavior*, *44*(4), 420–431. https://doi.org/10.1111/sltb.12065

Silverman, M. M., & Berman, A. L. (2014b). Training for suicide risk assessment and suicide risk formulation. *Academic Psychiatry*. https://doi.org/10.1007/s40596-014-0200-1

Simon, R. I. (2012). Suicide Risk Assessment: Gateway to Treatment and Management. In R. I. Simon & R. E. Hales (Eds.), *The American Psychiatric Publishing Textbook of Suicide Assessment and Management* (2nd ed., pp. 3–28). Washington, DC: American Psychiatric Publishing.

Sinacore, A. L., & Ginsberg, F. (2015). *Canadian Counselling and Counselling Psychology*. Montreal: McGill-Queen's University Press.

Skeem, J. L., Silver, E., Aippelbaum, P. S., & Tiemann, J. (2006). Suicide-Related Behavior after Psychiatric Hospital Discharge: Implications for Risk Assessment and Management. *Behavioral Sciences & the Law*, *24*, 731–746. https://doi.org/10.1002/bsl

Skodlar, B., & Welz, C. (2013). How a therapist survives the suicide of a patient-with a special focus on patients with psychosis. *Phenomenology and the Cognitive Sciences*, *12*(1). https://doi.org/10.1007/s11097-011-9205-3

Smith, J. A., Flowers, P., & Larkin, M. (2009). *Interpretative phenomenological analysis: Theory, method and research*. Sage.

Sommers-Flanagan, J. (2018). Conversations about suicide : Strategies for detecting and

assessing suicide risk. *Journal of Health Service Psychology*, *44*, 33–45.

Sommers-Flanagan, J., & Shaw, S. L. (2016). Suicide Risk Assessment: What Psychologists Should Know. *Professional Psychology: Research and Practice*, *48*(2), 98–106. https://doi.org/10.1037/pro0000106

Statistics Canada. (2017). Suicides and suicide rate, by sex and by age group (Both sexes rate). Retrieved September 20, 2017, from https://www.statcan.gc.ca/tables-tableaux/sum-som/l01/cst01/hlth66d-eng.htm

The Government of Canada. (2016). *Working Together to Prevent Suicide in Canada: The Federal Framework for Suicide Prevention*. Ottawa, Ontario, Ontario. Retrieved from https://www.canada.ca/content/dam/canada/public-health/migration/publications/healthy-living-vie-saine/framework-suicide-cadre-suicide/alt/framework-suicide-cadre-suicide-eng.pdf

Truscott, D. (2018). Ethics on the Edge: Working With Clients Who Are Persistently Suicidal Ethics on the Edge. In M. M. Leach & E. R. Welfe (Eds.), *Cambridge handbook of applied psychological ethics.* (pp. 134–153). Cambridge: Cambridge University Press. https://doi.org/10.1017/9781316417287.008

Truscott, D., & Crook, K. (2013). *Ethics for the Practice of Psychology in Canada* (1st ed.). Edmonton, Alberta.

van der Linden, W. J., & Hambleton, R. K. (2013). *Handbook of modern item response theory*. Springer Science & Business Media.

Waern, M., Kaiser, N., & Renberg, E. S. (2016). Psychiatrists' experiences of suicide assessment. *BMC Psychiatry*, *16*(1), 440. https://doi.org/10.1186/s12888-016-1147-4

Ward-Ciesielski, E. F., Wielgus, M. D., & Jones, C. B. (2015). Suicide-bereaved individuals'

attitudes toward therapists. *Crisis*, *36*(2), 135–141. https://doi.org/10.1027/0227-5910/a000290

Warm, A., Murray, C., & Fox, J. (2003). Why do people self-harm? *Psychology, Health & Medicine*, *8*(1), 72–79. https://doi.org/10.1080/1354850021000059278

Watson, D., Clark, L. A., & Tellegen, A. (1988). Development and validation of brief measures of positive and negative affect: The PANAS scales. *Journal of Personality and Social Psychology*, *54*(6), 1063–1070. https://doi.org/10.1037/0022-3514.54.6.1063

Wenzel, A., Brown, G. K., & Beck, A. T. (2009). *Cognitive therapy for suicidal patients: Scientific and clinical applications.* New York, NY, NY: Guilford Press. https://doi.org/10.1037/11862-000

WHOQOL group. (1998). Development of the World Health Organization WHOQOL-BREF Quality of Life Assessment. *Psychological Medicine*, *28*(03), 551–558.

World Health Organisation. (2012). *Public Health Action for the Prevention of Suicide: A Framework*. Retrieved from http://www.who.int/about/licensing/copyright_form/en/index.html

World Health Organisation. (2018). Suicide. Retrieved June 10, 2018, from http://www.who.int/en/news-room/fact-sheets/detail/suicide

Appendix A

Participant Recruitment Letter

Dear Colleague,

I am recruiting Registered Psychologists in the Alberta area to participate in a brief phone interview regarding their experiences conducting suicide risk assessments. If you are a Registered Psychologist who works in the Alberta area who regularly conducts suicide risk assessments, I would be interested in having a one-on-one phone interview with you to gain an understanding of your experience. I believe your experience can help us understand the factors that ameliorate and interfere with the ethical practice of suicide risk assessments.

The phone interview will last 25-30 minutes. Your identifying information (e.g., name, age) will be kept confidential. If you are interested in participating and/or have questions, please contact me (jdubue@ualberta.ca) for further details.

I greatly appreciate your assistance, and look forward to hearing from you!

Jonathan Dubue, Counselling Psychology Masters Student (Thesis), jdubue@ualberta.ca
William E. Hanson, Ph.D., whanson@ualberta.ca

Appendix B

Information Letter and Consent Form

Psychologists' experiences conducting suicide risk assessments.

Principal Investigator:
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Purpose: The purpose of this research is to explore psychologists' experiences in administering suicide risk assessments. Given the empirically supported influence of beliefs and attitudes on psychological practice, this study addresses a considerable gap in our knowledge base, and represents and important line of inquiry with implications for clinical practice and training nationally.

Study Procedures: If you agree to participate in this study, you will complete a demographics questionnaire and have an individual phone interview with me (Jonathan Dubue). Each interview will be audio-taped, so I can capture your experiences the best way possible. The recordings will be kept on a secure encrypted USB key that will be kept locked in a cabinet within the University of Alberta Education Clinic. Your name and any identifying information will be kept confidential. When I analyze the recordings, I will assign a number to your responses, so your name will be kept separate from your information. I will transcribe the interview and, afterwards, I will provide you with a written summary of the themes that emerged across all participants. Here, I am looking for your feedback on how the synthesized themes align with your own individual experience.

Duration of Participation: The interview will last 25-30 minutes. You will receive the written summary of the themes several months after your phone interview. Reviewing and submitting your feedback will take anywhere from 5-30 minutes, depending on how much feedback you wish to provide.

Benefits: Aside from providing the opportunity for you to reflect on your practice, we do not foresee any direct benefit for you as a participant in this study, and there is no payment or other compensation for your involvement. If you do choose to participate, you may benefit by discussing your experiences conducting suicide risk assessments, and you will be making a valuable contribution to helping us better understand how psychologists understand those experiences.

Risks: The potential risk of participating in this study is that you may discuss, or be reminded of, stressful or difficult experiences regarding suicide risk assessment. These risks can be minimized by my asking very open questions, so you can decide how much you want to share with me.

Confidentiality & Anonymity: All information received will be kept strictly confidential and will be seen only by the principal investigator (Jonathan Dubue) and the supervisor of this project (Dr. William Hanson). We may also seek to use the results of this study in future research. However, the Research Ethics Board of the University of Alberta will first approve any future use of your data.

Voluntary Participation: You are free to choose not to participate in this study, and you will experience no negative consequences whatsoever as a result. You are also free to discontinue your participation at any time, and you can modify your participation by skipping any questions you would prefer not to answer. If you choose to discontinue participation at a later point in time, you can request that your data be removed from the study and we will gladly remove/destroy your data up until the transcription of the interview, which is typically two weeks after the interview.

Dissemination: The data will be used for a Master's thesis and possibly in conference presentations or journal publications. The data will be anonymized two weeks after the interview, and the raw data will be kept indefinitely. At a future date, should the data be deemed unnecessary for retention, the supervisor of this project will destroy the data so that any information cannot be practically read or reconstructed.

Ethics: The University of Alberta's Research Ethics Board has approved this study by virtue of its adherence to ethical guidelines in conducting research. We encourage you to contact the board at reoffice@ualberta.ca or at (780) 429-2615 if you have any questions regarding your rights as a participant in this study, or research ethics in general. This office has no affiliation with the study investigators.

Further Information: If you have any further questions pertaining to your involvement in this study, or would like to obtain a copy of the results, feel free to contact us, Dr. William Hanson, or Jonathan Dubue, using the contact information provided.

Thank you very much once again for your time.

Sincerely,
Jonathan Dubue & William Hanson

--

I have read and understood the consent form and desire of my own free will to participate. I have been given the opportunity to ask questions and my questions have been answered. If I have additional questions, I have been told whom to contact. By indicating "yes" below, I agree to participate in the research study described above.

__ Yes | __ No

_____	_____
Name	Signature
_____	_____
Date	Witness Signature

Appendix C

Demographics Form

First Name: Click or tap here to enter text. Date: Click or tap to enter a date.

Demographics Questionnaire

Age: Click or tap here to enter text. **Sex**:Click or tap here to enter text. **Gender**: Click or tap here to enter text.

Please indicate the highest degree you have attained.

Ph.D. ☐ M.Ed. ☐
Psy.D. ☐ M.A./M.S. ☐
Ed.D. ☐
Other: Click or tap here to enter text.

When did you earn this degree?
Click or tap here to enter text.

How many years have you practiced as a psychologist?
Click or tap here to enter text.

What ethnic/cultural background do you identify most strongly with?

European Canadian / White ☐ Asian / Asian Canadian ☐
Indigenous / First Nations ☐ Hispanic / Latino / Latina ☐
Inuit ☐ African Canadian / Black ☐
Metis ☐
Other: Click or tap here to enter text.

Which of the following best describes your primary practice setting?
Choose an item.
Other: Click or tap here to enter text.

Which of the following best describes your theoretical orientation (please limit your response to 2 selections)?
Choose an item.
Other: Click or tap here to enter text.

Thank you for your time!

Please return this demographics form to Jonathan Dubue (jdubue@ualberta.ca).

Appendix D

Semi-Structured Interview Protocol

Semi-Structured Interview Protocol

Review consent form and confidentiality.

1. When you hear the words *suicide risk assessment*, what comes to mind? Initial feelings?
2. In general, what is your experience of suicide risk assessment?
3. I'd like for you to think about a time where you conducted a suicide risk assessment. Can you walk me through that time?
    a. How did you approach your client with the suicide risk assessment?
    b. How did your client seem?
    c. How did you want your client to feel while you conducted the assessment?
    d. How did you want to feel during the assessment?
    e. What was the experience of time like for you during the assessment?
4. What do you notice about yourself in telling me that story, right now?
5. What pressures do you feel when you conduct suicide risk assessments?
6. What would you say is your main reason for conducting suicide risk assessments?
7. What are your general beliefs about suicide?
8. Do you believe your training adequately prepared you to conduct suicide risk assessments?
9. What has been left unsaid in this interview, before we wrap-up?

Appendix E

Member-Check Document

Overview of Super- and Sub-ordinate Themes*

Superordinate/Subordinate Themes	Brief Description
Weaving Assessment and Therapy	Integrating the goals, practices, and worldviews of therapy and assessment into the SRA practice.
__Prioritizing Client Safety	Feeling a need to ensure client safety. Using discrete SRA checklists, being more direct, and prioritizing information over rapport.
__Building Rapport and Connection	Feeling a need to build rapport/connection. Using more open language, explaining SRA to the client, and using the SRA to explore the client's perceptions of suicide.
Relying on Clinical Intuition	Having a "gut feeling" about suicide risk and using this intuition to guide assessment and therapeutic practice.
Investing in the Suicidal Client	After hearing a suicide clue, the feeling of deeply and urgently investing in the client. Includes allocating more resources to their care, worrying about them after session, and feeling exhausted.
Positive View of Suicidal Clients	Having a generally supportive view of suicidal clients.
Clinical View	Seeing clients as having low affect, being dysregulated, and in deep despair.
Empathic View	Understanding suicide to be a product of psychosocial stress, and seeing the issues behind the suicidal ideation.
Suicide is a Choice, But Not a Good One	The belief that suicide/suicidal ideation can be rationale, but that it is most likely due to being in overwhelming stress, feeling ambivalent, or not fully thinking it through.
Fear of Client Suicide Drives SRA	Being uncertain about the SRA process, including proper assessment and future client behaviours.
Lacking Control/Autonomy	Being unable to control the client's behaviours causes stress/worry.
Wrestling with an Authoritative Identity	Being the authority in the room means making decisions for the client, with or without their permission.
The Pressure of Perfection	Needing to be immaculate during SRA, due to the perceived consequences of poor SRA.
Inside the Room	The feeling of wanting to help the client, and the pressure placed on the self to achieve that goal.
Outside the Room	Worrying about how supervisors, colleagues, and the ethical regulating body will appraise the SRA.
SRA is Setting-Dependent	The goals, frequency, and clinician/client comfort with SRA changes drastically depending on the practice setting.
Graduate SRA Training is Inefficient and Insufficient	Graduate-level SRA training is not proportionate to the amount it's used in practice, nor does it emphasize an experiential model of training. Prior volunteer/practicum experiences are the formative SRA training experiences.

*Note: some theme titles have changed after the member-check was completed.