Clinician's Experience of Suicide Assessment from a Qualitative Perspective

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CLINICIAN’S EXPERIENCE OF SUICIDE ASSESSMENT
FROM A QUALITATIVE PERSPECTIVE

by

Eric W. Macleod

A dissertation submitted to the Graduate College
in partial fulfillment of the requirements
for the degree of Doctor of Philosophy
Counselor Education and Counseling Psychology
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Doctoral Committee:

Alan Hovestadt, Ed.D., Chair
Stephen Craig, Ph.D.
Patricia Reeves, Ed.D.
Using a qualitative research method, the researcher explored the lived experiences of 17 clinicians in southwest Michigan who assess the risk of their clients committing suicide as a part of their professional practice. A phenomenological approach was used to interpret and understand the results. In-person interviews were conducted at a place chosen by the participant. Four broad interview questions with several subquestions within each created a semi-structured format. The questions explored the way clinicians assess suicide, the professional impact of suicide assessment, the personal impact of suicide assessment, and any changes in participants’ worldview as a result of suicide assessment. There was a consensus among participants that some questions must be asked to complete a suicide assessment. Participants’ emotional responses included feelings of anxiety, depression, and anger during the assessment process. Participants with the most experience reported less emotional discomfort during the suicide assessment process than was reported by less experienced participants. Scheduling disruptions in clinicians’ professional practice was widely reported. Several participants disagreed with the act of committing suicide personally, though all of them recognized suicide as an option open to everyone. Counteracting client’s suicidal ideation, many participants suggested exploring ways to resolve the
problems in the client’s life that lead to suicidal ideation. This is offered to the client as a means of offering hope to them. Widely reported was a criticism of participants’ educational background, which lacked specific training about suicide assessment. Cynicism, which was anticipated at the onset of the research, was not reported. It appeared that participants self-selected to remain in the crisis intervention field and were optimistic about their ability to offer help to their clients.
ACKNOWLEDGMENTS

A doctoral dissertation is at once a solitary endeavor and a group project. While the lion’s share of this work was done by me alone, I could not have attempted a project of this magnitude without help. While I fear I will forget to mention some of the people who have offered their assistance, I must acknowledge some individuals who have made extraordinary contributions to this effort. First of all, I would not be in a position to create a doctoral dissertation without the help and support of my doctoral committee. My committee chairman, Dr. Alan Hovestadt, has been a steadfast supporter, advocate, critic, and friend. His wisdom and guidance have helped me immeasurably. I cannot thank you enough. Dr. Stephen Craig asked many of the right questions early in the process that have driven me to create a well-considered work of scholarship. Dr. Patricia Reeves’ knowledge of qualitative research allowed me to identify a researchable question and helped me transform a concept into a real piece of research. Without these three individuals, my academic path would have been relegated to the scrapheap of A.B.D. (all but dissertation) academic endeavors. A special thanks is in order to the gifted and talented staff at the Kalamazoo College Student Counseling Center and particularly Dr. Debra Rose, who offered support and insight during and after my year spent there as an intern counselor.

Throughout my doctoral work I worked nearly full-time as a therapist at the Family Health Center of Battle Creek (FHC). The FHC staff was flexible and supportive of me from the beginning of the process to the end. Never did a day go by without a co-
worker asking about my progress and achievements. The support of the staff as a whole is greatly appreciated. Several of my co-workers put forth considerable effort to support me. They are Dr. A.J. Jones, Dr. Sam Grossman, Janis Dillard, Kathy Leeson, Andrea Bishop, and particularly Amy Dandenault. The love and support I received while working at FHC has been overwhelming. I have also received tremendous and steadfast support from my long-term supervisor and friend, Dr. Paul Metler, who helped me to complete my degree in more ways than I can mention. Thanks, Paul. I also want to express my sincere appreciation to my editor, Hope Smith, for her help in transforming my final draft of this dissertation into a professional piece of research.

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Eric W. Macleod
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CHAPTER I
INTRODUCTION

Beginning in the mid 1990s, I worked with an after-hours on-call crisis team through the local community mental health agency. Among the crisis situations I was called to address, the most concerning, and intriguing, were those where the client presented with serious risk of committing suicide. I interviewed many people who expressed suicidal ideation to varying degrees. Most of those people were in the midst of some sort of serious personal crisis. In 2009 (the latest year for which we have national statistics), there were 36,909 suicides in the United States (American Association of Suicidology, 2012b). Suicide occurs when psychological pain becomes too great for the individual to bear (Pompili et al., 2008). While one third of the general (nonclinical) population has suicidal thoughts at some point in their lives, the base rate of suicide is 12 per 100,000 in the general population (Meichenbaum, 2005). The suicide rate rises to 60 per 100,000 in a psychiatric population (Bongar, 2002). Suicidal clients expressed a significant degree of pain during the author’s interactions with them. Shneidman (1985) described this pain as a multidimensional malaise in a needful individual who defines an issue for which the suicide is perceived as the best solution. Often, the real question during a crisis intervention is to determine if the individual is truly suicidal and, if so, how serious is his or her attempt to end his or her own life.

Determining the true degree of risk is the primary job of the crisis intervention clinician. Frequently, determination of a client’s suicide risk potential is not empirical;
instead, one has to rely on unscientific methods, often relying on intuition and past experience. While there are instruments available to assess lethality, reliability is questionable. In a study examining six well respected suicide prediction scales, Bisconer and Gross (2007) found no single instrument predicted suicide risk without significant error. Given the lack of reliable suicide prediction tools, clinicians often decide the outcome of each case based largely upon intuition and past experience. As this dissertation was being considered, it became evident that suicide risk assessment often relies as much on the intuition of the assessor as empirical data. Not surprisingly, various surveys indicate that suicidal patients constitute the single most stressful aspect of most psychotherapists’ work (Deustch, 1984).

The Purpose of This Research

The purpose of this research is to gain insight into the lived experience of clinicians during and after they assess suicide lethality potential among their clients. Using a phenomenological approach, this study asked clinicians, who routinely assess suicide potential, to describe their experiences with clients. Utilizing an in-person interview, participants were asked to describe how they consider suicide lethality potential. While it was assumed when this research began, it was not yet determined whether or not suicide assessment has an impact upon the professional practice and the life of clinicians outside of the context of therapy. The experience of living through a suicide assessment process and the impact that experience has on a therapist’s clinical practice and personal life outside the work context appeared to warrant consideration through research.
An additional purpose of this study was to investigate the way clinicians assess suicide potential when they are facing crisis situations. It was important to this researcher to explore and understand how clinicians conceptualize and conduct suicide assessment. The proposed research explored this topic by addressing specific research questions that follow.

Because it is not an unusual occurrence during a clinician’s professional career to face a potential or actual suicide (Meichenbaum, 2005), this research appeared particularly relevant. Today, 1 in 6 psychology interns and 1 in 3 psychiatry interns experience the suicide of a client during the course of their training (Bongar, 2002). With additional clinical experience, incidence of a client committing suicide does not decrease; the average psychologist will see, on average, five potentially suicidal clients every month (Meichenbaum, 2005). Moreover, 1 in every 6 psychologists will experience the death of a client by suicide during the course of their career (Meichenbaum, 2005). With these facts in mind, the researcher set about learning more about the problem.

**Study Problem, Purpose, and Research Questions**

The problem identified by this study was this: we do not know what it is like for clinician to live through the process assessing suicide potential of clients. This problem suggested a specific path of investigation. The meta-question to be explored was as follows: *How does the practice of suicide assessment affect individual clinicians in their professional practice and their personal lives?* This question was the core of this research. It sought to understand the unique lived experience of each individual therapist as he or she conducted the assessment of potentially suicidal people. Of further interest
was the near and longer term perceived impact of suicide assessment on clinicians. Specifically, this research sought to understand the impact suicide assessment has on the personal life of clinicians outside the context of their practice. Within the broad meta-question there were four subsets of questions that arose. These subsets fell within the scope of (a) how clinicians assess for suicide lethality, (b) the perceived effect suicide assessment has on clinician’s therapeutic practice, (c) the impact it has on clinician’s personal lives, and (d) how the combination of changes brought about by the practice of suicide assessment impacts the personal and professional worldview of clinicians after the suicide assessment reaches completion.

This research was especially interested in several topics within these wider questions. First, it is likely that many clinicians have individually tailored approaches to suicide assessment. This research explored the methods clinicians use to assess suicide, and what, if any, commonalities existed between clinicians who routinely engage in suicide assessment. Secondly, changes in clinician’s therapeutic practice in the wake of suicide assessment were explored. Thirdly, this researcher anticipated that the practice of suicide assessment has a perceived personal impact upon the clinician conducting the suicide risk assessment. Fourthly, this researcher suspected that practice of suicide assessment has implications that reach beyond the current interaction. It was speculated that clinicians are personally impacted by the practice of suicide assessment and this may change personal lives and future interactions with others. Likely, there were some changes in the clinician’s practice that have in turn changed his or her worldview.
Research Questions Translated to Interview Questions

This section illustrates how the overarching research questions and the four research questions translate to actual questions that guided the conversation with participants through the semi-structured interviews.

Interview Questions and Subquestions

Within each of the preceding broad component questions there were subsets of questions that were of interest to this study. The first broad question, “What is your approach to suicide assessment?” explored the specific methods employed by clinicians to assess suicide. The broad question included the following: (a) “What is your conceptual framework when assessing client’s risk of committing suicide?” (b) “How do you determine the seriousness of a client’s risk potential?” (c) “Do you use any suicide assessment protocols or standardized instruments and what are they?” (d) “How valuable are assessment protocols and instruments to your practice of suicide assessment?” Subquestions a, b, and d were covered within the scope of the interview, while subquestion c was covered more directly in the demographic questionnaire.

The second broad question, “How has your professional practice changed as a result of conducting suicide assessments?” explored the specific changes in a clinician’s professional practice in the wake of the process of suicide assessment. Within the scope of this broad question were several subquestions that include the following: (a) “What changes in your therapeutic practice have you noticed in the wake of suicide assessments you have conducted?” (b) “Are there any changes in your daily routine on the day of a
suicide assessment?” (c) “Over time, have you had to make any systematic changes in your practice because of suicide assessments?” (d) “Are there any systematic barriers that hinder your ability to adequately conduct a suicide assessment?” These questions were designed to examine the clinician’s daily practice when suicide assessment was integrated into the day of a therapist.

The third broad question, “How are you personally impacted by the practice of suicide assessment?” sought to better understand the process of suicide assessment from the perspective of participants as people. This question had several subcomponent questions that were intended to increase understanding about what happens to the clinician in the midst and in the aftermath of a suicide risk assessment. These subquestions included: (a) “What happens to you emotionally during and after a suicide assessment?” (b) “Do you find yourself experiencing any change in mood during the assessment or at any time following the suicide assessment?” (c) “If your mood is changed because of suicide assessment, what, if anything, do you do with those feelings?” (d) “How is the rest of your day and time out of the office affected immediately following the process of conducting suicide risk assessments?” (e) “Does anything ‘spill over’ into interactions with other clients?” These questions were selected to directly explore the process of suicide assessment in the here and now, and in the period of time that followed the completion of the assessment. It sought to understand the thinking process and lived experiences of people while they were conducting suicide risk assessments.
The fourth broad question, “How has the practice of suicide assessment changed your worldview as a person both professionally and personally?” sought to understand the way clinicians processed and reflected upon the experience of suicide assessment. Within this broad question there were several subquestions: (a) “How has your personal worldview been changed by your practice of suicide assessment?” (b) “Have there been any changes in your practice if your worldview has changed?” (c) “Have you noticed any changes in your personal life after conducting a suicide assessment?” (d) “Can you describe the changes you have experienced in the weeks and months that you attribute to your experience conducting suicide assessments?” These questions attempted to get the participants to examine suicide assessment contextually in a retrospective fashion that would have made meaning for them personally.

This dissertation argues that the process of suicide assessment is a unique experience within the whole of clinical work. The point when a clinician identifies the client as being in the midst of a crisis with suicide potential begins a chain of events that can irreversibly change the course of all subsequent interactions between client and clinician. This point began the moment a client was identified as needing a formal suicide lethality risk assessment. This study sought to explore how assessment of suicide affected the individual in a holistic sense. As the clinician conducted suicide assessments, he or she gained experience. This exposure to suicide assessment influenced the clinician’s view of crisis assessment as he or she gained a body of experience. The experiences likely shaped the crisis worker’s personality outside the professional arena. In turn, crisis assessment procedures likely evolved as did the clinician’s outlook on life. This recursive
circular pattern was of interest to this researcher as it seemed to be an integral part of a comprehensive look at crisis assessment. Similar to Cybernetics theory, the recursive nature of these interactions emphasized the interconnectedness of suicide interventions and clinician (Becvar & Becvar, 2006).

**Significance of the Present Study**

There were several potential benefits to this dissertation. This research was intended to address a gap in the literature, specifically firsthand experiences of clinicians as they assessed individuals who presented with suicidal ideation. Although there is a significant amount of research being done about causes of suicide and there is research about crisis intervention tools, little appeared to be known about the lived experience of those individuals who assess suicide potential. This research was intended to be a step toward building that knowledge base and toward building the knowledge base about the process of assessing client suicide risk itself. It was hoped that by participating in this research participants and the author would add to the set of skills available to therapists as they work with a potentially suicidal. It was also possible that participants would benefit by clarifying their own crisis intervention process and suicide intervention technique.

**Intended Audience**

This research was intended to benefit clinicians and researchers. Additionally, it has the potential to benefit clients as their therapists may become increasingly mindful of their interactions with them during crisis situations. This study was designed to explore
the lived experiences of therapists working in the field while posing some questions that had not yet been answered. While adding to the knowledge base was a primary goal, it would be ideal if the end result of the research had utility for clinicians who assess client suicide potential as a part of their job.

The end product of this research was intended to be a doctoral dissertation. Like many dissertation projects, it presented further unanswered questions that could form the basis of future research. Ideally, both this author and other interested researchers will pursue many avenues of future research which may result in additional dissertations, journal article submissions, or professional conference presentations.

**Definition of Terms**

This study utilizes some terminology that is specific to the field of psychology and the area of crisis intervention in particular. These terms and definitions are provided in the section that follows below.

*Acuity* refers to the severity of the psychiatric symptoms experienced by the individual during the course of their crisis. Typically, an individual with severe acuity will warrant more intense interventions such as inpatient psychiatric hospitalization.

*After hours on-call team* refers to the group of clinicians employed, often by a county community mental health organization, to assess and intervene in crisis situations. These teams may utilize telephone interventions or may be mobile teams that conduct face-to-face assessments of suicide risk potential.
After hours resources are the tools and programs available to the crisis on-call clinicians. These may include specifically designed suicide assessment instruments, diversionary programs, and inpatient psychiatric hospitals.

Client/Consumer/Customer/Patient are terms that will be used interchangeably throughout this study. The terms are used to identify the individuals who receive the services of a clinician. The term used for the people who receive services varies by organization. The author most often refers to individuals receiving services as clients, though his professional practice is based in a medical facility where individuals who receive services are referred to as patients. The term patient is also the most frequently used term in a situation where the study participant works primarily in an inpatient hospital setting.

Clinician is the individual who conducts suicide assessment in crisis situations. For this research, it includes individuals trained as master’s and doctoral level psychologists, social workers, professional counselors, marriage and family therapists, and substance abuse counselors. Some participants had multiple credentials.

Compartmentalization is the ability identified by participants to keep distance between observing events and experiencing events personally in order to maintain professional objectivity and to preserve a professional stance during crisis intervention.

Crisis intervention is action taken by a clinician during the course of a suicide risk assessment. This intervention may vary widely and could include a telephone conversation with the individual, a face-to-face assessment, referral to resources in the
community including diversionary programs, crisis resolution programs, or inpatient psychiatric hospitalization.

*Crisis clinician* (alternately, on-call clinician) refers to the clinician or therapist who is called upon to resolve a crisis situation. Often this happens after regular business hours or during the weekends and holidays.

*Decompensation* is the loss of mental stability or connectedness with reality by an individual in the midst of a psychiatric crisis. These individuals present a significant risk of committing suicide because their symptoms can prevent them from recognizing the consequences of their actions. This failure to understand consequences can be lethal.

*Diversion* refers to the action of referring an individual who presents for suicide risk assessment to a program of lesser intensity than an inpatient psychiatric hospital. These may include referrals to partial hospitalization (day treatment) programs, crisis stabilization programs (an unlocked, voluntary treatment program), or referral to outpatient psychotherapy or case management services. Diversionary referrals will vary by county depending upon their available resources.

*Inpatient psychiatric hospitalization* is any overnight hospitalization of an individual in a locked facility. This action may be either voluntary, where the individual in crisis agrees to the hospitalization, or involuntary, where the individual is committed to the hospital against his or her will. The latter action typically requires an emergency court order.

*Involuntary inpatient psychiatric hospitalization* is an admission of a client into a locked psychiatric hospital against their will. This process typically requires someone,
typically a family member or a mental health clinician, to petition the court to order an examination by a licensed psychiatrist in order to protect the client from self-harm or to prevent harm to another person. An involuntary inpatient psychiatric hospitalization usually must occur with a signed order from a judge.

Major DSM mental health disorder, for the purpose of this dissertation, refers to a significant mental health diagnosis that would predispose an individual to suicidal thinking. These diagnoses would include, but are not limited to, diagnoses of bipolar disorder, major depressive disorder, post-traumatic stress disorder and schizophrenia.

Negative risk factors are the set of behaviors or thought processes that decrease a clinician’s concern for the safety of the client. These are behaviors or thought processes that tend to prevent a client’s suicidal behaviors.

Postvention is the intervention a professional conducts with the surviving family of a suicide victim. It is intended to allow the survivors to process their loss and understand the circumstances that led to the victim’s decision to commit suicide.

Psychopathology is the presence of symptoms of a mental illness.

Risk factors are the set of behaviors or thought processes that increase a clinician’s concern for the safety of the client. These are behaviors or thought processes that increase the likelihood that a client will commit suicide.

Suicide is the willful and intentional action of taking one’s own life.

Suicide assessment instrument (alternately, suicide assessment tool) is a list of questions or prompts that guides the crisis clinician’s suicide risk assessment process.
Suicide risk assessment is the process of interviewing an individual in the midst of a personal crisis to determine if he or she appears to be in immediate danger of committing suicide. Typically an assessment will have both a structured and unstructured components.

Suicide risk potential is an individual’s degree of risk for committing suicide as determined by a clinician specially trained in crisis intervention. Part of the concern is how soon an individual may choose to act on his or her inclination to commit suicide. This is taken into account when suicide risk potential is considered.

Voluntary inpatient psychiatric hospitalization is an admission of a client into a locked psychiatric hospital with his or her written consent or agreement. Some clients refer to this process as “committing myself” or “signing myself in.”
CHAPTER II
LITERATURE REVIEW

Use of the Literature

This review of the literature is specific to clinician’s experience of assessing suicide. It will form a framework for the research questions by considering the ways suicide assessment is approached in the literature from a wide range of perspectives. The review of literature will consider the effect suicide assessment has on a clinician’s practice and will delve into the question of how a clinician’s life is affected by the process of suicide assessment. Next, this literature review will look for any impact suicide assessment may have on clinician’s worldview. In concluding the literature review, the author will look for ways the literature suggests directions for this dissertation.

This chapter identifies and explains the resources cited for this research project using sources that were available at the time of the final draft. This researcher wanted to be as comprehensive as possible while allowing for the possibility that there may resources that are outside this researcher’s knowledge. Suicide is a broad topic in psychological journals. This researcher intentionally excluded quite a lot of literature about the topic of suicide because it fell outside of the scope of this dissertation. This researcher acknowledges that there are almost always additional research projects in process that may be related in some way to this dissertation. Until these other projects are published, there is a low chance that they would be known to the author of this project.
Despite this limitation, this researcher has made an effort to comprehensively explore the current literature and to be as exhaustive as possible, while simultaneously maintaining a focus that is narrow enough to target the specific topics that are relevant to the experience of suicide assessment as experienced by the clinician.

**Suicide in the Literature**

Counselors and other mental health professionals frequently encounter suicidal clients in the course of their practice. It is a common and highly stressful aspect of their work (McNiel et al., 2008). Nearly half of psychiatrists and 1 in 4 psychologists who are actively involved in service to clients have experienced the suicide of a client (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989). According to Kleespies, Deleppo, Gallagher, and Niles (1999), a crisis occurs when a person’s baseline level of functioning has been disrupted, while an emergency occurs when an individual reaches a state of mind where an imminent risk of self-harm is present. Suicide assessment has been very thoroughly researched (Beck, Resnik, & Lettieri, 1986; Bongar & Harmatz, 1991; Brown, 2001; De Leo, 1998; Goldson, Reboussin, & Daniel, 2006; Joiner, Walker, Rudd, & Jobes, 1999; Lester, 1992; Morris, 1995; Nock & Banajai, 2007; Range & Knott, 1997), as has depression in clients (Beck, Ward, Mendelson, Mock, & Erbaugh, 1961; Goldson et al., 2006). The same is true of the specific disorders that cause those afflicted to be especially prone to suicidal behaviors (Beck & Steer, 1989; Bisconer & Gross, 2007; Linehan, 1993; Shneidman, 1985). There is also a large body of research that explores the prevalence and risk factors associated with suicide (American Association of Suicidology, 2012a). While these sources provide a significant amount of information to
guide the clinician, little has been done to explain how the clinician actually uses the suicide assessment tools in a crisis situation. Research indicates that mental health clinicians assess suicide potential of their clients using a wide variety of assessment tools (Niedermeier, 2008; Range & Knott, 1997). There has also been some research that seeks to understand the effects of suicide upon survivors, including clinicians (Meichenbaum, 2005; Pompili et al., 2008). The work focusing on survivors has included a small, but important, body of research that explores the experiences of a therapist after a client has successfully completed suicide (Knox, Burkard, Hess, Jackson, & Schaack, 2006; Werth & Liddle, 1994). These works will be explored in detail as this chapter progresses.

**Suicide Assessment in the Literature**

Clinicians have many resources for suicide assessment. These resources focus on specific risk factors that predispose an individual to consider attempting suicide. These include alcohol use (Canapary, Bonger, & Cleary, 2002), age (De Leo, 1997, 1999; Hawton, 1998; Scott, 2003; Zayas, Fortuna, Lester, & Cabassa, 2005), cultural considerations (Hawton, 1998; Mishara, 2006; Neelman, 2002; Zayas et al., 2005) and the presence of psychopathology (Douglas, Herbozo, Poythress, Belfrage, & Edens, 2006). Others have suggested that a set of core competencies, or abilities to reliably assess a mental illness, must be developed before an assessment can be conducted reliably (Rudd, Cukrowicz, & Bryan, 2008). This section of the literature review focuses specifically on research related to the practice of suicide assessment. Literature will be incorporated that explains the etiology of suicide and will include both successful and unsuccessful suicides as a means of broadening the scope of knowledge.
Kleespies and his colleagues (1999) recommend approaching all situations of suicide risk as potential emergencies until they are convinced otherwise. Suicide, they find, does not fit neatly into a specific diagnostic profile. In order to make a good decision about the direction of treatment and disposition, the clinician is encouraged to document facts of the case carefully and consult with others to ensure that decisions are reasonable and prudent. This allows others to fully understand the clinician’s thinking process in the midst of the crisis.

The specifics of what to include in suicide risk assessment has been addressed in many publications, including a short article, “What Should Our Suicide Assessment Involve?” (Joint Commission, 2011) that appeared in the Patient Safety Monitor Journal. According to the article, suicide risk assessment should address the immediate safety needs of a client and should provide suicide prevention information. The article recommended teaching staff members to recognize suicide risk factors, including situations that have historically been sentinel events. They emphasize true assessment of clients, not simply using check-off boxes on a form. While the article recommended using risk assessment tools, none were specifically identified as being particularly useful. Instead, the author recommended conducting a literature search to identify appropriate tools for specific client populations, based on the perceived risk they could pose.

Another article that appeared in the Journal of the American Academy of Child and Adolescent Psychiatry in 2001 suggests methods for the specific assessment needs of children and adolescents (“Practice Parameter for the Assessment and Treatment of Children and Adolescents with Suicidal Behavior,” 2001). The article indicates that a
primary skill for clinicians is to determine how to identify those who are at the greatest risk for suicide among the large number of relatively benign attempters. The authors found males to be at higher risk than females, particularly those of age 16 or more with previous suicide attempts, and an associated mood disorder or the presence of a substance abuse disorder. Among females, those with previous suicide attempts and with diagnosed mood disorders were seen to present the greatest risk of completing suicide. When both clinical depression and manic behaviors are present in the same individual (otherwise known as bipolar disorder), the combination of the two symptoms can contribute to an increased risk of suicidal behavior. The authors identified some specific risk factors that clinicians should consider when assessing suicide. Presenting the greatest danger of committing suicide is the combination of a diagnosis of major depression and a previous suicide attempt. Other significant risk factors include a diagnosis of substance abuse and, among boys, disruptive behavior. Additional factors to consider include psychosocial stressors, cultural factors, maladaptive coping skills, parental psychopathology, and potentially life-threatening medical diagnosis such as HIV positive or AIDS.

Berman (2009) identifies adolescents as a group that has presented a significant challenge for clinicians dating back to the days when Freud was a practitioner. At that time, adolescent suicide rates were increasing, vexing social scientists of the era. While the science of suicidology has progressed since that time, the adolescent population continues to present some unique challenges from the perspective of an assessor. The individuals Berman identifies as being at high risk include adolescents who are at risk of dropping out of school, those who have been expelled from school, and students enrolled
in alternative schools. Berman echoes the previous author’s concern for the increased suicide risk among males, citing a five-fold risk of dying by suicide as compared to their female same-aged peers. A thought-provoking concern raised by Berman is the greater prevalence of suicide in rural parts of the country, suggesting the greater distance a teenaged youth resides from mental health services, the greater his or her chance of dying by suicide. To increase the chances of correctly identifying the individuals who are at the highest risk of death, Berman has suggested a screening measure, the Suicidal Ideation Questionnaire (Reynolds, 1987). This instrument was the most accurate measure Berman found to assess the risk potential of individuals in this age range, thus suggesting that something measuring suicidal ideation may be a better way to assess suicide risk potential than a tool that merely assesses depression. Despite this, Berman feels there are questions about the efficacy of programs designed to intervene when suicide risk is high, suggesting more research is needed.

A method of assessing the actual suicide attempt was described in the Patient Safety Monitor Journal (Joint Commission, 2011). The article stresses the importance of identifying the method used in the suicide attempt, the potential lethality of the attempt, the planning involved in the attempt, and the degree to which the chance of intervention was minimized. Each of these factors can increase the risk of suicide lethality. Underlying conditions, such as a psychiatric diagnosis, can also increase the risk factors, thus should be considered carefully. The article further suggests gathering information from multiple sources as a means of determining reliability and validity of the observed behaviors.
The American Association of Suicidology (2012a) has a series of risk factors they feel are important to consider when assessing the danger of suicide. They look at chronic risk factors as well as predisposing, but potentially modifiable risk factors. While the chronic risk factors are often outside the influence of the clinician, the modifiable risk factors can be reduced with proper intervention.

Chronic risk factors include the client’s demographics, history of suicide attempts, especially repeated suicide attempts, history of self-harm, one (or more) completed suicide in the family, parental history of violence, substance abuse, psychiatric hospitalization and divorce, history of trauma or either physical or sexual abuse, history of inpatient psychiatric hospitalization, history of violence, and a history of impulsivity or recklessness. Additional chronic risk factors to be considering are the presence of a major DSM (Diagnostic and Statistical Manual) Axis I or Axis II psychiatric disorder, a major medical disorder, particularly if it involves significant functional impairment or physical pain, traumatic brain injury, poor self-esteem or self-loathing, a tolerant or accepting attitude toward suicide, exposure to the death of another by suicide, lack of familial acceptance of one’s sexual orientation, smoking, and perfectionism. The presence of a major mental health disorder as a significant risk factor was also identified by Douglas and his colleagues (2006), who expressed concern about the comorbidity of psychopathology and suicidal behaviors.

The American Association of Suicidology (2012a) authors continue by considering other risk factors that can be modified. These include the ownership of a firearm; unemployment; stressors involving a job, school, marriage or relationship; and
recent losses such as a divorce or relational separation. Other risk factors include behaviors that are potential harmful to the individual, such as a recent suicide attempt and excessive use of substances. People who have considerable psychological pain, who have recently been discharged from an inpatient psychiatric hospital, or who have anger management problems, aggressive behaviors, anhedonia, anxiety or panic problems, physical agitation, sleep disruption and nightmares, are considered to be of high risk. Additional contributing factors include suspiciousness or paranoia, feelings of confusion or disorganization, command hallucinations that urge the individual to commit suicide, mood changes, hopelessness and thought constriction, a perception of being a burden to others, recent diagnosis of a terminal illness, feeling trapped, like there is no way out, loss of purpose in life, poor attitude toward accepting or receiving help from others, and reckless behaviors. Any real or anticipated event that could either cause or threaten shame, guilt, despair, humiliation or loss of status, or pending legal problems, financial losses, or abandonment can be considered triggering stimuli that could heighten the risk of suicide.

Clinician and researcher Jack Klott (2012) states it is essential to examine the risk factors that encompass a set of “early warning signs.” Klott suggests these risk factors fall into three categories: (a) psychiatric disorders, (b) social stressors, and (c) psychological vulnerabilities (p. 1). An individual’s vulnerability to consider suicide as a management or coping strategy increases when any of these early warning signs are present. Klott feels it is essential to evaluate whether potentially suicidal individuals see suicide as the best way to alleviate their pain. He explores their experience of fatalistic
despair or hopelessness. He also considers feelings of helplessness and if they feel the problems they are facing cannot be resolved. Considering these factors carefully and inquiring more deeply into the idea of suicide when the factors are present allows the clinician to evaluate the seriousness of a client’s risk potential.

Another prominent researcher, Marsha Linehan (1993), has written an exhaustive book focusing on the assessment and treatment of borderline personality disorder. According to Linehan, one of the key symptoms of an individual suffering from borderline personality disorder is an increased risk of suicidal behavior. Linehan states the importance of questioning the client about intended methods of self-harm, access to those methods, whether or not the client has taken steps to assure he or she would be rescued, and if there is any substance abuse going on at the time of the assessment. Linehan, like Klott (2012), subdivides suicide risk factors into a variety of categories, though she considers them from the perspective of direct indices of imminent risk, indirect indices of imminent risk, and circumstances associated with suicide in the next couple days. Ultimately, the response to the client’s suicidal threat is based upon an estimate made by the therapist to determine the actual risk of suicide. When a client threatens suicide, Linehan offers a highly structured approach. She indicates assessing the risk of suicide is the first step. This should be followed by either removing or convincing the client to remove items that could pose a lethal threat. Next, and Linehan admits this may be an obvious point, the client should be emphatically instructed not to commit suicide. The client is then told that suicide is not a good solution to the present problem. This is followed by generating statements of hope and offering solutions to the present
problem. In the case when suicide risk appears imminent, the clinician must keep in contact with the client and should adhere to his or her plan of treatment. Upon resolution of the crisis, there should be an anticipation of a recurrence of suicidal urges. Finally, the client should be clear that when suicidal threats or behaviors are present, confidentiality may be compromised. Linehan states emphatically that this should be made very clear to the client.

Yet another prominent suicide researcher, David Lester (1997), has published a list of risk factors in his highly influential book *Making Sense of Suicide: An In-depth Look at Why People Kill Themselves*. The factors he lists are quite similar to those listed by other researchers. He indicates there are multiple factors that should be considered when assessing the risk of a client committing suicide. These include identifying if the client is experiencing suicidal ideation, is feeling depressed, is involved in substance abuse, has demonstrated a change of behavior, becomes disinterested in sex or other daily activities, has a change in sleeping pattern, has lost energy, changes from extreme depression to a feeling of being “at peace,” has been withdrawing from friends and family, makes negative comments about himself, or experiences a significant change in either work or school performance.

Lester (1997) continues by identifying a list of life circumstances that may significantly increase the risk of a person committing suicide. These include recent distressing frustrations; disappointments or losses; a loss of the person’s normal support network resulting from divorce, job loss, or migration; recent stressful events such as the loss of a loved one or a divorce; exposure to the suicide of another person; ready access
to firearms; serious illness; changes in close relationships; history of suicide attempts; making a will or arranging a life insurance policy; cleaning up or resolving personal affairs; giving away important possessions; and a history of suicide in the family. The more factors that are present, the greater the clinician’s concern for risk of suicide becomes.

Shawn Shea (2009) identified a factor that did not appear in any other aspect of this literature review. Specifically, Shea believes that clients do not always divulge their complete thoughts or, if they do, they do not always divulge their thoughts honestly. With regard to suicidal thinking, Shea looks at suicidal intent using the following equation:

Real Suicide Intent = Stated Intent + Reflected Intent + Withheld Intent

Explaining that all three factors, to differing degrees, combine to equal a client’s actual intent to commit suicide, Shea purports that clients may not even be aware of their own true risk because they may underestimate their own risk factors. As a means of uncovering the actual risk potential of such clients, Shea emphasizes the importance of attempting to gather information from outside sources such as family members, therapists, and the police as a means of formulating a more complete prediction of suicide risk potential.

De Gioannis and De Leo (2012) caution that risk assessment tools cannot be used to predict suicide. They say the most comprehensive tool can only gauge the level of risk of that particular individual for that particular time. No suicide assessment prediction tool can predict suicide risk potential over a span of time because risk factors can change. De Gioannis and De Leo identify a set of risk factors associated with increased risk of
suicide including the following. These are grouped into demographic factors, including male gender, single, separated or divorced, widowed, elderly, adolescent, and gay/lesbian (during “discovery” time). A second grouping includes those with suicidal thoughts and behaviors such as suicidal ideation, suicidal plan, previous suicide attempt, severity of a suicide attempt, lethality of a suicide plan, suicide intent, and psychiatric hospitalization. Another risk factor grouping includes those with mental illnesses including major depressive disorder, bipolar disorder, schizophrenia, anorexia, alcohol abuse, Cluster B personality disorders, and psychiatric co-morbidity. Psychological factors such as hopelessness, panic attacks, severe anxiety, and aggression or impulsivity should be considered. Genetic factors such as a family history of mental illness or suicide should be included in a risk assessment. Traumatic childhood events may contribute to suicidal ideation. Psycho-social factors like unemployment, public humiliation, divorce, loss of support, stressful life event, and access to lethal means of suicide all should be assessed. Most importantly, De Gioannis and De Leo emphasize that clinicians should demonstrate care for their clients. They caution that a perception of being insufficiently caring may constitute the last link of a long chain of disappointments for a client.

Joiner, Walker, Rudd, and Jobes (1999) devised a method of making the process of suicide assessment more scientific and more routine. They suggested an assessment process that focused on two domains of risk factors—history of past attempts and the nature of current suicidal symptoms. Joiner et al. suggest that the most important domain of risk assessment is determining if a client has a previous history of making a suicide attempt and if there is a current attempt in progress. They believe there is a significant
contrast between people who attempt suicide one time and people who make multiple attempts, with the latter having an elevated risk. Contrasting these people with people who have suicide ideation or who have only attempted suicide once, the multiple attempters appear to be people, who in combination with one other identified risk factor, become those who should be seen as having at least moderate suicide risk on a scale ranging from no risk to severe risk (p. 449). They authors feel identifying the presence of a combination of factors, the key factor being a previous suicide attempt, provides clinicians clarification when attempting to make clinical decisions about the course of treatment with an individual.

When comparing the lists of risk factors compiled by these prominent researchers, it becomes apparent that there is a consistent set of factors to be considered when exploring suicide. While many of the researchers have different ideas of how to ask about which factors to consider, the set of factors must include at least some questions about future orientation, questions about a means of committing suicide, questions about circumstances that may increase a client’s predisposition toward committing suicide (such as an irreversible loss), questions about the client’s mood, questions about substance abuse, and questions about the client’s current support system. There are many variations within this set of questions; it appears that these topics are addressed by nearly every publication as well as nearly every participant in this research project. The consistency between the literature and the participants in this research project is encouraging.
Suicide Assessment Tools

There are many tools and instruments, with varying degrees of reliability, that offer utility to the assessors of suicide risk potential (Brown, 2001). A significant problem facing mental health clinicians is that it is virtually impossible to reliably predict suicidal behavior (Jobes, Jacoby, Cimbolic, & Hustead, 1997). The inability to predict future suicidal behavior is the primary weakness inherent in all suicide assessment tools, clinical interviews, and client self-reports. To mitigate this weakness, Jobes and his colleagues advocate a combination of clinical interviews augmented by routine use of a specific suicide risk assessment instrument, the Suicide Status Form (SSF). They believe the SSF has good convergent, strong criterion-prediction and moderate test-retest reliability. An advantage of this methodology was that the SSF could be completed by either clinicians or using a client self-report method. The authors acknowledge that when the SSF is used correctly, there are clinicians who likely will still have difficulty assessing certain aspects of suicidal behaviors. Though outpatient counseling can help decrease suicidal tendencies, there are some clients who remain suicidal during and after the time when they seek help. For them, better means of identification, assessment, and treatment is essential. Jobes and his colleagues recommend more intense levels of care for the clients who have sought and engaged in treatment without success. This may include more frequently scheduled counseling sessions or inpatient psychiatric hospitalization.

There are specific behaviors that elevate counselors’ concern for the safety of their clients. These behaviors are identified in a variety of suicide risk assessment scales
(Beck et al., 1986; Bongar & Harmatz, 1991; Brown, 2001; De Leo, 1998; Eyman & Eyman, 1992; Goldson et al., 2006; Joiner, Walker, Rudd, & Jobes, 1999; Lester, 1992; Morris, 1995; Nock & Banajai, 2007; Range & Knott, 1997; Van Orden, Witte, Gordon, Bender, & Joiner, 2008). While clinicians use these instruments, the degree of utility they offer appears to be unclear. Eyman and Eyman (1992) conducted a meta-analysis of a variety of instruments used to augment clinician’s ability to assess suicide risk potential. Disturbingly, suicide assessment tools that are used, many with great frequency, offered very little accurate predictive information about the risk of a client committing suicide. This was also true of the Eymans’ findings about a stand-alone instrument that is frequently used to measure suicide risk potential. The instrument, the Minnesota Multiphasic Personality Inventory (MMPI), one of the most commonly used and well researched psychological assessment tools ever created, did not appear to demonstrate any reliability when used to predict suicidal behaviors. While the authors acknowledge that the MMPI is not specifically designed to assess suicide, many see the results of this test as a predictor of suicidal tendencies. The Eymans’ research did not support the use of the MMPI to assess suicidal behavior.

Gutierrez and Osman (2009) conducted a more focused research project looking at sensitivity, specificity, positive predictive value, and negative predictive value of the Suicide Ideation Questionnaire (SIQ) and the Reynolds Adolescent Depression Scale (RADS-2). The researchers hypothesized that, in combination, the two instruments would provide the best predictive utility when used to assess suicide risk potential among adolescents. While this was demonstrated to be partially true, Gutierrez and Osman found
the RADS-2 did not perform as well as predicted. They found the most cost-effective and
reliable suicide risk predictor assessment scale was the SIQ as a stand-alone tool, though
it should be noted these two instruments were not measuring exactly the same construct.
While the SIQ is specifically intended to assess suicide risk, it is not specifically designed
to assess suicide risk in adolescents, while the RADS-2 is designed to assess the degree
of depression present in adolescents, but is not specifically designed to predict suicide
risk. In spite of these and other limitations, the results of the study would seem to offer
some reason to be optimistic. Despite this, the authors reported that the results were
inconclusive at the time of publication.

Osman et al. (1999) investigated the factor structure of the Adult Suicide Ideation
Questionnaire (ASIQ) and the Linehan Reasons for Living Inventory (LRFI). Osman and
his colleagues found there was strong construct validity in both of the instruments.
Specifically, each of the two instruments demonstrated a better than chance
differentiation between the suicide attempter and a psychiatric control group. While
encouraging, it is noteworthy that the researchers were comparing two groups of people
who were already involved in psychiatric treatment. They were careful to note that their
instruments would be most useful in prediction of suicidal behavior in a patient
population with a history of long-term psychiatric treatment.

A novel way of looking at suicide lethality risk was created by Kenneth Morris
(1998a). He developed an instrument to assess suicide lethality potential, named the
Suicide Lethality Assessment Profile (S.L.A.P.). The S.L.A.P. is a lengthy and exhaustive
tool that was designed to offer a comprehensive and well balanced picture of a client’s
suicidal behavior, as well as his or her attitude about suicide (Morris, 1998b). Clinicians assess the problems and challenges the client is experiencing in life that may pre-dispose an individual to commit suicide, but this is balanced by considering the client’s pool of resources (K. Morris, personal communication, 2007). This method is a way assessing suicide risk potential that had not been attempted prior to the publication of the instrument (K. Morris, personal communication, 2007). Unfortunately, to date, no work has been done to determine if the findings produced while using the S.L.A.P. are valid (K. Morris, personal communication, 2007).

Another way of assessing suicide risk was described by Stovall and Domino (2003). They created a list of questions that is intended for physicians to use if they suspect a patient is feeling suicidal. The list of questions uses a non-threatening and minimally invasive method of exploring the patient’s potential risk of suicide. Their questions for assessing suicidality include the following examples:

- Other people with similar problems sometimes lose hope; have you?
- This must be a hard time for you; what do you think about when you are feeling down?
- Do you ever consider running away from your problems?
- With this much stress, have you thought of hurting yourself?
- What has kept you from acting on these thoughts?

Stovall and Domino recognize this is not an all-inclusive list. Pragmatically, they recognize that many physicians are not comfortable asking their patients about suicidal thoughts during an interview. These questions are more comfortable for physicians to ask
than more direct queries about a patient’s plans for self-harm, while still covering all of the most important aspects of the assessment process. While designed specifically for physicians, the method of inquiry they describe could be a way for clinicians to extract information during a crisis intervention.

Clinical Training

Adverse outcomes have led to lawsuits against psychologists and psychiatrists, in part because many practitioners receive only limited training in suicide assessment (McNiel et al., 2008). They believe when a clinician is inadequately trained in suicide intervention, the clinician becomes liable for damages if their client commits suicide. The position McNiel et al. have taken is not without good reason. A survey of clinical graduate programs in North America by Bongar and Harmatz (1991) indicated that only 40% of graduate programs in clinical psychology offer any formal training in the assessment and crisis intervention of suicidal individuals. Half of all pre-doctoral psychology interns report having no previous formal training specific to conducting a suicide risk assessment.

In a related field of study, only one fourth of all psychiatry residency programs offer training. Often this training is offered in the form of a workshop targeting suicide assessment and intervention (Ellis & Dickey, 1998). While this sort of training tends to be quite brief, such workshops have been demonstrated to improve clinical documentation as historical, clinical, and risk management variables can be better identified and their significance quantified (McNiel et al., 2008). Additionally, McNiel et al. found that training in evidence-based suicide risk assessment could improve the
case conceptualizations by increasing their explicitness in ways that are consistent with current standards as identified in professional literature. Perhaps even more importantly, the authors found the self-confidence in risk assessment skills increased among the participants of their study, which mirrored their objective improvements in clinical skills (McNiel et al., 2008).

A segment of the population that is most at risk of committing suicide, yet is very likely to seek services from the medical community, are clients who are of an advanced age (Huh et al., 2012). Huh and his colleagues conducted a study to assess the effect of a 6.5 hour long workshop focused on the assessment and management of suicide risk in older adults. The participants in the Huh et al. research completed pre- and post-workshop case notes and wrote reports about changes in knowledge, attitude, and confidence in their skill set specific to assessment and management of risk in an older adult population. The participants reported improved case notes as well as a greater ability to recognize important conceptual suicide risk categories. An important finding was the improvement in confidence occurred equally between the participants trained in mental health service provision as well as those who were trained in the general practitioner model of health care delivery.

While it is concerning that suicide assessment and intervention training does not appear to be a universally integrated aspect of many counseling or clinical psychology training programs, it is encouraging that measurable improvements in the ability to assess and manage suicide risk may be accomplished by participating in a fairly brief workshop.
Such results may encourage the integration of such training programs into academic curriculums. This will be considered as a topic of future research later in this dissertation.

The Effect of Suicide Assessment on Clinicians

The work of psychotherapists is widely believed to be stressful (Deutsch, 1984). Therapists who are exposed to clients’ trauma by way of listening to their experiences, including graphic descriptions of horrific events or bearing witness to the cruelty of people, can transform the worldview of a therapist in a harmful way (Pearlman & MacIan, 1995). Deutsch notes that people often ask counselors if their work is depressing. There is some truth to this notion. The work of therapists involves interacting, on a daily basis, with clients who experience intense emotions, conflicts, and suicide ideation. According to Deutsch, it is nearly unavoidable to be disturbed by clients. Such interactions take a toll on the therapist. When Deutsch published her paper in 1984, few studies had been conducted to assess stress among psychotherapists. Despite the relative rarity of literature relating to the topic of psychotherapist stress, what has been written confirms, with Deutsch, that psychotherapy is a hazardous profession. The hazards identified stem from the professional role and the social expectations associated with psychotherapy and the nature of working with clients. Among the most stressful experiences Deutsch found in her research, therapists considered clients’ suicidal statements to be the most stressful, a stressor identified by 61% of her respondents. Deutsch reports this compares favorably to another smaller study of psychoanalytic psychiatrists conducted in 1979 by Farber. Of great concern to Deutsch is the frequency that suicidal statements are encountered by therapists; some in her research stated they...
encounter suicidal clients on a weekly basis. In fact, she found suicidal statements were encountered in 11% of all client contact hours, or nearly twice per week for the average therapist. Between suicidal threats and other stressors Deutsch measured, serious levels of stress are encountered by clinicians in her research on a daily basis.

While Deutsch explored the impact of suicidal thinking on experienced clinicians, Kleespies, Penk and Forsyth (1993) explored the stress of this behavior on a closely related field, psychiatrists, during their clinical training. Of concern to Kleespies et al. was the tendency of the mental health system to rely upon the relatively inexperienced clinician in-training to treat some of the most impaired and difficult patients. The impact of these patients’ suicidal behaviors on the in-training clinician is as significant as the actual loss of a patient that was reported by experienced clinicians. This stress lasts as long as two weeks. While it may seem self-evident, the researchers found that the only things trainees found more stressful than suicide attempts by their clients were actual suicide completions and a physical attack on the therapist by a client. They suggest if an intern or trainee experiences a suicidal threat or attempt, the event would warrant greater support and possibly intervention from the appropriate supervisory resources. Without proper support after the suicidal threat, Kleespies et al. found the intern or trainee may be incapacitated in future work with suicidal clients.

These results were echoed by Selakovic-Bursic (2001), who indicated that even when it is difficult for survivors of suicide to talk initially, family members of suicide victims often need to talk. Upon establishing trust with their interviewers, survivors of suicide indicated feelings of guilt, remorse, doubt, and sorrow. Other reactions involved
blaming others and intellectualizing their reactions, a set of responses that were seen by the researchers as decidedly unhealthy. While Selakovic-Bursic’s research was focused on family members of suicide victims, these results could be applied to clinicians. Although not stated specifically in her research, it could be extrapolated to clinicians’ facing the loss of a client to suicide who likely would benefit from talking about their experiences.

The perceived level of stress experienced by trainees and professionals during psychotherapy and supervisory activities was explored by Rodolfa, Kraft, and Reilley (1988). The researchers found that while suicidal statements were stressful, they were not as stressful as other researchers had reported. They suggest this may be more of a product of differences in the perception of the degree of stress among professionals rather than the lack of stress itself. In essence, what one professional finds stressful may not be the most stressful event for another.

Stovall and Domino (2003) look at the death of a patient by suicide as a devastating experience for a family physician. They find deaths by suicide can undermine a family physician’s willingness to work with patients who have an underlying mental illness. Exacerbating their reluctance to treat suicidal patients are the potential legal and litigious factors that can lead to professional and legal problems. They recognize that it is unfortunate that some patients do sometimes successfully commit suicide. Intense feelings of sadness, anger, and helplessness, and the fear of legal and professional repercussions can follow a successful suicide of a patient. Stovall and Domino recommend the physician should express condolences to the family, but should do so
without accepting or placing blame. They believe it is important for the treating physician to regain his or her confidence and be able to maintain a professional approach the next time a patient presents with suicidal ideation.

McAdams and Foster (2000) explored the impact a suicide can have on counselors. Among the 23% of their respondents who have experienced a suicide of a client who was under their care, the response was reported to be moderate to moderately high impact. Counselors were particularly hard hit with both intrusive and avoidant thoughts about the crisis as compared to psychologists and psychiatrists. The authors found that their participants universally reported the suicide of a client under their care was stressful, though the authors believe that therapists in training may have a reaction to the suicide of a client that is stronger than those therapists who have more experience. It is moving to report that, for many, the event has a lasting impact on their personal and professional experience. Noteworthy, Brown (1987a, in McAdams & Foster, 2000) found that every individual interviewed remembered the name of the deceased client, and the details of the incident remained vivid 20 to 30 years later. Brown’s findings were echoed by McAdams and Foster, who found that counselors are impacted by client suicide with statistics similar to psychologists and psychiatrists. While 76% of the participants in their study had not experienced a client suicide, the majority of respondents considered it an “occupational hazard” of working in the mental health field. They recommend that students should develop the professional ability to constructively cope with difficult client problems, treatment failures, and stressful events, including client suicide.
Knox, Burkard, Hess, Jackson, and Shaack (2006) explored the effects of client suicide on a clinician in training. The results of their research, which was specific to pre-doctoral supervisees, echo many of the findings previously described. The death of a client is a devastating experience and one that requires intervention to address the needs of a client and the needs of the therapist as well. It is important for the therapist to process the loss but to do so when and where it is comfortable to do so. Additionally, it is worthwhile considering the clinician’s beliefs about suicide and how his or her work is affected after the suicide occurred. The supervisees in this research recognized that the suicides took place amidst considerable suffering on the part of the client, thus was not a sin or a sign of weakness. Noteworthy was that most of the participants in this research reported they received remarkably little training specific to suicidal behavior as part of their graduate program.

Chemtob, Bauer, Hamada, Pelowski, and Muraoka (1989) have also adopted the viewpoint that the potential client suicide is an occupational hazard in the counseling field. Approaching the suicide of a client as a probable experience through the course of a career in the mental health field may seem detached or even fatalistic, but it seems to be a safer and more pragmatic viewpoint than a rather hazardous viewpoint of hoping it never happens and then experiencing significant emotional damage if a client suicide does occur. The authors recognize that little research has been done to identify characteristics of therapists that may put them at risk of losing a client to suicide. They found client suicides that have the most profound impact on the therapist were long-term clients who
spent significant time with their therapists. The more time the clinician has invested in the treatment of a client, the greater impact the client’s suicide has upon the therapist.

While it may be a given that the suicide of a client is likely to happen at some point in a therapist’s career, there is also a general agreement that such an event is therefore traumatic experience (Michel, 1997). Common reactions include disbelief, shame, vulnerability, guilt, and loss of confidence. Impressions of professional inadequacy, doubts about competence, and fears about professional reputation are common as well. To address this, Michel suggests some things that could be done better. He begins by calling for an increased awareness among health professionals to create an institutional culture in which postvention, after the suicide of a client, is a natural and common practice. Michel further calls for debriefing sessions with professional counselors. Finally, he suggests implementation of training programs for health professionals.

Wong, Chan, and Beh (2007) took a broader view by exploring the effect of suicide on survivors of suicide and how best to help them. Wong and his colleagues found it is comfortable for survivors to talk about the suicide of their loved one, welcoming the opportunity to ventilate their thoughts. They found that some people are hesitant to introduce discussion about the loss out of fear of re-traumatizing the bereaved individual. They felt it was important to mention that providing both support to the therapist and encouraging the therapist to seek professional assistance is vital. These are not mutually exclusive; both should occur in the wake of a client suicide. The insights of
Wong and his colleagues may offer some direction for mental health clinicians who have experienced a suicide among their clients.

Berman (2006) believes one of the most challenging populations to treat is the group of clients who are chronically at risk of committing suicide. Therapeutic alliances are difficult to form, and if the client commits suicide while under the care of a clinician, there is the ever-present risk that the bereaved family will be angry and will hold the clinician responsible and will file a malpractice lawsuit. Berman suggests the best way to avoid such a suit is vigilance when assessing the client’s risk of suicidal behavior and being careful to manage and tolerate one’s own emotional responses as a behavioral health professional. As a means of self-preservation on the part of clinicians, Berman recommends that the number of significantly at-risk patients in one’s practice be limited as a means of increasing the accessibility patients have to the clinician during the most acute periods of crisis. Berman suggests this will demonstrate a higher level of concern for at-risk individuals, thus reducing the risk of suicidal behaviors.

Kleespies (1993) explored the stress psychiatry interns experience when they work with suicidal clients. It is clear that the death of a client by suicide has significant emotional impact on an individual in-training. Not a low frequency occurrence, this happens frequently enough that Kleespies suggest interns should be prepared for such an event during their training because nearly all clinicians will experience the suicide of a client at some point during their practice. While all pain and distress cannot be removed from the experience, greater preparation is in the best interest of clinicians training to work with this population. While they identified no characteristics of therapists that
predisposed them to experiencing the suicide of a client, those who work with an
inpatient population and with a severely mentally ill population would be well served to
prepare themselves for the possibility that they could experience the loss of a client by
suicide.

One is encouraged by the data generated by Pope and Tabachnick (1994), who
surveyed 800 psychologists about their experience as clients themselves. Pope and
Tabachnick found that of therapists who returned a survey about their experiences as
clients, 84% had been in therapy. This implies that within the human service field there is
considerable faith in the practice of counseling as a helping tool. Disturbingly, though,
the most frequently endorsed focus of discussion was depression and general
unhappiness, as 1 out of 4 respondents mentioned it. Suicidal thinking was not mentioned
as a primary focus of therapy by any of the respondents. Despite this response, 1 out of 4
respondents felt suicidal during the course of their own therapy and almost 4% made a
suicide attempt during the course of their own treatment. These numbers suggest that
when therapists become clients themselves, they are reluctant to reveal their own suicidal
thoughts to a therapist. With professionals experiencing such difficulty addressing
suicidal thinking, it is not difficult to imagine the difficulty someone new to mental
health treatment could have discussing the matter with a relative stranger.

The Worldview of Suicide

In Lester’s (1997) significant work entitled Making Sense of Suicide: An In-depth
Look at Why People Kill Themselves, the author explores the question of the thinking
process and motivations experienced when an individual decides to take his or her own
life. This is no simple task to explain, which is why nearly 200 pages of text are spent on the topic. Lester is clearly disturbed by the high rate of suicidal behavior he has seen and that there are so many variables that contribute to an individual’s decision to commit suicide. While Lester recognizes that there are some people who believe prolongation of life is always desirable over death, thus suicide should always be prevented, there are some who believe suicide is a reasonable option.

Lester (1997) offers many reasons for preventing suicide, including cultural taboo, emotional pain of survivors, potential for survivors to be negatively impacted financially, and concerns for children, believing they may inherit suicidal tendencies. Despite these arguments, Lester believes that there may be circumstances where the prevention of suicide may not be the best thing for a client. He says an existentialist argues that at times suicide is a healthy act. This may be due to the preoccupation and near constant monitoring some people require. It may also be due to an individual’s compromised state of dignity.

Lester (1997) says choosing suicide is a relevant topic today in light of the increased number of people living with terminal illnesses such as AIDS. He feels there are some people who would rather die by suicide than live a life of suffering. The argument he presents is that, for some, suicide may in fact be the best solution to an impossible situation. Given that people have so many styles of life, so too should they have a right to their own style of death.

This viewpoint is not shared by everyone. Lester (1993) cites Schneidman and his colleagues (1965), who argued that even when people are severely ill, they should not
commit suicide because there is hope any time there is life remaining. Expanding upon Schneidman’s sentiments, Richman (in Lester, 1993) indicates, for some clients, suicide is a means of acquiescing to their illness. Instead, he believes more strenuous efforts should be made to improve the quality of their final months or years of life. Lester writes that it is relatively rare for a person who is approaching death to be totally cured and return to normal life. Recognizing this, Lester believes the wishes of the dying person should be the chief concern; thus, quality of life should take precedence over quantity of life.

Werth and Liddle (1994) explored the attitude psychotherapists have toward suicide. They surveyed 400 members of APA division 29 using four scenarios. They found that nearly 80% of the therapists surveyed believed there were some circumstances when suicide was acceptable. This was particularly true when the individual in question was facing a terminal illness. This result confirmed earlier research that Werth and Liddle reviewed involving the views of suicide held by college students. The authors indicate the results may indicate that it is time for the mental health profession to re-examine their stance regarding a professional’s ethical obligation to intervene with every actively suicidal individual, particularly those people facing terminal illnesses and those living with chronic pain. They feel it may be worthwhile to research the “intensity of suicide intervention” in order to establish a continuum of suicide interventions.

Further complicating matters has been Oregon’s 1994 Death with Dignity Act. Farrenkoph and Bryan (1999) explored the repercussion of this act, finding that only in the case of impaired judgment on the part of the client should their right to a prescription
of a lethal dose of medication be denied. Of concern is the possible presence of a personality disorder, so the authors caution readers to carefully assess for that condition. Of note, while the authors encourage treatment of depression, with complicated medical situations, it is best to consider a psychiatric consultation before proceeding with making recommendations. Perhaps more interesting was what they did not say, which is for such practices to end.

Thoman Szasz (1986) offered another argument opposing suicide prevention. Szasz argued that it is wrong to hold the mental health professional accountable for the death of a client by suicide. Instead, he suggests the client is responsible for his or her own actions, thus absolving the mental health clinician from having to be forced into contradictory and conflicting roles. Szasz believes the best way to view suicide is in parallel to procreation. By looking at suicide this way, self-harm can be seen as a morally complex behavior and therefore a basic human right. Szasz feels that accepting suicide as a right does not mean it is accepted as a morally legitimate option. Instead, it means that the state should abstain from being empowered as agents to prevent suicide.

While these arguments are persuasive, there are those who could certainly take exception to suicidal behaviors, among those in one subset of the population: women who are pregnant. Vaiva, Teissier, Cottencin, Thomas, and Goudemand (1999) explored this topic because they believe there is a misconception about suicide risk among pregnant women. While many believe pregnancy prevents suicide, Viava et al. find the suicide rate among pregnant women to be just as frequent as the rest of the population. While they suspect this may be a product of a combination of both mental illness and unwanted
pregnancies, they believe it is important to explore this part of the population carefully. They strongly encourage caution because acceptance of the notion that pregnancy will prevent suicide in certain women only will lead to those women committing suicide and being overlooked.

**Concluding Remarks**

The review of literature explored the problem of suicidal behavior as it presents itself to clinicians. The literature indicates that suicide assessment is an aspect of the work of behavioral health professionals that likely cannot be avoided. Clinicians would be well served by increasing their familiarity with the common risk factors and should develop a way to assess a client’s risk of suicide that is both comfortable and rather routinized. That would serve the clinician as a means of conducting a thorough assessment of the client and could possible stave off litigation should a client make the unfortunate decision to commit suicide. Of the common risk factors, the literature indicates the presence of any of the following—depressed mood, suicidal ideation with a plan, a sense of hopelessness, or a lack of an intact support system—significantly increases the risk of a client committing suicide. These risk factors are exacerbated when the client is abusing drugs or alcohol and are further increased when they are present in combination.

While there are a variety of suicide assessment instruments available to the clinician, nothing in the literature suggests that a single instrument can accurately and reliably predict suicide, particularly as a stand-alone procedure. The utility of such instruments is primarily in the area of augmenting the assessment skills of a clinician
interviewing a client. Despite the considerable body of research written by highly competent experts, everything that was reviewed for this dissertation indicated the decision of whether or not to intervene on behalf of a client is colored by the experiences of the mental health professional that has had a personal interaction with the client. The final decision of whether to intervene when a client has decided to commit suicide becomes a personal matter that reflects the clinician’s view of the act of suicide. Many clinicians are opposed to suicide for any reason, while a great many more seem to believe the final decision to end one’s life is one that is made autonomously, in light of mitigating factors. Those must be explored in-depth with clients individually, with mitigating factors being discussed at that time. Almost universally, there is a belief that when a client is facing a terminal illness, suicide becomes a reasonable decision.

Jobes, Rudd, Overholser, and Joiner (2008) considered the competency of those working with suicidal patients and the challenges associated with the practice. Among those are an inadequate or incorrect assessment of the severity of the suicide risk, inability to get proper insurance coverage to allow a long enough stay to ascertain the safety of a client, and the emergent client who has never been in treatment, yet at the onset of care appears to be very seriously compromised. They suggest assessing the current suicide risk of any client suspected of having any suicidal behaviors every time there is an interaction with that individual. Among the critical issues involved with adequate assessment of suicide risk is helping students develop an adequate competence in various clinical skills, including working with suicidal clients. Despite considerable progress in the field, the authors were left feeling that deaths by suicide are going to
occur simply because intervention techniques remain imperfect. Of great concern is the paucity of training by many graduate programs in the mental health field. While there are resources available to the clinician who is interested in participating in suicide-specific training, they appear to be largely relegated to attending professional workshops.
CHAPTER III
METHODOLOGY

Tasks of This Research

The task of this study was to record, interpret, and understand, in the form of a doctoral dissertation, the lived experiences of clinicians who actively assess suicide lethality potential in crisis situations. A typical research project in the social sciences would make an attempt to quantify these experiences and offer the statistical results as a means of understanding the process. This dissertation differs from those approaches. Instead of attempting to quantify the experience, it attempts to understand and explain the process of suicide assessment from a personal perspective. The data utilize the participants’ own words to portray their firsthand experiences more accurately. Great care has been taken to be certain the experiences of the participants are not diluted through over-interpretation. Instead, the interpretation process has taken the form of this researcher attempting to group broad ideas into common themes, while maintaining a position that unique experiences (typically treated in a quantitative study as an “outlier”) are worthy of exploration based upon their own merits.

Research Paradigm

The phenomenological research question for this study was, “What are the lived experiences of clinicians as they assess suicide risk potential of their clients?” To answer this broad question, the researcher conducted a series of in-depth interviews that provided
a semi-structured framework for their responses. The interviews were guided by the following preliminary questions:

1. “What is your approach to suicide assessment?”
   a) “What is your conceptual framework when assessing client’s risk of committing suicide?”
   b) “How do you determine the seriousness of a client’s risk potential?”
   c) “Do you use any suicide assessment protocols or standardized instruments and what are they?”
   d) “How valuable are assessment protocols and instruments to your practice of suicide assessment?”

2. “How has your professional practice changed as a result of conducting suicide assessments?”
   a) “What changes in your therapeutic practice have you noticed in the wake of suicide assessments you have conducted?”
   b) “Are there any changes in your daily routine on the day of a suicide assessment?”
   c) “Over time, have you had to make any systematic changes in your practice because of suicide assessments?”
   d) “Are there any systematic barriers that hinder your ability to adequately conduct a suicide assessment?”
3. “How are you personally impacted by the practice of suicide assessment?”
   
a) “What happens to you emotionally during and after a suicide assessment?”

b) “Do you find yourself experiencing any change in mood during the assessment or at any time following the suicide assessment?”

c) “If your mood is changed because of suicide assessment what, if anything, do you do with those feelings?”

d) “How is the rest of your day and time out of the office affected immediately following the process of conducting suicide risk assessments?”

e) “Does anything ‘spill over’ into interactions with other clients?”

4. “How has the practice of suicide assessment changed your worldview as a person both professionally and personally?”
   
a) “How has your personal worldview been changed by your practice of suicide assessment?”

b) “Have there been any changes in your practice if your worldview has changed?”

c) “Have you noticed any changes in your personal life after conducting a suicide assessment?”

d) “Can you describe the changes you have experienced in the weeks and months that you attribute to your experience conducting suicide assessments?”

For the purposes of the current qualitative investigation, this research utilized a phenomenological methodology. The present research is an exploratory study that used in-person interviews of practicing clinicians to gather information about their lived
experience of suicide assessment. A phenomenological qualitative approach was selected because the lived nature of suicide assessment differs from one individual clinician to another. This type of interviewing is very specific and grounded in philosophical tradition (Marshall & Rossman, 2006). There was an assumption that individuals can narrate shared experiences. These experiences can get to the essence of the event with proper structure (Marshall & Rossman, 2006). Phenomenology provides a way to describe the meaning of a particular experience that is based on a common perspective shared by several individuals (Creswell, 2007). This approach is important so the essence of the experience of suicide assessment could be captured from the perspective of clinicians who conducted these assessments. The phenomenological approach allowed an explicit focus on the researcher’s personal experience in combination with the experience of the participants (Marshall & Rossman, 2006). Because of the nature of the material to be studied, a semi-structured approach to the interview process was seen as offering the most useful way to gather information about how individual clinicians assess suicide risk potential of their clientele. The semi-structured interview offered the participants some latitude to answer broad questions while staying focused on the topic.

**Phenomenology Explained**

The term *phenomenology* was used as early as 1765 in philosophy (Kockelmans, 1967), in part as a criticism to positivism and natural science for taking an objective reality that is independent of individual consciousness (Nagy Hesse-Biber, 2006). Edmund Husserl (1859-1938) attempted to develop a new philosophical method which would lend absolute certainty to a disintegrating civilization (Eagleton, 1983). Husserl
named his philosophical method “phenomenology” or “the science of pure phenomena” (Eagleton, 1983). Long seen as the originator of 20th century phenomenology, Husserl believed that consciousness is always intentional (Vandenberg, 1997). The aim of phenomenology is the return to the concrete, captured by the slogan “To the things themselves” (Moustakas, 1994). The researcher who adheres to phenomenological traditions describes things as accurately and factually as possible without a preconceived framework.

Creswell (2003) indicated that phenomenological research identifies the “essence” of human experiences as described by the participants themselves. Understanding the “lived experiences” of those participants (Greene & Holloway, 1997) marks phenomenology as a philosophy as well as a method, bringing it full circle to its original definition from the 18th century. According to Welman and Kruger (1999), “phenomenologists are concerned with understanding social and psychological phenomena from the perspectives of the people involved” (p. 189). In addition, the phenomenological procedure involves studying a small number of subjects through extensive meetings to develop patterns and relationships of meaning (Moustakas, 1994). There are two main trends in phenomenological research: empirical and heuristic.

Moustakas (1994) wrote that the empirical phenomenological research refers to obtaining a comprehensive description that provides the basis for a reflective structural analysis to portray the essences of the experiences. The approach seeks to disclose and clarify the phenomena of behavior as it is manifested (Moustakas, 1994). Heuristic research incorporates creative self-processes and self-discoveries. The process of internal
search allows one to discover the nature and meaning of experience and to develop methods and procedures for further investigation and analysis. There are six phases of heuristic research that guide unfolding investigations and comprise the basic research design. The phases include the initial engagement, immersion into the topic and question, incubation, illumination, explication, and culmination of the research in a creative synthesis (Moustakas, 1994). For the phenomenologist, there is no “one reality” to how an event is experienced. A variety of methods such as observation, in-depth interviewing, and examining written accounts of experiences found in materials is used to understand the phenomenon (Nagy Hesse-Biber, 2006).

A research proposal is basically a plan for engaging in systematic inquiry to bring about a better understanding of the phenomenon and address problematic social circumstances (Marshall & Rossman, 1999). This study explored the lived experiences of clinicians who assess the suicide lethality potential of clients in crisis. This was done by investigating the lived experience of assessment of suicide potential as it is done by clinicians. Utilizing a phenomenological approach, the proposed research explored this topic by addressing several questions. These questions included inquiries into the way clinicians assess suicide risk potential, how their professional practice is impacted, how clinicians are personally impacted by assessing for suicide potential in their clients, and the way their worldview changed as a result of suicide assessment.

A phenomenological approach was selected because an understanding of the essence of the experience of assessing suicide was desired (Creswell, 2007). It was
anticipated that utilizing open-ended questions within structured interviews would allow the clinicians to describe the essence of their experience as suicide potential assessors.

**Philosophical Correlates of the Research Paradigm**

Phenomenological philosophy and phenomenological psychology have been intertwined since the inception of the phenomenological traditions. Sokolowski (2007) discusses the philosophical underpinnings that are common to both branches of phenomenology. According to Sokolowski, the term most closely associated with phenomenology is *intentionality*. At the core of intentionality is teaching that every act we perform and everything we experience is intentional (Sokolowski, 2007). Numerous sources cite Husserl as the founder of phenomenology (Creswell, 2007; Douglass & Moustakas, 1985; Giorgi, 1985; Langdridge, 2007; Sokolowski, 2007). At the core of Husserl’s phenomenology is the activity of giving an account and the events that are remembered (Sokolowski, 2007). This accounting of things recognizes the public aspect of the mind and how the mind creates an individual reality (Sokolowski, 2007).

While the mind has a public aspect, there is a private nature of the mind that is kept from others, which include perceptions and preferences (Moustakas, 1985). According to Moustakas (1985), all of this must be set aside in order to achieve Epoche, a process that requires a high level of sustained attention, concentration, and presence. Epoche can be either inward, to connect with preconceived ideas (Moustakas, 1985), or outward, so things can be observed with an open presence (Moustakas, 1985).
Assumptions of the Phenomenological Research Paradigm

Phenomenological research must begin with a phenomenological attitude (Sokolowski, 2007). According to Sokolowski, a shift into a phenomenological attitude is an “all or nothing” change of mindset that focuses the researcher in a reflective manner on everything including the underlying worldview of the participants. Using this viewpoint, all of the “particular intentionalities” of the participants are considered and described (Sokolowski, 2007). The interviews were conducted on an individual basis with clinicians with a wealth of experience in the field. These participants were purposely selected to represent an “elite” clinician with specialized training that is of great interest to the researcher (Marshall & Rossman, 2006). Some clinicians may share anecdotal stories about things they have done in the midst of a crisis situation. While anecdotes can be reminiscent of break room conversations, there was considerable wisdom contained in these tales that offered the researcher valuable information. This was not inconsistent with phenomenological verbal traditions (Giorgi, 1985). Anecdotes can be rich with real-world information about the ways crisis management can be of significant benefit to a troubled individual. Conversely, there were narratives of interventions gone wrong. These stories were equally valuable as they provided the researcher with information about potential pitfalls in the crisis management process. People with rich experience were selected, specifically because of the expertise they offered to this study (Marshall & Rossman, 2006).
The Researcher’s Relationship with the Participants

The researcher purposely selected the participants in such a way to get the best qualified reporters of the phenomenon that was of interest to this study. In some cases, the participants were former colleagues of the researcher. Others were individuals known to colleagues of the researcher. The participants were drawn from a purposely selected sample of elite reporters within the field of crisis assessment clinicians, with the selection criterion weighted more in favor of a broad clinical experience than an attempt to draw a representative sample from the field. This selection method resulted in a group of participants who were uniquely qualified to provide a rich source of data for this study.

The Research Method

While there are many standardized instruments and tools that can be used to structure suicide assessments, we did not know the specific ways that individual clinicians assess for suicide potential when they were with their clients in therapeutic settings. Using a phenomenological approach, this study asked 20 behavioral health clinicians to describe their lived experiences as they assess clients’ risk potential for committing suicide. Initially, it was thought that 12–17 participants would be adequate to achieve a level of saturation that is ideal for qualitative research. The researcher maintained a stance that was open to the possibility that additional participants would need to be recruited in order to get a full understanding of the phenomenon. In order to increase the likelihood that there was some measure of diversity and to be certain of drawing an expert sample, 20 participants were selected, with 17 qualifying for
participation. All of the behavioral health clinicians who comprised the pool of potential participants routinely assess suicide risk potential in active mental health treatment clients as a part of their work. Utilizing an in-person interview, participants were asked to describe their lived experiences as they consider the suicide lethality potential among their clients. The interviews were conducted face-to-face, so the researcher could best explore the full range of emotions as expressed by each participant. The interviews took place in settings selected by the participants as a means of increasing the participants’ comfort level during the interview while assuring the maximum level of confidentiality. Thus, the interviews took place in the participants’ homes, offices, and, in two cases, a secluded public area over a lunch hour. Participants were asked to describe what it is like to interact with a client in the midst of a suicide assessment. By encouraging the clinician to return to the experience, the researcher hoped to learn about the ways he or she interprets crisis assessment on a personal level. An additional step was to learn how clinicians reflect upon crisis assessments in retrospect. How a clinician is affected by crisis assessment personally and how he or she functions as a counselor in the wake of a crisis was of interest to this researcher. Finally, it was theorized that the impact of suicide assessment likely has some effect on the participants’ lives and could affect the way clinicians do their jobs. This experience was explored in detail.

The research took the form of an exploratory study based in the traditions of phenomenology. It explored the work experiences of clinicians who routinely conduct crisis interventions that assess the lethality potential of mental health clients in crisis situations. The research was conducted using a sample that was selected in a purposeful
manner by the researcher, typically focusing on clinicians known to the researcher through professional contacts. Additional contacts were achieved through referral sources and networking. The pool of potential participants included a variety of mental health professionals, but those individuals who have a social relationship with the researcher were excluded. There was a series of contacts that were structured in a way that ensured consistency across all interviews, yet allowed sufficient flexibility to be tailored to the individual participant. These contacts consisted of the initial contact, the structured interview, written follow-up, and, if necessary, a telephone discussion or written feedback to correct any discrepancies between the participant’s recollection of the interview and the transcribed document. At no point was the identity of the mental health clients either discussed or revealed.

It was important for the researcher to bracket the interviews by putting aside all preconceived notions about what the participant may offer during the contact session (Creswell, 2007). While it would have been easy to enter the data collection process with preconceptions, by setting aside biases, the researcher was better able to absorb the full implications of the participant’s contribution. By adopting a bracketed mindset, also known as a transcendental approach, the data were perceived with a fresh mindset, as if it was being experienced for the first time (Creswell, 2007). It was assumed that individuals experience phenomenon differently, so a stance of neutrality was imperative before beginning the data collection process.
Participant Selection

The sample consisted of 2 subjects for a pilot test and 17 subjects for the full study. The objective of this sample size was to achieve a saturation point when collecting data. The researcher anticipated 12–17 subjects, grouped into two groups that would represent two distinct subsets of the clinician community—private practitioners and community-based mental health programs. Because the saturation point of information was not achieved with that number, additional subjects were recruited until saturation was achieved. By the end of the 20th interview, it seemed there was a satisfactory level of saturation and recruitment was discontinued. The researcher was open to the possibility that more subjects than the originally anticipated 12–17 would be necessary and this was fortuitous. Throughout the written portion of this research, subjects will be referred to as “participants” to more accurately reflect the active and collaborative role of participants that is inherent in qualitative research traditions. The sample was chosen purposely as a representation of professional psychotherapists and mental health workers who had at least two years of experience assessing suicide as a part of their clinical practice. The selected participants were active mental health practitioners drawn from a pool of mental health clinicians who met specific inclusionary and exclusionary criteria for this research. The criteria are listed below. The pool of potential participants was recruited by direct inquiry using contacts and referral sources known to researcher Macleod. By including individuals who worked for community-based mental health programs and private practices, the researcher had the opportunity to explore if there were any differences in experiences between these two
groups and what these differences might have been. The pool of potential participants was comprised of individuals who were not social acquaintances, but rather people who could be introduced to the researcher through professional colleagues of the researcher. The technique of acquiring additional potential participants, commonly referred to as snowball sampling, was used to expand the pool of potential participants. Such a technique involved asking active participants in a study to refer the researcher to other potential participants who may have had an interest in the present study. If the active participants agreed, they provided the researcher with contact information of other potential participants.

The recruitment process was augmented by researcher Macleod discussing this study with colleagues who were known to have experience with suicide assessment. Researcher Macleod contacted each potential participant directly to explore his or her willingness to participate in the study. Potential participants were queried about other professionals who may have had an interest in this research in order to obtain referrals for additional potential participants. Researcher Macleod contacted these potential participants directly and asked them about their willingness to participate in this study. These conversations adhered to the “Script for Initial Phone Contact” included in Appendix C. The script included an explanation of this research project. In some cases, this inquiry took place face-to-face. Those conversations also adhered to the “Script for Initial Phone Contact” that is included in Appendix C.

The pool of potential participants selected included seasoned therapists who either conducted outpatient therapy with an established caseload or routinely conducted
crisis assessments as an integral part of their primary professional role. The pool of potential participants met inclusion criteria for participation in this study that are listed below. Potential participants were informed of the voluntary nature of their involvement in this research project. They were informed that there was no cost to them. There was full disclosure about the referral and recruitment process as well as the purpose of this research study. Potential participants were informed of their right to discontinue participation in this research project at any time. They were informed that they faced no personal or professional consequences if they elected to end their participation in the research project, though none of the recruited individuals chose this option. Participants were informed that they were to make no mention of the names or identifying information of any of their clients, and none of them broke this agreement. They were informed of the anonymous nature of their participation and the importance of their privacy. Any information a potential participant provided will be kept in a locked cabinet located in the office of researcher Hovestadt upon completion of this dissertation.

**Inclusion Criteria for Participation in This Study**

1. A minimum of two years of experience working with potentially suicidal individuals;
2. At minimum, a master’s degree and appropriate licensure in the mental health field;
3. Current employment in a job that requires suicidal assessment on a routine basis;
4. Completion of at least one suicide assessment in the past year and a minimum of three suicide assessments in the past five years.

This information was collected by asking potential research subjects if they met the minimal qualifications during the initial telephone or personal contact. To increase the chance of producing a representative sample, the potential participants were chosen from varying human service fields. The participants were employed as master’s and doctoral level psychotherapists, counselors, hospital crisis workers, private practitioners, and social workers.

Protection of Participants

Potential participants were recruited by researcher Macleod via the telephone, email inquiry, or a personal conversation inviting their participation. During the initial telephone contact, potential participants were informed that participation in the study was entirely voluntary. If the potential participant demonstrated interest in the proposed research study, more in-depth details about the study itself were verbally given to the possible participant. If he or she verbally agreed to participate in the study, he or she was either hand-delivered or mailed a package including a cover letter, demographic questionnaire, consent form, and a list of research questions (these are included in the Appendices). Potential participants were asked to return the completed demographic and consent forms prior to any personal information being gathered. (Additional demographic and consent forms were available at the interview site in the event that the potential participant forgot to return the original form. These were utilized on several occasions.) At the time of the interview, and prior to commencement of the interview,
the potential participants were reminded that their participation was entirely voluntary. Responses to all research questions and information on all forms, including the demographic questionnaire, were anonymous. All individuals in the pool of potential participants were also given an opportunity to ask any questions about the interview, and the consent form in particular. If they did not wish to complete the consent form, for any reason, the interview would conclude immediately. In this event, the prospective participant would have been thanked for his or her time and the research relationship would have been terminated. This did not occur with any of the participants in this research. If any potential participant had the experience of a client successfully committing suicide at any time in the past two years, he or she would have been excluded from participation to avoid any potential detrimental effect stemming from participating in this study. This did become an issue with one participant who was, in fact, excluded from the study.

**Data Collected for the Research**

Researcher Macleod collected data from participants in the following manner:

1. A series of three contacts utilized a semi-structured format. The contacts each had a specific focus. The first contact was a telephone call that gauged potential participant interest in the research. This telephone call followed the “Script for Initial Telephone Interview” form found in Appendix C. Potential participants who agreed to continue were scheduled with researcher Macleod for a face-to-face second contact to collect and digitally record data. This contact used the interview questions found in Appendix B. Following
transcription of the data, the participant received a written copy of the
transcript. Once the participant had been given an opportunity to review this
material, an optional third contact took place. This took the form of a
telephone interview that allowed participants to make any corrections or
revisions to the transcript and discuss additional information, if the
participant chose to do so. This option was utilized by only two participants.

2. Each contact was individually tailored to the individual participants as
needed. This was suggested by data collected via the demographic
questionnaire and/or information collected throughout the contact.

3. The initial contact, which gauged participants’ interest in the interview, was
recorded on a form specifically designed for this purpose. All subsequent
interviews were digitally recorded with the participant’s prior consent.

Following the data analysis, the recordings of the interviews were destroyed
by the researcher.

4. Transcripts of the interviews were entered by the researcher into a computer
software program for analysis.

This research drew from the following sources of data: (a) an initial telephone
phone contact to screen possible participants for inclusion or exclusion criteria;
(b) digitally recorded interviews with participants (which were transcribed by researcher
Macleod into a Microsoft Word document); (c) a demographic questionnaire that was
sent or delivered by hand to participants along with the consent form; (d) a written copy
of preliminary results of the transcribed interview for participants to review; and (e) a
narrative response, written by the participants, to the transcribed interviews as a means of a member check for accuracy. The interviews took place face-to-face in a location of the participants’ choosing. This arrangement ensured that the location was comfortable and convenient for the participants and provided a comfortable degree of anonymity. Copies of a consent form were sent to the participants prior to the date of the interview. Additionally, a cover letter, demographic questionnaire (which was completed prior to the contact), and a list of research questions were included. At the time of the contact, the completed consent form was collected prior to the collection of any personal information about the participant.

**Data Collection Procedures**

For this research, researcher Macleod utilized semi-structured face-to-face contacts with participants. The research questions follow in Appendix B. The research process allowed participants to freely reflect upon the experience they have had with suicide assessment. Open-ended questions were used to allow participants to express their opinions. The primary interest of this study was the lived experience of participants through the process of assessing potentially suicidal individuals. A semi-structured set of research questions was designed to increase the likelihood that the targeted research questions would be fully addressed. It was thought that the questions would prompt avenues of discussion that were not directly linked to the research questions. Furthermore, it was believed to be likely that some of the research questions would have resulted in responses not anticipated by the researcher. Contacts were
conducted in such a way that the topic discussed could have been connected to one or more of the research questions.

All contacts following the initial contact to gauge interest in the study were recorded using a digital audio recording device. All recorded interviews were transcribed word-for-word by the researcher. Following the transcription, the participants were offered the opportunity to review the transcription and correct any inaccuracies in the transcription.

**Notes and Record Keeping**

Throughout the research process, there were records kept to assure accuracy. Specific records included notes from all interactions with participants. These notes were kept strictly confidential, to be seen only by members of the research team. While the notes had items that corresponded to each participant, specific items that identified participants were kept confidential, with coding procedures available only to the researchers. The daily activities of the research were maintained in a specific binder that is kept securely locked by the researcher. The same is true of information pertaining to decision-making procedures. As the research process evolved, the starting point and evolutionary process was recorded to maintain a high level of consistency between participants. The research questions were used in pilot format with two individuals before embarking on the full study. The research questions were revised upon completion of the pilot aspect of the research. It was anticipated that there would be some problematic areas that would arise either with the questions themselves or through a debriefing with the participants in the pilot study. This proved to be an accurate prediction. This process was
slightly different in the full study. Problematic questions were managed by allowing participants to review their responses and offer input about the process. Of the aspects of the research process that demonstrated problems consistently, all of the participants were offered an opportunity to respond to the question again during the debriefing phase of the research.

It was expected that participating in this study could have produced extreme emotional reactions in some participants. To protect them, there were safeguards to ensure their emotional well-being. While an emotional reaction was considered a normal part of the research process and was to be expected at differing levels in all participants, if any participants had a high degree of discomfort during any aspect of the interview process, they would have been offered the opportunity to terminate the research interview process and would have been offered resources to discuss their discomfort if they chose to receive them. If necessary, a crisis referral would have been provided by the researcher at no cost to the participant, though the cost of counseling would have been the responsibility of the participant. This was made clear to all participants involved in this study. Fortunately, none of the participants needed to avail themselves of these safeguards.

Personal notes about experiences with participants are kept in a secure confidential setting by the researcher and will be destroyed upon completion of the research process. Any personal notes are maintained by the researcher and will be attached as an appendix if any material contained within them proves to be of benefit to either the present research project or could provide future researchers insight into new
avenues of research. Notes regarding reactions to the research process are kept by the researcher in the form of an electronic log and are maintained in a confidential manner throughout the term of the research.

It was anticipated that some of the questions would have to be modified from their original form, or asked in manner different from how they were designed originally. It was expected that in the case of such an occurrence, the researcher would maintain a log of these revisions and include them as an appendix. In the case of a question that would need to be changed for all interviews, the revision was reflected in all subsequent interviews and a record made of the change to the interview procedure. As it turned out, one question had to be added pertaining to the loss of a client to suicide. This was pointed out during the pilot phase of the research so there were no variations in the questions asked of all participants.

**Data Analysis**

Initial data analysis utilized inductive methods. Researcher Macleod looked for significant statements, meaning units, and textural and structural description. From this process, the essence of the description of suicide assessment became much more clear. As a means of identifying common words and themes, further data analysis was performed using Max QDA qualitative analysis computer software. Data analyzed included information gathered using the following methodology:

1. An initial telephone conversation with potential participants ascertained their ability to meet the minimum requirements for participation in the study.
2. There was either a face-to-face or telephone contact with each of the potential participants.

3. Demographic questionnaires were completed by the potential participants.

Data analysis included the following steps:

1. Researcher Macleod listened to the digitally recorded contacts.

2. The digitally recorded contacts were transcribed into a Microsoft Word document by researcher Macleod.

3. Researcher Macleod read the individual contact transcriptions.

4. Researcher Macleod wrote notes outlining significant findings.

5. Researcher Macleod wrote summaries of the interviews using direct quotes from transcribed data, including all responses that were clinical in nature, regardless of the connection to the question.

6. The transcribed summaries were entered into the Max QDA computer program to identify salient points.

7. Using the Max QDA computer software, researcher Macleod identified themes and content patterns that emerged in the contact summaries and began grouping salient points by question.

8. Within each of the salient points, clusters were named.

9. Data that appeared peripheral (which did not respond directly to an interview question) were placed into an additional themes category so they were not lost. This category was analyzed separately.
10. Researcher Macleod engaged in a peer review process by collaborating with the participants to review resulting data. Doing so raised additional questions about the data as well as provided possible alternative explanations of the results.

11. A preliminary summation of the results was written and researcher Macleod provided a copy of this summation to participants so they could further validate and/or clarify resulting themes.

12. Researcher Macleod wrote a final copy of the results portion of this dissertation, including any feedback from participants. This final edition included a discussion of the researcher Macleod’s prior biases regarding the phenomena being studied that may influence the results of this study.

**Data Analysis Procedures**

It was anticipated that some large groups of themes would emerge as a result of this research. Because many of the individuals who were involved in this research project were performing similar tasks in the field, it was anticipated that many of their experiences would be similar. This proved to be an accurate prediction, so these similar experiences were grouped into themes and were analyzed collectively. It was also anticipated that there would be some experiences that were unique to each individual. This also proved to be accurate, though not as widespread as was expected. Rather than treating these experiences as outliers, they were analyzed separately, as they may offer some insight into the variation that is inherent in the practice of crisis intervention work.
Data Reduction and Software Utilization

Each contact contained some specific forms of data. All of the contacts were digitally recorded and were transcribed verbatim by the researcher. During the contacts, the researcher Macleod utilized written notes to serve as a means of recalling particularly salient points as they occurred during the research process. These notes were used as a means of highlighting aspects of the transcription that were worthy of more in-depth analysis or were a point of discussion during a follow-up contact.

Currently, the computer program that seemed to offer the most utility for analyzing the data is the Max QDA software package. It was released for sale in the spring of 2012. Given the fluid nature of computer software development, it seemed prudent to remain open to a variety of computer software options as they were developed, as updated software might have offered a richer and more detailed set of data by the time the first stage of the research process was completed. This proved to be accurate through the course of the dissertation writing process, as several programs were offered for sale and were subsequently supplanted by better systems.

Evolution of the Research Design

It was anticipated that the research design would evolve as the research process transpired. This seemed likely because some themes that were not anticipated by the researcher may have become evident through the course of the research. In this case, it was wise to allow some latitude for respondents to add information that fell outside the original set of research questions as a means of adding to the richness of the data. To
maintain consistency, the questions that were added or modified in any way were added to the set of questions utilized in the follow-up process for all participants who did not have the opportunity to answer them. All answers were added to the compiled data gathered during the first round of contacts. Summary conclusions were reviewed by the participants prior to data analysis.

**Organization, Format, and Presentation of Data, Interpretations, and Conclusions**

The data were roughly grouped into similar groups or clusters as much as possible. Next, the data were interpreted using software to augment the rough groupings created by the researcher. All data were organized in Appendix F so consumers of this research would have a simple means of understanding the data both in raw form and as interpreted by the researcher.

Given the nature of qualitative research, reliability was managed quite differently than it would be in a quantitative design. The contacts with all participants were carefully transcribed verbatim by the researcher. Initially, this was a job that was going to be assigned to a professional medical transcriptionist, but later it was seen as important for the researcher to have an additional opportunity to listen to the raw data without the interpretation of an outside observer. Member checking was accomplished by mailing the completed documents to all of the participants for their review. As an additional member check, all corrections or additions to the documents were made before the analysis of the data occurred. The nature and extent of the corrections and additions were discussed with each of the participants following each of the contact sessions. There was an opportunity
for participants to participate in a formal debriefing session following the structured research process and again during the follow-up contact session.

**The Researcher**

The results of a qualitative research study can be colored by the experiences, preconceptions, and biases of the researcher. This author is a white, middle-class man with extensive professional experience working in the mental health field with potentially suicidal individuals. It was imperative that he maintain as much objectivity as possible. This required a stance of neutrality and openness to responses that fell outside his previous experience. This stance was challenging to maintain but allowed the researcher to gain a richer and more complete view of the subject matter.

Participants in this research study were purposely selected from a regional pool of potential participants drawn from organizations where the researcher has professional contacts. The potential participants were selected specifically because of their extensive experience in the field, which this author thought would provide a very high quality cross-section of responses. As a result, the pool of potential participants came from small to mid-sized communities in southwest Michigan, where the researcher could easily access them for the purpose of interviewing them face-to-face. Such a sampling method allowed the researcher to manage the data collection process much more efficiently yet limited the heterogeneity of the participants. For this study to offer a more comprehensive picture of the mental health community as a whole, it would have been necessary to broaden the scope of the research to both smaller and larger communities and to replicate the methods in other geographic locations.
Despite some limitations of this study, it was anticipated that the responses provided by the participants would offer some valuable insights that could be used by the wider community of mental health practitioners. By focusing on lived experiences, there were comments and themes that could be generalized to the practice of mental health clinicians.
CHAPTER IV

RESULTS

Overview of Chapter IV

This chapter begins by reviewing the purpose of the research. Next, it will discuss some background information about the participants as a group. Included in this discussion will be some extensive details about their credentials, therapeutic orientation, weekly caseload, and place of work. This will be followed by a description of the data analysis process within the context of the interview questions. This will be used as a means of immersing the reader in the data set. The description of the data will be followed by a discussion of the findings in detail. The chapter will conclude with a description of the findings and how they relate to the questions and purpose of this study.

The Purpose of the Research

The primary purpose of this research study was to explore the lived experiences of clinicians as they assess suicide risk in their clients utilizing the following research questions: (1) How do clinicians assess for suicide lethality? (2) What effect does suicide assessment have on clinicians’ therapeutic practice? (3) What impact does suicide assessment have on clinicians’ personal lives? and (4) How does the combination of changes brought about by the practice of suicide assessment impact the personal and professional worldview of clinicians after the suicide assessment reaches completion? These questions will be answered utilizing, first, a summary of individual interviews.
Using a phenomenological approach, this study asked clinicians who routinely assess suicide potential to describe their experiences with clients. In an in-person interview, participants were asked to describe how they consider suicide lethality potential. It was assumed that suicide assessment has an impact upon the professional practice and the life of clinicians outside of the context of therapy. The experience as a therapist living through a suicide assessment process and the impact that experience has on a therapist’s clinical practice and personal life outside the work context was explored in a series of face-to-face interviews.

**Summary and Description of Participants**

The sample consisted of a panel of psychologists and counselors who were purposely selected because of their expertise in the field of crisis intervention. Initially, there were 20 participants who were invited to participate. Of those 20 individuals, 3 were disqualified because they did not meet inclusion criteria. Two lacked enough years of experience as a master’s or above level crisis intervention worker to qualify. A third was disqualified because of a recent suicide on his/her caseload.

Of the 17 remaining individuals qualified to participate in this research, 9 were women and 8 were men. Their ages ranged from 32 to 72 years old with a mean age of 51. Although significant attempts were made to create a more ethnically diverse sample, all qualified 17 participants were of Caucasian background. All of the participants had at least one degree at the master’s level or higher. Three had PhDs, five had MSWs, and nine had MAs in counseling psychology. The participants’ experience as a psychotherapy and crisis intervention practitioner ranged from 3½ years to 33 years, with a mean of 16
years specifically conducting crisis and suicide assessments as a part of their practice.

Current licensure or practice credentials are described using Table 1. As can be seen in Table 1, some participants hold multiple degrees and credentials. Some of them listed all of their credentials and degrees on the demographic questionnaires, while some others listed only the highest degree attained.

Table 1

*Credentials of Each Participant*

<table>
<thead>
<tr>
<th>Credential</th>
<th>Participant 1</th>
<th>Participant 2</th>
<th>Participant 3</th>
<th>Participant 4</th>
<th>Participant 5</th>
<th>Participant 6</th>
<th>Participant 7</th>
<th>Participant 8</th>
<th>Participant 9</th>
<th>Participant 10</th>
<th>Participant 11</th>
<th>Participant 12</th>
<th>Participant 13</th>
<th>Participant 14</th>
<th>Participant 15</th>
<th>Participant 16</th>
<th>Participant 17</th>
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<tbody>
<tr>
<td>PhD, LP</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
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<td>MFT</td>
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<td>LPC</td>
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<td>X</td>
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</tbody>
</table>

There was considerable variation in theoretical orientation among the participants. As can be seen in Table 2, the most frequently occurring theoretical orientation that was identified by the participants was CBT (Cognitive Behavioral Therapy). Many of the participants endorsed multiple other theoretical orientations to augment their therapy.
practices. Several stated that they utilized a variety of approaches tailored to the presenting problems of their clients.

Table 2

*Therapeutic Orientation of Each Participant*

<table>
<thead>
<tr>
<th>Therapeutic Orientation</th>
<th>Participant 1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
<th>6</th>
<th>7</th>
<th>8</th>
<th>9</th>
<th>10</th>
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<th>12</th>
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<th>14</th>
<th>15</th>
<th>16</th>
<th>17</th>
</tr>
</thead>
<tbody>
<tr>
<td>CBT/Behavioral</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td>X</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
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<tr>
<td>Eclectic</td>
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<td></td>
<td>X</td>
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<tr>
<td>DBT</td>
<td></td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Experiential/Reality</td>
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<td></td>
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<td></td>
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<td></td>
<td></td>
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<td>X</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Motivational Interviewing</td>
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<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td></td>
</tr>
<tr>
<td>Other</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

This was a bifurcated sample with 9 participants employed in either a community mental health or hospital setting; the remaining 8 participants were employed in either a private or community based-outpatient treatment setting. Participants saw a wide-ranging number of clients each week, with one individual seeing as few as 5 or fewer clients every week, while others see more than 20. There were four participants who saw between 10–19 clients per week. The majority of participants (13) indicated that they saw 20 or more clients each week. These caseloads are illustrated in Table 3. All of the participants have assessed 3 or more clients for suicide risk in the past 5 years. There was
a wide variation in number of clients that have been assessed for suicide risk, ranging from 10 to more than 500. On the low end, participants were typically employed as private practice clinicians. Participants on the high end were typically employed full-time as crisis intervention specialists, who, for their full-time job, assess suicide as a primary function in their job. The worksite distribution by participant can be seen in Table 4. Most of the participants scored this part of the demographic survey using an estimated number only.

Table 3

*Weekly Client Caseload by Participant*

<table>
<thead>
<tr>
<th>Client Caseload</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>&lt; 5</td>
<td>X</td>
</tr>
<tr>
<td>10–19</td>
<td>X</td>
</tr>
<tr>
<td>20+</td>
<td>X</td>
</tr>
</tbody>
</table>

Table 4

*Worksite by Participant*

<table>
<thead>
<tr>
<th>Worksite</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Hospital/CMH</td>
<td>X</td>
</tr>
<tr>
<td>Outpatient Clinic</td>
<td>X</td>
</tr>
</tbody>
</table>
As reported on the demographic questionnaire, the participant’s brief description of their training in crisis intervention provided a wide variety of responses. These included training on the job, graduate coursework, seminars, workshops, self-study, personal investigation, self-instruction, training at a crisis intervention call center, graduate internships, critical incident and stress management trainings, conferences, journals, and state-sponsored training programs.

Participants indicated they currently assess clients’ suicide risk potential with frequency ranging less than 5 times per month to over 20. This number was an approximation based on the participant’s recollection. It represents the range of both high and low scores endorsed by participants. With regard to timeframe, the most recent suicide risk assessment ranged from earlier in the day of the interview to two years prior to my interview with them.

While 14 of the participants use some form of suicide risk assessment paradigm, 3 indicated they never do. The instruments include forms developed by their employer, the S.L.A.P. (Suicide Lethality Assessment Profile), Marsha Linehan’s *Reasons for Living Inventory*, and Johnson’s *Therapist Guide to Clinical Intervention* and *1-2-3’s of Treatment Planning*. Nine of the participants have had to involuntarily commit a client to an inpatient psychiatric treatment in the past 5 years, while the remaining eight have not. All but two have recommended voluntary hospitalization to a client in the past 5 years.

**Analysis of the Data**

Data for this research project took the form of lengthy written transcripts of face-to-face interviews conducted by researcher Macleod. Initially, the researcher anticipated
that a paid professional transcriptionist would be the best means of converting the data from a set of digitally recorded interviews into Microsoft Word documents. While immersed in listening to the recorded interviews, it became clear to the researcher that to best capture the nuances of the interviews, only the researcher himself could properly transcribe the data in a way that would capture the richness of the interviews as they took place. The transcription was accomplished by listening to the recordings multiple times, typically two to four times each, then transcribing the interviews into a Word document. Once these documents were transcribed, any data that were not related to the process of suicide assessment were placed into an additional category for additional analysis. The data were thus reduced to a form that could be easily downloaded into the MAX QDA data processing software. Based upon the results of the software, the data were broken into clusters that responded to each question as well as a subset that held data that fell outside the original set of questions. These clusters were analyzed on a variety of levels to determine the presence of salient points. The salient points were then extracted and recorded. In order to determine these salient points, the subsets were explored by participant, looking to see if there were commonalities that emerged as broad categories or as typical responses. Second, the subsets where explored within each of the interview questions as a means of exploring the range of responses within each question. For example, the response to the question “What is your approach to suicide assessment?” drew quite a wide range of responses, all clustered around an idea of trying to determine the potential risk of self-harm posed by an individual client.
As the findings are reported for each of the major research questions, the researcher will generally report more principal and widely occurring findings first under each category, with other less prevalent findings following in descending order. For the presentation of the findings, the researcher has categorized the numerical values of the number of participants responding into ranges utilizing descriptive words. The ranges chosen are in Table 5 below.

Table 5

*Response Frequency and Correlating Descriptive Words*

<table>
<thead>
<tr>
<th>Descriptive Word</th>
<th>Number of Participants Making the Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Most</td>
<td>14–17</td>
</tr>
<tr>
<td>Many</td>
<td>11–13</td>
</tr>
<tr>
<td>Several</td>
<td>8–10</td>
</tr>
<tr>
<td>Few</td>
<td>4–7</td>
</tr>
<tr>
<td>Some</td>
<td>1–3</td>
</tr>
</tbody>
</table>

Each interview question generated a group of responses that began to form clusters of related responses. It should be noted that participants did not always respond to the interview questions as the researcher anticipated. There were several instances where participants gave responses to interview questions that likely would seem more appropriate under another heading. In those cases, the researcher elected to leave participant responses grouped within the heading of the question where they provided their response instead of trying to move their response to a prompt that seemed more
appropriate. This approach seemed to be in better accord with qualitative traditions than making an attempt to better categorize recurring concepts and ideas (meaning units) within their responses. The clusters of meaning units within their responses were gradually distilled into the series of themes and subthemes for each research question that are presented as follows.

**Interview Question 1: What is your approach to suicide assessment?**

**Subquestion 1a: What is your conceptual framework when assessing client’s risk of committing suicide?**

Several broadly grouped responses emerged from an analysis of the question about the approach to framing suicide conceptually. The first of these groups of responses involved exploring the participant’s philosophical views of the act of suicide. Another common response came from several of the participants who felt it was important to ask very direct questions about their suicidal thinking. Conversely, others felt it was important to build a rapport first. Finally, many participants discussed the specific aspects of their suicide assessment with a focus on a set of risk factors that was remarkably consistent across the pool of participants. These risk factors tended to be variations of a theme that was repeated by the majority of the participants.

The philosophy of suicide included considering what suicide means to the client as well as what suicide means to the clinician conducting the assessment. Primary among the views of suicide from a philosophical perspective was an association of the act of suicide with depression as a disease process. Suicide is commonly viewed as an act of desperation or as an act of last resort. This was a common theme held by all of the
participants. This view led nearly all participants to explore the degree of depression and the ways of assessing this.

Depression was ascertained by considering the history of the depression illness. Many participants spent considerable time looking at depression as a disease and considering specific symptoms. Chief among these symptoms were consideration of recent losses, irreversible losses, feelings of agony, feelings of apathy, and the impression that the world would be better off if the individual were no longer here.

Specific methods of considering suicide emerged as a significant theme. Primary among these methods was the notion that exploration of suicide risk should be no secret to the individual being assessed. Most were emphatic that using language such as “Are you planning to kill yourself?” “Have you been considering suicide?” or “Are you planning to hurt yourself?” should be used specifically. While there was no consensus about the exact wording of this question, all participants felt it was imperative that ambiguity should not be part of this line of questioning.

Another area of agreement included getting a general sense of how sincere a client is when answering the clinician’s assessment questions. This included gathering a sense of the future orientation of the client, determining if there is a sense of hopelessness, and identifying the resources available to the client that might prevent suicide from taking place. Conversely, nearly every participant was interested in learning what plan had been created by the suicidal individual, the specificity of the plan, and the availability of the plan to the person in question. If there appeared to be a realistic,
specific, and doable plan to commit suicide in place, clinicians were unanimous in their concern for the safety of the client.

The client’s support system was another area of agreement. Many of the participants felt a client had a lower level of risk in situations where there was a strong support system available, while there was a higher level of risk in the cases where a client had lost or become estranged from people who would serve as supports for them. The identified risk was much higher when a suicidal individual had recently lost, or irreversibly lost, a loved one. Similarly, a client was considered a much greater risk for suicide completion if a loved one or close family member had committed suicide in the past. Of even greater risk was the situation when a client felt he or she was to blame for the suicide of a loved one.

**Subquestion 1b: How do you determine the seriousness of a client’s risk potential?**

Clinicians participating in this study identified a several factors that were considered by nearly every participant during the suicide risk assessment process. These risk factors were many and were broad-ranging. The most serious consideration noted by most participants was to assess if the individual had actually attempted suicide in the past and, if so, how serious that attempt had been. Looking at suicide attempts, all participants considered if the individual had a clear expectation that the suicide attempt would result in death. Another important factor was the means selected to end the life of the client. The more lethal the means, the more seriously was the suicide attempt taken. Using a means that was highly lethal, such as a firearm or jumping from a tall structure, raised concerns for the safety of the client. Highly significant among the considerations was the
notion that the client had a clear expectation of death and did not anticipate he or she would be rescued. An accidental rescue elevated concerns for the client’s safety.

Use of alcohol and drugs in the process of a suicide attempt was assessed by all participants but was not necessarily considered to be a factor that raised lethality risk from the viewpoint of every participant. In some cases, the presence of alcohol was seen as lowering inhibitions of the client, thus creating a more careless attitude that was not necessarily seen as contributing to suicidal ideation. Instead, it could be seen as reducing judgment to a level where the suicide attempt could have been inadvertent. Others saw the use of alcohol or drugs as a factor that raised the risk of a successful suicide attempt.

Age of a client considering suicide was seen by many participants as a significant factor. Some participants felt teenaged clients were particularly risky because of their high level of impulsivity, while others were more concerned with men in their early 20s who would have easy access to lethal means of self-harm. Nearly universal was the view that elderly men, particularly those living alone, represented a very significant risk, especially if they had recently suffered an irreversible loss or had a history of mental illness during their lifetime.

A seemingly rapidly improving client was considered to be a serious risk by many. These people were worrisome because of the possibility that their improved countenance was a result of relief that a decision had been made to end their life. This was noted by several participants.

Other serious considerations that were mentioned by multiple participants were symptoms indicative of the presence of clinical depression. These included evasiveness,
anhedonia, hopelessness, lack of future orientation, the presence of hallucinations, change of personality, decreased energy, fatigue, and lethargy.

One participant summarized how he conceptualized suicidal thinking in the following series of questions he could consider during a suicide assessment:

Is there hope in this person’s life? And is there something to live for? And of course other things such as the standard things like do they have a plan? Do they have the means? And what is the likelihood that it would be fatal? Or is this person simply crying for help?

Another person had this viewpoint on how to look at suicide attempts:

To what extent is this a real attempt to end one’s life or a ploy to get attention or a manipulation? Or I prefer to say, is this an operant behavior? Is this something that will produce a change in the environment, which of course it will.

**Negative Risk Factors**

Negative risk factors tend to lower the chances of a client successfully attempting suicide. Looking at the process of suicide assessment, many participants considered the process from another viewpoint. There were factors seen as decreasing a client’s risk of self-harm. Thus, these were referred to by several participants as negative risk factors.

High among the negative risk factors were people who had been repeatedly assessed for suicide assessments of attempts repeatedly deemed to be less than lethal. These attempts were labeled by participants as suicidal gestures. Gestures included harming oneself in front of someone else, calling for a rescue while in the process of taking an overdose, driving oneself to the emergency room, people who want to know the reaction from others to their suicide attempts, and people who attempt suicide with a clear expectation that someone will interrupt them in the process.
One participant summarized the mindset of suicide gesturers in the following way: “I want people to know I am suicidal. Why do I want them to know? I want them to do something to keep me from doing it.” Another participant said, “The very fact that the person is in my office and is talking to me about suicide means that they are ambivalent. I want to align myself on the side of that ambivalence.”

**Subquestion 1c: Do you use any suicide assessment protocols or standardized instruments and what are they?**

Not surprisingly, the use of standardized instruments drew a dichotomous set of responses with the participants falling into two distinct camps—those who see such tools as useful and those who do not. Of those who feel the use of instruments is beneficial to their practice, most often utilize a tool that has been developed by the organization where they work, most typically some version of the Suicide Lethality Assessment Profile (S.L.A.P.) or the Beck Depression Inventory.

The participants who use assessment tools tend to see them as guidelines that help them with the discussion about suicide assessment. Often the tool is not a form that is read in front of the client; rather, it is memorized and is woven into the assessment discussion. Thus, it helps the clinician feel a level of assurance that they have not missed asking any important questions in the process of a suicide assessment. Used in this manner, standardized assessment tools were seen as helpful to many of the participants early in their career. One participant said he uses a tool as a place to start. Another finds that reviewing a list helps remind him of the things that he wants to make sure not to overlook. He noted this was particularly true because sometimes the process of suicide
assessment can be stressful and anxiety-provoking, making it easy to overlook a critical piece of information such as a family history of suicides.

Conversely, there were many participants who saw little value in any sort of structured assessment, particularly those that have made some attempt at standardization. One participant was particularly adamant, stating,

There’s not a one of them that’s valid. Useless, unless of course you have nothing but Caucasian middle class middle age males. If that is all you see is Caucasian, middle class, middle age males, then these protocols like the Suicide Probability Scale, Becks Hopelessness Inventory are probably very helpful because that’s who they were tested on.

Another participant felt assessment instruments have little face validity. He particularly dislikes the variety that groups people’s risk only into “low, medium, and high” categories. Yet another noted that it is highly awkward in the midst of an assessment where suicide risk is suspected to interrupt and say, “Excuse me. I need to go down the hall and get a standardized assessment device. Would you take this?” He continued by stating it is very awkward for new clients if there is an open book on the desk. He sees more value in having the tool in his head. Table 6 compares responses of all participants within this group of questions.
Table 6

Summary of Each Participant’s Response to the Question “What Is Your Approach to Suicide Assessment?” and Associated Subquestions

<table>
<thead>
<tr>
<th>Approach</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17</td>
</tr>
<tr>
<td>Symptom determination</td>
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</tr>
<tr>
<td>Case conceptualization</td>
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</tr>
<tr>
<td>Direct approach</td>
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</tr>
<tr>
<td>Philosophical</td>
<td>X X X X X X X X X</td>
</tr>
<tr>
<td>Establish rapport</td>
<td>X X X X X X X X X</td>
</tr>
<tr>
<td>Peer group membership</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>Negative risk factors</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Experience of anxiety</td>
<td>X X X X X X X</td>
</tr>
<tr>
<td>Instrument is not helpful</td>
<td>X X X X X X X</td>
</tr>
</tbody>
</table>

Interview Question 2: How has your professional practice changed as a result of conducting suicide assessments?

Subquestion 2a: What changes in your therapeutic practice have you noticed in the wake of suicide assessments you have conducted?

Reflecting on their suicide intervention history, the participants were nearly unanimous that there had been some changes in their practice in the wake of the suicide assessments they had conducted. Those changes fell into several broad categories, including adopting a more pragmatic attitude toward their work, developing a sense of excitement regarding the course of events during a suicide assessment, finding increased confidence in their own skills as a clinician, sensing an increase in fear or anxiety specific
to the safety of the client, finding a need to more deeply explore the presenting symptoms during a suicide assessment, and they identified some specific changes in their assessment methodology. Only one participant indicated no change in practice in the wake of suicide assessments, though that was an individual who assesses suicide as a primary part of their clinical work.

Those who developed a more pragmatic attitude toward their work adopted this mindset in direct response to events during suicide assessments. One participant noted that there is always a point during the assessment process where the clinician has to be very decisive. As she put it, “The reality is in half an hour you are going to have to walk out of this door and we still need a plan.” Another person, when considering suicide risk potential, said he now considers suicide risk during every session. “You know, it is always a possibility in my mind now. When I first started practicing it wasn’t, but now it is. Essentially, every time I see a person that’s kind of at the back of my mind.”

Another pragmatic theme was a tendency for clinicians to emotionally distance themselves from their clients. One participant noted this is a means of self-preservation. These experiences were described as things that would “tear me up.” Now depersonalizing both the client and the issue is used by this participant to maintain a sense of healthy distance. Another participant attempts to head off personal entanglements by explaining his initial framework during the initial session. “I’ll tell them I am not an emergency room. I’m not available at 4:00 in the morning to talk you out of suicide. I give them options. If you want me as a therapist, yes, I would be happy to work with you, but these are the parameters I am working under.”
An unexpected finding during the interview process was the sense of excitement some of the participants indicated they felt through the course of conducting a suicide assessment. One participant indicated feeling a rush of adrenaline, while another said he enjoys the complexity of suicide assessment: “the more chaotic the better.” A heightened sense of alertness was a commonly reported feeling. Another participant succinctly explained her feelings:

Well, to be truthful, it’s one of the most exhilarating feelings I have ever felt. I am just thinking about the physical response. Your adrenaline kicks in so your pulse is going faster. You are breathing faster. It’s arousal. You’re alert.

Many participants noted an increased level of confidence in their own clinical skills as their experience has broadened. Several indicated a considerable decrease in their feelings of anxiety and fears of broaching the topic of suicide. One participant noted an increased level of comfort when interacting with the population who is most at risk of attempting suicide. Another person discussed feeling increasingly confident with the topic of suicide. Yet another said practicing asking difficult questions helped to hone her ability to ask questions in a way that elicited honest answers. “I think I have become more comfortable in just trying to be forthright so I can say, ‘hey, what’s going on?’”

In order to more deeply explore the symptoms that heighten suicide risk, several participants changed their methods of suicide assessment over time. Many indicate they are now better able to tailor their approach to the person being assessed. One participant felt that he was more thorough, now getting more detailed information about past attempts, precipitating events, and monitoring his own responses to the information. Mirroring that comment, another participant noted she is increasingly alert to the
possibility of suicidal thinking. This is stark a contrast from her previous practice of waiting for the client to bring up the topic by his or her own accord. This participant now keeps the thought in her mind, always aware of what the client could be thinking. A common theme was to focus very carefully on non-verbal cues that could indicate a more serious risk than the client acknowledges verbally. These include changes in the client’s body language, eye aversion, or an overall sense that the client is more guarded with the line of questions than he or she had been previously.

Some specific methodological changes were noted by some of the participants. A few of these were specific to the documentation they make that addresses liability issues. One participant always uses the statement, “This person does not appear likely to harm themselves or others at this time.” While he feels nobody anticipates a 100% correct prediction, there are numerous legal precedents indicating a need for a prediction to be made every time a client is seen. He wanted to be clear though; his statement is about behavior, not about thoughts. Another common change is an increased willingness to consult with a colleague or peer. Several participants noticed a reluctance to consult early in their career, at a time when they needed the assistance most. Several indicated this reluctance was a product of fear of appearing incompetent. This has evolved into a more collegial interaction as a means of getting as many perspectives on the problem as possible.

**Subquestion 2b: Are there any changes in your daily routine on the day of a suicide assessment?**

Those clinicians responding to the question “Has there been a change in your daily routine after completing a suicide assessment?” were a mix of denying the presence
of a change and those stating some specific changes in the course of their day. Those who noted changes indicated disruptions in their work flow, an increased attention to client needs, higher levels of energy, and feeling the need to consult with a peer. Finally, several indicated they felt an increased level of fearfulness and anxiety.

A heightened feeling of fearfulness and anxiety was by far the most common response to this question and is worthy of some further exploration. One of the biggest sources of anxiety was the disruption in the schedule and daily routine in the wake of a suicide assessment. Many respondents indicated they were constantly mindful of the balance they had to strike between a very seriously compromised individual who was with them and the potential to have another seriously compromised person in their lobby at the same time. One participant indicated a feeling of relief “if I find I don’t have to hospitalize them and they show up for partial the next day.” Another person said they feel better once they have done some follow-up the next day, adding, “You wonder why you are questioning yourself.” Only when unanswered questions are resolved can the person feel a sense of relief.

Those who had no changes in their day often were participants for whom suicide assessment is a routine part of their day. One noted suicide assessment is a daily and expected occurrence. Another indicated that the assessment process is an aspect of the day that is most enjoyable. Yet a third was more pragmatic, indicating “if they ask for an assessment they get an assessment.” Continuing, that individual explained his role as a crisis worker thusly: “I fully expect that, that (suicide assessment) is what I am going to
do. And so, it actually sometimes makes it more clear cut when I, when I know that it is what I am going to do.”

Subquestion 2c: Over time, have you had to make any systematic changes in your practice because of suicide assessments?

Subquestion 2d: Are there any systematic barriers that hinder your ability to adequately conduct a suicide assessment?

All of the participants were asked to identify if there are any systemic changes in their practice or any barriers that interfere with their ability to adequately conduct a suicide risk assessment. The question was asked in two parts, but almost all of the participants blended their responses, discussing both barriers and changes in their practice while answering. As a result, the responses in this section are reported together. Some participants identified problems with insufficient staffing, fearfulness and anxiety in the process of completing the assessment, isolation from family members because the real nature of their work, and difficulty finding backup for consultation needs.

By far, the most commonly identified systemic barrier is time. By the nature of the work, most people in the mental health field tend to pre-schedule their clients. The process of suicide assessment does not lend itself well to such a model and can greatly disrupt the course of a work day. This was a problem identified by 11 of the participants in one way or another.

Other systemic barriers ran deeper, often directly targeting a problem that has affected a participant or his or her ability to adequately assess a client. One participant identified his frustration with organizations he has worked for in the past.

You talk about agency things in different places that I have worked, if the clinician didn’t do the paperwork then they couldn’t schedule an appointment
with a client, but the client might be suicidal and it might be avoiding a hospitalization. And it’s, you know, really? Come on.

Another participant expressed his frustration when his organization is blamed for the behavior of a client. “It is easy for the community to blame [when a suicide happens]. ‘Why isn’t someone doing something?’ But who is the ultimate someone? That’s when they point to us.”

An even larger problem was identified by another participant. The comment pointed to a problem associated with the reluctance of a therapist to engage a client in a topic that could potentially create a need to immediately resolve a crisis situation.

The problem is my own not really wanting to know the answer. Um, I think that, certainly I always think that you know unconsciously I can portray that to someone and I have to be very diligent about how I am asking the question. And making sure my body language is not, you know, indicating to them that I really want you to say no even though you are suicidal.

This participant indicated she believes such interactions are much more common than any clinician wishes to admit, even to themselves. The changes discussed above are illustrated in Table 7.
Table 7

Summary Results of Responses to the Question “How Has Your Professional Practice Changed as a Result of Conducting Suicide Assessments?”

<table>
<thead>
<tr>
<th>Response</th>
<th>Participant</th>
</tr>
</thead>
<tbody>
<tr>
<td>Assess risk</td>
<td>X X X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Establish rapport</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Increased anxiety</td>
<td>X X X X X X X X X X</td>
</tr>
<tr>
<td>Consultation/Training</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Separation/Distance</td>
<td>X X X X X X X X X X</td>
</tr>
<tr>
<td>Adrenaline/Excitement</td>
<td>X X X X X X X X</td>
</tr>
<tr>
<td>Focus</td>
<td>X X X X X X X X X X X X</td>
</tr>
<tr>
<td>Scheduling/Reprioritizing</td>
<td>X X X X X X X X X X X</td>
</tr>
<tr>
<td>Insufficient staffing</td>
<td>X X X X</td>
</tr>
</tbody>
</table>

Interview Question 3: How are you personally impacted by the practice of suicide assessment?

Subquestion 3a: What happens to you emotionally during and after a suicide assessment?

This question elicited a broad range of responses. These responses were led by a mix of feelings of depression and sadness and by a sense of cynicism. Other participants
indicated they experienced a heightened sense of alertness, feelings of anger, guardedness, and some anxiety or fearfulness. This last response is noteworthy because during the course of my discussion with participants, it became a response that nearly every question extracted from at least one person, and often from several people.

The feeling of depression was common with some participants commenting about the level of energy required to get through the assessment process. “I think if you are not careful in this line of work,” one person said, “it can certainly bleed over into your personal family life.” Another mentioned that it is for this reason that she finds it very important to establish good boundaries and avoid emotional enmeshment. Continuing, she said, “I mean we see some nasty, naughty shit. And we still live.”

The risk of the work bleeding into one’s personal life was echoed by several participants. One cautioned that it is most dangerous when you are not attending to the risk carefully.

It sort of sneaks up on you in your personal life when you try to just pretend it doesn’t exist in your personal life. And when it does I think it’s even more hard than when you don’t do this all day. ’Cause it’s not supposed to happen in your personal life. You’re not supposed to have work related issues when you go home.

Another participant discussed the realization that the depression they witnessed professionally was impacting their mood. “It obviously has an emotional toll on me, but I mean, does that mean I don’t love my job? No. I love it but there’s obviously a price to pay for doing this kind of work.” The feeling of sadness for the lived experiences of clients was particularly poignant when one participant said, “I guess it was disturbing to
me that he would be that committed to this [suicide attempt] and nobody in his life ever thought to get him some help.”

The feeling of anger was experienced by several participants and it was clearly not a source of pride for them. “I realized if I had not debriefed when I went home, I was just pissed off.” Another mentioned that periodically the people get under their skin. This frustration was more noticeable when discussing the relative apathy family members can have for one another during times of desperation.

It’s hard when the parents don’t believe you when you talk about, “Gosh, your child came in today and we talked for an hour and a half and the things they are telling me is telling me you need to come to the school right now and drive them to the ER.” And even hearing all that, they [the parents] won’t come. Yeah, that’s hard.

Of all the responses to this question, it was most moving to hear one respondent discuss the feeling she had when entrusted with the responsibility to make an assessment that could have life and death consequences. She found herself humbled by the trust of her colleagues as well as the trust of the person she was assessing. The job of assessing client risk is work that she finds exciting and fulfilling, and it is something she sees as a very honorable profession.

**Subquestion 3b. Do you find yourself experiencing any change in mood during the assessment or at any time following the suicide assessment?**

This question was viewed by some participants as redundant, as they felt it mirrored the previous question. As a result, most of those responses fell into the categories similar to the previous section. Many participants reported feeling either depression or sadness in response to their assessment experiences, followed by a feeling of guardedness, cynicism, heightened sense of alertness, and feelings of anger. Once
again, many of the participants indicated a sense of anxiety or fearfulness in the process of assessing suicide risk.

Discussing depression and sadness, one participant responded in the following way:

I was interviewing a client at the hospital and she wrote a really in-depth suicide note. It was probably six pages long. Yeah. It...(long pause) the overwhelming feeling of sadness just reading it. It was pretty incredible.

Other participants reported feeling emotional, feeling sad for the client, and being horrified when hearing a child expressing suicidal ideation. Another participant was moved to tears when presented with a child who was suicidal. Yet another sometimes cries in the car on the way home.

Fear and anxiety are moods that have been noted many times throughout this process. It is clear that many of the participants, even though they are competent to complete suicide assessments, still have significant fear as a part of the process of assessing suicide. One participant summarized this feeling thusly:

I think there is a certain level of concern, which I suppose you could say is emotional. When your concern level goes up it is kind of a mixture of compassion and concern and worry, and I suppose anxiety could be in there to some degree.

Cynicism about the work was also common. Among the most prevalent feelings of cynicism tended to follow late night crisis interventions. This was particularly true when clients left the participant with an impression that they are more interested in getting attention or medication than suicide intervention. One participant was very disappointed in his own cynical feelings.

I get involved with these inappropriate conversations with my clients in an emergency room at 2:00 in the morning because I was pissed. And then I’m
driving home saying XXXX, jeeze. You’re supposed to be above this. And yeah, I used to do that stuff. 20 years ago, oh my God! 2:00 on a Sunday morning, 4 degrees outside, wind and snow blowing and here I am in an emergency room talking to you. I could be in bed or I could be at my child’s baseball game right now. And then on my way home thinking to myself, I did absolutely nothing to help that client. Absolutely nothing. Instead what I could have said is “you’re having a tough time right now. I know the hospital provides you with a sense of security and a sense of relief. We need to talk about other ways that you can do that other than going into XXXX hospital every other week.” But not 20-25 years ago, and I felt like crap after words. Sheeze, I’m supposed to be helping these folks. Not get involved in the battles.

When exploring this kind of a reaction, it became clear that much of the cynicism appears to be a product of frustration with the inability to help the client before their situation reached the point of becoming a crisis.

Compassion was another commonly expressed feeling. One participant reported feelings of care and trying to be present as the most important emotional reaction to a suicidal client. Conversely, several participants experienced feeling a degree of guardedness in response to suicidal thinking. One reported feeling it was important to stay calm as they were likely the only person in the room who could do so. Another indicated feelings of emotional detachment, while yet another indicated a knowledge that while emotional attachment is supposed to be excluded from the assessment process, it is very difficult to achieve.

Heightened alertness was an interesting and, to some participants, surprising finding. One mentioned the feeling of exhilaration while assessing suicidal ideation. Another mentioned a feeling of adrenaline.

I realize I’ve got somebody’s life in my hand. And if my adrenaline is flowing, I might not be thinking as logically as I might otherwise because I am sensing some urgency or some panic or some anxiety myself, which can cloud my vision.
This feeling is very satisfying for some participants. One described the excitement in the following manner:

I love what I do. I couldn’t imagine you know, I have worked in private practice, I’ve done other things and you know. This it more my speed and more what I like to do, but um, I think the more busier I am, the more assessments I do, the more uh, energetic, awake if you will, I feel.

Helping others through moments of crisis can be of some benefit emotionally to some of the participants. One said, “Sad as it might sound, it kind of puts me in a little bit better mood because I’m doing what I love to do.”

**Subquestion 3c: If your mood is changed because of suicide assessment what, if anything, do you do with those feelings?**

While there was a wide variety of answers, the most common response to this question was either to distance oneself from the events that transpired or to compartmentalize oneself as a means of keeping work events at work and home events very separated. Other common responses included utilizing family and friends as a personal support system. Others consulted with coworkers as a means of coping with internal feelings. Several participants identified a recreational outlet to cope with stress. A final common response was in a category of increasing self-awareness by using mindfulness, prayer, or other meditative activities.

Several participants identified a need to establish a separation from work. The term *compartmentalization* was used by many of the participants. They made it clear that without the ability to keep some distance from their work, they could not continue with suicide intervention. Pragmatically, several individuals said they realized that establishing distance from their work cannot occur immediately, particularly when
another client awaits attention. These participants indicate they do some things purposely to keep from dwelling on the events at work. This distance has taken the form of taking breaks, walking away from the environment, and mentally “switching gears” between clients. One person indicated she has to “keep herself from the emotions witnessed” by reminding herself that the client’s emotions need not be her own. Another indicated he “does not do psych things all the time.” This allows him to focus on other aspects of his life when he has time off work. Perhaps the healthiest response came from a member of a daytime crisis response team. This participant indicated that members of their team “probably laugh more than anyone else in the organization.” Contrasting with this, another member of a similar team indicated a need to “tuck emotions away,” because the experience of those emotions can interfere with their ability to do their job.

Family and friends play an important role in coping with the events in the wake of suicide assessment. One participant responded with the following: “My husband and I will do things together and I call it parallel play ’cause we’re not talking but we are in the same vicinity and that feels very comforting. But I am able to just have my thoughts.” Another described a problem she has had explaining the stress at work without getting into the specifics that could compromise client confidentiality: “We just have this code word that something bad happened at work.” Another participant described the efforts she makes to distance herself from people who can negatively influence her mood. “I tend to not surround myself with people who have a lot of their own drama going on. My friends are very stable and very down to earth. Um, that’s a welcome relief after a long day at work.”
Consultation with coworkers provides many participants with immediate relief from the stress of suicide assessments. Several participants noted they appreciate the ability to immediately debrief with someone who knows from experience what is stressful about the process of suicide assessment. Identifying a need for self-care, one participant noted that coworkers can often be the best people to provide it.

We have to be aware of self-care because of the fact that’s all we do is deal with homicidal and suicidal and psychotic folks every day all day long. We’ve got to make sure we take care of ourselves. Um, and one of the things that is helpful is not only having a competent and capable team that you work with but being able to vent and laugh, is probably the most important thing that [we] probably have.

The role of supervision was noted by several participants. Both a direct supervisor and peer support were identified by participants as sources of stress reduction. Times of consultation varied. Some participants indicated the ability to look for any open door, while others indicated some lunchroom discussion about stressors. Describing a typical post-intervention conversation, one participant shared the following:

We vent. We, we, uh, process what just happened in the session. You know, hey, can you believe this just happened, or, let’s listen to this. We have our own team meeting or peer review and we talk about cases and stuff like that, that are difficult. But we generally lean on each other for support when we need to.

Several participants identified some very healthy recreational outlets used to diffuse stress at the end of the day. Music, breathing techniques, yoga, prayer, and exercise were all identified as offering some use when trying to cope. One participant noted that while her coping mechanisms may seem conventional, they are effective for her.

Once I was being interviewed by a student who said, “Well, what do you do to take care of yourself?” I said, “exercise, appropriate diet, books, movies, music,
duh, duh, duh …” and she looked at me and said “is that all?” And I was like, what else is there? *(laughs)*

Many of the participants mentioned the role self-awareness has played in their ability to cope with the stressors involved in suicide assessment. These included an awareness of the potential for burnout, an awareness of internal feelings and self-talk, re-evaluation of thoughts, and an ability to both recognize and identify personal limitations.

Not all of the coping mechanisms indicated were healthy. Several participants indicated either they, or clinicians known to them, turn to substance abuse as a means of coping with the stressors. Others noted episodes of highly destructive self-talk. These include considering oneself as rather cavalier when assessing a suicidal client, seeing themselves as powerless, and becoming angry with the client.

**Subquestion 3d: How is the rest of your day and time out of the office affected immediately following the process of conducting suicide risk assessments?**

The impact of a suicide assessment on the rest of a work day can be tremendous. Participants reported a variety of direct results from the process of suicide assessment. These have included a change in mood and changes in coworker interactions. Most commonly, problems with the flow of their workload for the rest of the day were reported by many of the participants.

Discussing the effect a suicide assessment can have on his day, one participant reported, “It can be awful.” Elaborating, he reported he is not nice to his family and the problem is compounded by his inability to tell them exactly what is wrong because of confidentiality concerns. Another participant reported that frustration can be discussed
with family members, though there is always a concern because of the inability to be fully present for family members due feeling preoccupied by the suicide assessment.

While one participant reported feeling that he or she could cope fairly well after suicide assessments.

I think I found some personal peace and, um, I don’t know if tranquility is the right word but peace is a good word. In doing what I need to do. I need to come to that point before I can move on to anything else. The job is not really over until I get to that point.

Another participant felt quite the opposite.

It, it [a suicide assessment] will sometimes ruin your day and you go home wondering and worrying and anxious about it. You feel like you have done everything but what if? The what if comes up. It gets into fear of the person dying, fearing of losing your license, fear of a lawsuit, fear of losing everything. You can go into a pit real fast.

These disparities were reconciled to some degree by another participant who discussed the importance of getting to a place of personal closure with an intervention.

Closure is huge. But there are also times when you go, you know what? I worry about this person at a lot of levels but they are not meeting the criteria for hospitalization. That’s when I feel a little more like I hope I am making the right call. Those are exhausting.

While a few participants mentioned talking with coworkers later in the day, the most common response when reflecting on how the day is impacted was in the area of work flow. Nearly every one of the participants mentioned that suicide interventions create a time management problem of some sort. These took the form of time spent on paperwork, having to make extra telephone calls, or canceling clients to accommodate the required workload associated with suicide assessment and intervention. The workload appeared to be impacted even more heavily when facing a client who is not cooperative
with the recommended forms of treatment. “It is very labor intensive when you have a highly lethal suicidal client who is not under any circumstances willing to engage in a protective setting.” Another mentioned how it impacts the rest of his caseload: “I’ve had situations where I would spend an entire day having to cancel clients and work on hospitalizing this person.” Sheepishly, one participant had the following to offer when reflecting on losing a day of work because of a suicide assessment: “If you are a private practitioner you are, excuse this, if you are a private practitioner you are losing money.”

**Subquestion 3e: Does anything “spill over” into interactions with other clients?**

Several of the participants were rather sheepish when responding to this question. A significant reason for this was a common occurrence of confusing clients when there were several similar cases in a row. Other participants mentioned dealing with an increased workload, problems with time constraints, and the opportunity to learn from the clients.

Far more commonly mentioned was an intentional separation between the completed suicide assessments and presenting problems of the current client. One participant mentioned, “I really have to be mindful of not allowing that tension to bleed into their session.” Another was concerned that it was difficult to fully attend to the client immediately following a suicide assessment. This was echoed by an admonishment to remember to keep every client separate.

By far, the most common response to this query was a concern with feeling preoccupied following a suicide assessment, thus affecting the ability to fully attend to
subsequent client needs. A participant indicated that the words of one client can cause the
“light bulb to go off,” thus returning the therapist to thoughts of the suicidal individual.
Another participant, with remarkable candor, mentioned the problem of treating a client
who bores them. “Sometimes I drift off and think of another client.” Difficult sessions
can create situations where inattentiveness occurs. “After a really rough session where
there has been a suicide discussion, the next time I don’t give the client my full
attention.” The lack of attentiveness is of great concern to one participant. “My mind is
jumping back and forth between who I am seeing now and the situation. So it definitely
affects my concentration.” To combat that, another respondent views the ability to remain
focused in the following way: “I have to challenge myself to stay focused and not let my
mind drift back to that other client.”

Other participants expressed their concern about the clients being aware of their
preoccupation. “Even though I try not to, other clients are not going to get as much of my
attention. They are not. I really don’t think they know. They will not get that focus.”
Another suggests clients are aware of his preoccupation. “It can be interfering. When you
are not totally with a client, the clients know that.” Yet another discussed his concern this
way: “Part of you is there, but part of you is still with that person from 9:00 in the
morning who you have walked out to their car and you don’t know …boy oh boy. Yeah.”

While none of the participants consider their own preoccupation with a completed
suicide assessment as a positive, viewing the process pragmatically seemed to be helpful
to some of them.

I think there have certainly been times where I have maybe continued processing
what happened with a previous client and sometimes we can be dealing with more
than one client at one time, so you know, yeah, it’s kind of hard for it not to. Especially with some of the chaotic stuff that we deal with. It’s going to lead into the next person.

As stated earlier, there is clearly a personal impact associated with conducting suicide assessments. The impact is largely felt emotionally, though part of the impact necessitates consulting with another professional to reach a feeling of resolution. Clearly, as Table 8 demonstrates, adrenaline and excitement, as well as anxiety, are emotional responses experienced by every participant in this research.

Table 8

*How Are You Personally Impacted by the Practice of Suicide Assessment?*

<table>
<thead>
<tr>
<th>Response</th>
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<tr>
<td>Anxiety/Rumination</td>
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<td>Consultation</td>
<td>X X X X X X X X X X X X X X X</td>
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<td>Distance self/Detachment</td>
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<td>Anger/Frustration</td>
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<td>Humbled</td>
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<td>Depression/Sadness</td>
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<td>Relief</td>
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</tr>
<tr>
<td>Compassion</td>
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<tr>
<td>Mindfulness/Relaxation/Prayer</td>
<td>X X X X X X X X X X X X X X X X</td>
</tr>
</tbody>
</table>
Interview Question 4: How has the practice of suicide assessment changed your worldview as a person both professionally and personally?

Subquestion 4a: How has your personal worldview been changed by your practice of suicide assessment?

By a wide margin, this question evoked the largest number of responses, with the highest number of them, not surprisingly, being of an introspective nature. There were also a significant number of responses that reflected a change in how the participants viewed the act of suicide. Many participants commented that there are factors that trigger suicidal thinking that are beyond the control and influence of the clinician conducting the suicide assessment or were simply realities in the life of the client that were of significant influence. Several clinicians reported feeling that the process of suicide assessment improved their clinical skills. Several discussed the way their interactions with family members had changed. Finally, there were a few clinicians who commented on the change in their mood and disposition in the wake of suicide assessment.

Comments of an introspective nature were of a wide range. Some were reflective of the job done as a crisis intervention worker, while others included the limitations of that job. Others considered the significance of the role of crisis intervention worker, or, in some cases, the relative insignificance. One participant reflecting on the ability to foresee suicide risk in clients said, “There is no crystal ball; we cannot prevent everything.” Another felt it was important to consider the job and the limitations associated with the job: “You can only do so much.” Considering the work as a part of one’s identity was the following:

They bring out a level of for me heightened level of sensitivity and compassion. Um, I think it is a lot of responsibility to be put in a situation where someone
shares that kind of information. So do I feel changed by that? Maybe I feel you
know, Eric, maybe the word is I feel a certain level of what’s the word? It’s not
honor, but it’s like that. You know that someone would trust you with the
responsibility to tell you that they don’t want to live any more.

Another participant described the work as a “spiritual calling.” Mirroring that was a
participant who feels the work as a counselor gives real purpose to their life. Another
offered the following: “It [suicide assessment] makes me see the value of life. Uh, how
we all live in glass houses. ’Cause that person wasn’t always that way but they are now.
So it gives you that sense of your own vulnerability.”

The act of suicide was viewed in very different ways by many of the participants.
Pragmatically, one took the view “it’s okay if you feel that way.” Another said they could
understand why people would want to kill themselves and could understand why people
would follow through and do it. Adding to that viewpoint, one participant offered this:

I think I can wrap my head around it a little bit better in the sense that it is not just
someone being selfish. Although that is part of it but someone is suffering that
they are in so much pain that the only thing they can do or the only reasonable
solution they feel they have is to kill themselves. Thinking about it that way
allows me to empathize more with the pain that they are going through versus the
actions that they want to take.

An opposing view was suggested as well. “You know, talking about suicide
lightly or casually, like it’s an okay thing to do, it cancels out your problems, to me is the
wrong message.” Another, while seeing suicide as a choice, believes it the job of the
clinician to convince the client not to make that choice, though he sees the job of
preventing suicide as being the job of the police. One participant sees part of the problem
with the acceptability of suicide as a common behavior lying with society’s
desensitization to the behavior.
In the middle were many participants who recognize the choice of suicide and the legitimacy of that choice, while seeing their role as offering the clients an alternate choice to committing suicide.

My view is not totally culturally acceptable. I mean it’s perfectly rational, can be, that suicide is an option. It’s, from what I have learned about ancient Greece it was culturally acceptable. It was like this is one of the options that a person always has. That doesn’t fit in our culture and I certainly don’t live or practice that, but yes, I do think it and consider it and I can see the reasonableness of that. So it’s in that aspect that suicide and the thought of suicide doesn’t shock me.

**Subquestion 4b: Have there been any changes in your practice if your worldview has changed?**

Many of the participants identified factors leading to suicidal behaviors that are outside the control of the clinician. These included clients who have made a decision to end their life but have also decided not to tell anyone about it. They have also identified people who seem bright and intelligent, yet have decided life is not worth living. One participant opined that if a client truly wants to die, there is very little that can be done to stop him or her. Expanding on this theme was the following:

I recognize the fragility of, of what we all take for granted. Life is going to go on this way so I recognize that, that’s not true. Just like that *(snaps her fingers)* be it suicide or be it an accident … anything. A person’s whole world changes just when they are not planning on it.

Another noted that part of doing the work with the mental health population implies that one must accept that people who are at risk of committing suicide is “part and parcel with the job.”

A significant theme involved the recognition that suicide has become part of the reality in some communities. One found herself frightened by the frequency of suicidal
thoughts among the youth of the population. Another pondered, “What has gone wrong in society?” Considering the ebbs and flows of societal opinion of suicide, the following was suggested:

In the sense that I think years ago the pendulum would have been over here where with suicide you were thought of as kind of an outcast. At least for, only those on the very periphery of mental health stability would ever go there.

In retrospect, one participant summarized his career in the following manner:

I have gotten a little more realistic as far as realizing I’m not going to be able to change an entire system. I’m not going to change an entire culture. But I can help one person or one family at a time to get them in a more stable situation mentally and emotionally.

Another offered this compassionate view of the act of suicide.

As a therapist who works primarily with this population, [the work] is wonderful, just wonderful. What that has done for me is it has really enhanced for me the absolute essentialness of hope, resiliency and friends. Hope, resiliency and friends. Hope for a better future. Resiliency, the ability to keep trying, keep trying, keep trying. And friends sharing what’s going on. Avoiding any sense of isolation. Friends are the most important thing you could ever have. Never ever keeping stuff to yourself.

Looking at the mental health system as a part of the larger society, one participant summarized their education and experiences in the following:

If you go through a physician they’ll give you a prescription or a treatment and they’ll say this has so much efficacy to help and I think what’s changed for me is the realization that you can do the best job possible but the efficacy of what you do always has some limitations. And we have to acknowledge that. That’s what it’s done for me. As long as I’ve done everything that I think I should do then if it occurs then I’m okay.

Subquestion 4c: Have you noticed any changes in your personal life after conducting a suicide assessment?

Changes that participants identified primarily centered on the overlap between their social life and their professional life. The overlap that was identified was a difficulty
turning off the “radar,” as one participant put it. Many of the participants indicated they
looked at every social interaction from a therapist’s perspective. This included some
isolative behaviors at social gatherings, with a preference to be more observant rather than
interactive. One participant noted that the typical banter at social gatherings lacks both
the intimacy and excitement of a crisis assessment. Another person noted feeling little
need to connect to people outside work.

Other participants noted the changes in their mood that has occurred over time.
One found many reasons to be thankful for the quality of their life and their relationships,
while another found himself saddened by how tragic some of his clients’ lives have
become. Another mentioned his awareness of the futility of the world for some people
and the apparent difficulty they have to endure. For at least one participant, this
profoundly affects her mood. “I’m really drained. I don’t have the patience I would
normally have just from being, you know, kind of emotionally exhausted, you know?
You know I can be quicker to get upset or little things bother me more.” Looking at these
results, it seems clear that many of the participants carry a great burden, both during their
work day, and after their work day has concluded.

Subquestion 4d: Can you describe the changes you have experienced in the
weeks and months that you attribute to your experience conducting suicide
assessments?

Participants were asked if they had any reflections on the practice of suicide
assessment as they have gained experience over time. Responses were fairly evenly split
between taking a pragmatic view of suicide assessment, feeling greater confidence in the
practice of suicide assessment and an increased level of empathy for the clients who were
experiencing suicidal behaviors. There were two participants who reported experiencing some feelings of self-doubt. One asked if she made the right decision noting her belief that likely everybody asks that. Another added there is no way to see inside the head of the client. Two other participants commented on the emotional reaction they have to the practice of suicide assessment.

The pragmatic view offered by participants included the realistic possibility of losing a client in the course of a professional career. Many of the participants described this as an occupational hazard. One suggested that it is unrealistic to believe that all suicides can be prevented, though he feels a reduction in the rate of occurrence is more realistic. Another wondered how she could accept the loss of a client.

How would I deal with that as a professional? 'Cause if you do this job long enough that’s going to happen. That’s just the reality of it. Doing you know, over 200 or however many assessments in the last three years, if, if, if, I keep at that pace I’m going to miss something or I’m going to meet someone [who will complete suicide].

An increase in the ability to adequately assess suicide risk potential was identified as often as pragmatism. One participant noted that mistakes have been made over time but they have learned from them, and this has been encouraging. Another found that the practice of suicide assessment is no longer the intimidating process it once was, while another mentioned a reduction in his level of anxiety. Having someone with suicidal thinking was a source of embarrassment for one participant. In the past she would hesitate to discuss this with a supervisor. This has changed over time so that now few reservations are experienced.
Many of the participants noted an increased level of empathy for the plight of their clients as well as their colleagues. One finds they are now more human in their work. Another had empathy for the colleague who lost a client to suicide. “I have tremendous respect for them.” A judgmental aspect of the assessment process was identified and has subsequently been changed by one participant:

What has changed is the judgmental aspects of it. I think when you first come into it you don’t get a grasp of how severely people are grappling with pain. And you kind of say buck up, it’s not an emotion. It’s also brings to light that your own limitations about what a person is doing. If a person wants to do it they’re going to do it despite what you do. So you have to pull some externals in. So some of what it says in the literature becomes more real.

This was echoed by another who evoked the memory of Freud in the following:

The Menninger idea that suicide is I want to kill, I want to be killed and the narcissistic idea that one can determine one’s own destiny. They said Freud’s suicide was about that. He wanted to control. He had mouth cancer. But there’s also a lot of rage directed toward yourself. You want to kill yourself but it should be externalized somewhere. And the rigidity and dissociative aspects are very interesting.

Another discussed the idea of suicide as a choice in response to this question. “I think of suicide as a choice. So we as therapists need to respect it as a choice, in that sense it is an operant, an operant behavior. It’s a way to end the pain when there is no other way out.”

Because it is a choice, a participant mentioned the importance of respecting the client’s ability to make the choice. “We can’t prevent them [from committing suicide] but we can convince them.”

Clinicians reporting changes to their worldview was universal in this research. As Table 9 shows, there was a wide range of changes reported. These ranged from pragmatism, to taking suicides personally.
Table 9

*Have You Noticed Any Changes in Your Worldview in the Weeks and Months Following a Suicide Assessment?*

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**Additional Comments**

At the end of the structured interview, participants were asked if there were any comments they wanted to add or if there was anything that surprised them because it was not asked. By the end of the third interview, it was clear that there should have been two questions that were not part of the original set of questions. From that point, those
questions were asked of all of the other participants. Those two questions were, “Over the course of your career, have you lost a client to suicide?” and “Reflecting on your training in your academic program, how well has it prepared you for suicide assessment?” The results of these two questions follow.

**Losing a Client to Suicide**

It became clear that the original question on the background questionnaire did not sufficiently assess how participants had been affected by the loss of a client to suicide. Several of them mentioned, “While you asked if I have lost a client over the past two years, you never asked if I have ever lost a client to suicide through the course of my career.” Several participants had lost a client, though those losses had occurred outside the timeframe that would have rendered them ineligible for participation in this research.

Responses included both acceptance of the client’s choice to end his or her own life, and self-blame on the part of the participant for that choice being made. Other responses, predictably, included a feeling of depression or sadness on the part of the participant, noted by several individuals. Others experienced a feeling of empathy, while one felt some anger and yet another found himself distancing himself from the emotions.

Among those who were able to accept the loss of their client, one mentioned a feeling that everything that could have been done for the client had been done. Another felt the client had a right to withhold the information, though it made it difficult for her to be treated. One participant noted that, for some people, suicide is their “way out of living hell.” Another framed the experience this way:
The whole death thing. Mental health is about relationships with the living. And as I said, sometimes those relationships have gone on for years, professional relationships. And then a person successfully takes their life. That’s had a big impact. Just the reality of that.

Other participants had a tendency to blame themselves for the loss of their clients.

One did not lose the client but came alarmingly close to doing so.

This [nearly losing someone to suicide] was a big wake up call for me. After having been in the field for so long you begin to take your skills for granted. And it, maybe not be as careful. And it made me realize to be very, very careful with what I say to people and how I handle that.

Another felt considerable self-doubt when considering the assessment process and the ultimate outcome. “There is still some question about how that all worked out but you know I felt like I wish … you always have the what if’s.”

One participant acknowledged a feeling of anger toward the client, even though he does not feel good about it:

I have lost 4 clients to suicide. Um, one, was a guy I saw for an evaluation and he scammed me through the whole thing. And uh, his suicidal death, I was brought into litigation but it was thrown out of court for insufficient evidence, but two of them really … they were two young men who took their lives while they were clients of mine in my private practice. Uh, good god. I went to their funerals. One of the men had two young kids. And while I was in touch with this level of pain, when I saw his kids at the funeral and I’ll never forget what those little kids who could not have been 8-9-10 years old, how could you do that? How could you do that to those kids? I’m sorry but there is no level of pain that justifies this. And I began to develop a perspective of those folks who die, by suicide and leave behind horrific griever, it’s pretty narcissistic.

Finally, another individual found herself taking a pragmatic approach of distancing herself from the suicidal individual. “This is not about me. This is about people and their choices.” Despite this, many of the people were adamant; the choice to commit suicide is a choice to be avoided if at all possible.
Academic Training

Many of the participants made comments about their own academic training, specifically commenting about how well prepared they felt to conduct suicide assessments upon graduation. The results were not good. Almost of the comments reflected a feeling that training for suicide assessment at the graduate level was inadequate.

Several participants indicated that one must be prepared to accept the reality that some of the people who are your clients will die by their own hand. Another noted the isolation she feels when she is alone in a room with a suicidal client. “I used to think all us therapists were a united front against the dark forces of mental illness. Not really. It is really me against it every session.”

Considering the incidence of suicidal thinking in the mental health population, the following commentary was offered as a reflection upon academic training. “It’s absurd. The most common dilemma we face! XXXX University has a program in addiction disorders; a specialty program in addiction disorders, but nothing in suicide.” Continuing, he said, “There are no formal courses, protocols, course curriculum in suicidology in any major graduate program for social work or psychology.” Another noted his concern that more compassion for the dilemma faced by the client is not taught at the graduate level. “That’s what I hate about suicide. A lot of blame.” Finally, one person offered the sage advice they wish had been offered in their coursework: “Find something you like about everyone you see.” Concern about the future of the field this was mentioned: “It is ironic,
tragically ironic, that one of the more profound dilemmas, human dilemmas that a professional is going to face in their career they are going to learn about on the fly.”

**Exploration of Themes and Subthemes Across the Research**

**Approach to Suicide Assessment**

The most frequently stated theme by participants when considering their approach to assessing suicide was identification of current symptomology experienced by clients. Most of the participants identified a set of symptoms that were reflected in the research also. Primary among the symptoms identified by both participants and within the literature was the presence of depression, and a clear plan to end one’s life.

The presence of this combination emerged as a subtheme. For many participants, the combination of depression and a plan to commit suicide influences all their decisions that follow. In essence, all of the participants were interested in determining exactly what the client has been experiencing symptomatically that would leave them thinking that continuing their life was no longer a good option for them.

A secondary theme that emerged was a need to develop a conceptualization of the case presented. This was identified as a way to understand contextually what the client was experiencing in such a way that the thinking process behind the suicidal ideation or suicide attempt could be understood. Participants stated it was very important to try to gain a full understanding of the person, viewing their role as gaining an understanding of the person’s thinking in a broader context than just a set of symptoms.
As a subtheme, many of the participants identified using a very direct approach to their line of questioning. Using words like *suicide, death,* and *killing yourself* were considered important to many of the participants who felt crisis situations were not the time for ambiguous language. Several mentioned the importance of asking questions about suicide using simple and clear statements.

When determining the risk factors for committing suicide, participants explored symptoms and then considered a specific set of specific risk factors. A theme developed of considering if the client was a member of any group that would be at higher risk of committing suicide. These groups included teenagers, elderly single men, and people who had been diagnosed with borderline personality disorder, schizophrenia, or severe depression. When clients were seen as being part of very high risk groups, participants found themselves experiencing a higher degree of anxiety.

While many of the participants found standardized instruments and other measures useful as guides to lead the conversation about suicide risk assessment, the overwhelming majority of participants appeared to see their use as being very limited. A subtheme emerged which was a dismissal of the value of any standardized risk assessment by the more senior participants in this study. As a group, the more experienced participants viewed any standardized scale with skepticism and, in some cases, outright disdain. Interestingly, the more years of experience assessing suicide risk that was endorsed by a participant, the lower his or her reliance on a standardized instrument and the lower his or her anxiety with the suicide risk assessment process. This was true even for those who had lost a client to suicide.
Professional Practice Changes

As participants gained experience, they found their risk assessment skills had improved and had become better able to ascertain the risk of committing suicide among their clients. Several of the participants said they had become increasingly cautious as they gained experience in the field and they had become more focused on symptomology. A frequently cited method of assessing suicide risk involved establishing rapport first before attempting to explore the more complicated questions of suicidal ideation and desire to die. Several participants mentioned the importance of establishing a sense of trust and relationship with their client so they could share painful experiences more completely and honestly.

Time constraints emerged as a subtheme across many of the interviews. Participants struggled with having insufficient time to properly care for their clients and attend to their needs, particularly when they were faced with other clients waiting for pre-scheduled appointments, the pressures of paperwork or, in some cases, the possibility of losing money because of cancelled appointments. A larger concern was a fear that they were preoccupied by client’s suicidal ideation and could not properly attend to additional clients. While many participants discussed, with no small measure of pride, their ability to compartmentalize clients, it became clear that the sense of anxiety when thinking about a potentially suicidal client was very pervasive.

The interplay between time and anxiety emerged as a subtheme that continued over the course of almost every interview. While it is true that participants reported less anxiety when they had greater experience in the field, the tension between adequate
attention to a client’s suicidal behaviors and the responsibilities of the remainder of their practice created high levels of anxiety for many. Constant balancing and refocusing led several participants to believe they were doing nothing adequately with attendant worry about the safety of some of their clients. Rumination and preoccupation later in the day was the result.

While there were changes in the way suicide was assessed and an emerging feeling of anxiety, what was significant when considering this question was the lack of specific changes in practice as a result of suicide assessments being conducted. While there were reports of schedule changes, reprioritization, and inherent paperwork, none of the participants reported doing anything differently on a day-to-day basis. This lack of change in practice may indicate many things, including a need for routine or consistency in the course of a day, or perhaps that suicide assessment really does not change things so significantly that it necessitates change in the work of a clinician.

**Personal Impact**

As had been true in earlier aspects of the research, anxiety was endorsed as a response to nearly every question about the personal impact of suicide assessment. This was least surprising when considering this in the context of how people feel about interacting with a client who is considering ending his or her life. Anxiety appears to be a significant feeling until the crisis was resolved in a way that assures the safety of the client.

Many of the participants mentioned using detachment as a means of isolating themselves from the client’s emotions, often mentioning that it was a means of self-
preservation. Some of the participants said they could not keep doing the work unless they added some professional distance between their own feelings and the events taking place around them. Without the establishment of some significant distance emotionally, some participants said they would feel similar levels of depression in the wake of suicide assessments.

Despite establishing professional detachment from the events, the most frequently endorsed feeling in relation to suicide assessment was depression and sadness. Some of the participants reported being moved to tears either during or immediately after conducting a suicide risk assessment. Despite the frequent emergence of depression and sadness as a theme, none of the participants noted that the symptoms had become so uncomfortable that they could no longer do the work. Instead, several felt the most sadness because there was not more they could do to be of help to their clients.

While many participants endorsed the use of consultation with a friend, co-worker, or supervisor when faced with especially difficult client situations, it is noteworthy that it did not emerge as a major theme of this research. Intrinsically, one would think consultation would be a significant means of addressing the feelings of anxiety and depression that many report are associated with suicide assessment. While there were many coping strategies that did emerge, consultation was no stronger of a theme than any of the others, only being noted by the participants as a result of one question. While it is outside the scope of this research project, the relationship with one’s supervisor has been a topic of a large body of research and may be worth exploring for insight into this finding.
Change in Worldview

A pervasive worldview, which almost every participant recognized, even if they did not agree with it, is that suicide is an individual decision that is an option available to everyone. It is viewed as an individual choice that often is outside the influence of others. This may go a long way toward explaining why the process is anxiety-provoking. With research pointing to a very real possibility that a clinician will experience the death of a client by suicide at some point in his or her career, every interaction with a suicidal individual has the potential to be a highly anxiety-provoking experience.

As can be seen in Table 10, there is a wide range of additional comments that followed the semi-structured interview questions developed by this research. In spite of the anxiety-laden view of suicide intervention, participants still look at their role as a suicide interventionist with some awe and as a highly honorable position. Several participants reported they look at their role when assessing suicide as a privilege. The view of their work as a privilege relates strongly to an approach to suicide assessment of meeting clients where they are emotionally, instead of having clients approach the client-therapist relationship by the standards of the therapist. This interaction seems to be central to the philosophy of many of the participants. The result of this mindset is to focus more strongly on the behavior of the client than the client as a person.
Table 10

*Themes Elicited by Interview Questions*

<table>
<thead>
<tr>
<th>Themes</th>
<th>Interview question #1</th>
<th>Interview question #2</th>
<th>Interview question #3</th>
<th>Interview question #4</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Approach to suicide assessment</td>
<td>Practice changes</td>
<td>Personal Impact</td>
<td>Worldview</td>
</tr>
<tr>
<td>Identify symptoms</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Determine risk</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Feelings of anxiety</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Feelings of anger</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Problems with time management</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Suicide as a choice</td>
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<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Detachment from the assessment process</td>
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<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Depression/ Sadness</td>
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<td>X</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Compassion</td>
<td>X</td>
<td>X</td>
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</tbody>
</table>

**Summary of the Findings and Overarching Themes**

The primary purpose of this dissertation was to explore the experience of clinicians as they assess suicidal ideation in their clients. Exploring the presence and severity of symptoms that could contribute to suicidal ideation was paramount among the responses. Participants were most concerned about the presence of depression in their clients, with the presence of a plan for self-harm and the access to a means of carrying out that plan being of great concern. Participants identified a set of topics they explore in
the process of a suicide risk assessment, and this list closely mirrored the list of risk factors most frequently mentioned in the literature.

When the emerging themes and subthemes were explored, it became clear that one of the first overarching themes is clinicians find suicide assessment is an anxiety-provoking process. Expression of a feeling of anxiety was by far the most commonly mentioned emotion. While the feeling of anxiety was frequently mentioned, it is more important to note the contextual aspects of anxiety within the interview process. Anxiety was a response expressed in relation to client safety, time constraints, personal competency, litigation, and when considering the decision-making process. Respondents were very well aware that to some degree they held sway over the future direction of a client’s life.

Time is a factor that was mentioned by nearly every participant. While it was not a predominant theme across the interviews, it was an aspect of a second overarching theme, which was consideration of barriers to adequate assessment and treatment of clients. Many participants complained of the time parameters involved when intervening in a suicide attempt. A frequently noted problem is the difficulty balancing the needs of a suicidal person against the remainder of their caseload, with a very real possibility that someone else could feel suicidal at the same time, yet not have the full attention of the therapist because of the previous suicide intervention. This possibility was deeply disturbing to a number of participants. None of the participants who mentioned time as a factor in the process of assessing suicide felt there was ever enough time to adequately and thoroughly assess the risk presented by the client.
The ability to exert some influence in a client’s life was important when considering to what extent or even if interventions should take place. As a third overarching theme, there were many participants who took a pragmatic view of suicide. Many felt it was a real possibility that the suicide of a client would be something they would experience in the course of their professional career. This created a dichotomous line of thought. On one hand, many felt it is always a choice a client has available to him or her. Others found this choice was the very aspect that caused their increased anxiety, with the very real eventuality of losing a client to suicide in the course of their career creating much of their anxiety.

To cope with the stress and anxiety that was mentioned, a fourth overarching theme developed. Many of the participants identified routines they had developed an ability to detach themselves from their feelings. While this was the most frequent response, it is worth mentioning that several felt it was important to internally process the feelings using prayer, medication, or mindfulness techniques during their work day. Others incorporated after-work activities such as physical practices, exercise, or relaxation methods. Other ways that were identified to cope with stress included co-workers, spouses, or friend networks. Disturbingly, only two participants mentioned turning to their supervisors as a resource to manage their anxiety, while two other participants said their supervisor was actually a source of increased anxiety after stressful assessments. A term that was mentioned by almost every participant was compartmentalizing their feelings as a means of continuing their work, particularly in the
cases when the participant was involved in a therapy practice with a pre-scheduled clientele.

While there was a broad range of emotions in the wake of suicide assessment mentioned, ranging from anxiety and depression to exhilaration and excitement, it is evident that the process of suicide assessment is highly emotion charged. Of the emotions mentioned, following anxiety, the feelings of depression and sadness were most prevalent. While it was not a pervasive theme, it is worth noting that nearly everyone who mentioned feeling angry toward their clients was ashamed to feel that way. Several participants felt their anger was unprofessional, while others were clearly embarrassed to admit to the feeling. For several other participants, they were left primarily feeling a sense of compassion for their clients.

The process of suicide assessment is seen as important work and highly responsible work. This was a fifth overarching theme. Several of the participants alluded to the work as a spiritual calling and an awesome responsibility. While many of them recognize that suicide is a choice that clients can make, they see themselves as responsible for offering their clients better choices. The ability to help other people and offer them something better was a highly appealing aspect of the intervention process for many participants. While they feared looking at every person in their life through a therapeutic lens, most participants expressed tremendous satisfaction in the work of suicide assessment. Money clearly is not the factor that motivated the participants to do the work. It is the intrinsic rewards that draw them to the field, including a feeling that their intervention had done something profoundly impactful in the life of their clients.
For many participants, the process of suicide assessment was a life-changing event. It impacted their personal worldview and changed the way they look at their own lives. As described by participants in this research, it became a final overarching theme. The ability of clinicians to see their own lives through the lens of their clients’ problems allowed them to feel a greater level of personal satisfaction with their lives as well as recognizing the relative insignificance of their own problems. For many participants in this research, this was comforting.
CHAPTER V
DISCUSSION

Anticipated Findings and Predispositions of the Researcher

At the onset of this project, I was biased because of my professional experience. For nearly 10 years I worked as the team leader of an after-hours crisis on-call. While working in the community, I developed some biases based upon my interactions with the people and situations I encountered on a routine basis. Despite discomfort encountered during such situations as domestic violence, self-mutilating behaviors, and clients who threatened suicide under the influence of drugs and alcohol, upon receiving a call, I could expect to encounter clients who were in genuine pain. In each of these cases, it was important for me to keep an open mind and listen to the person in crisis. Holiday weekends were an especially stressful time because they were so difficult for clients to manage alone. Sadly, for many clients, only crisis intervention workers would respond to them in their moment of need. Often this resulted in a busy weekend that was especially exhausting. Despite the physical exhaustion, there were times when the work was rewarding. As a crisis on-call clinician, the work was challenging but intrinsic compensation was considerable. Many times, people I encountered in crisis situations became clients of mine in my outpatient therapy practice. These people often expressed considerable gratitude for the way they were treated in the most stressful of situations. Some of these individuals credited the work of professionals on the crisis team with saving their lives. In a field that offers limited feedback from clients, this was highly
satisfying. The appeal of this aspect of crisis work has drawn others to the field of crisis intervention, including the participating therapists in this research study.

In light of these experiences, it was important for me to position myself as much as possible as an outside observer during the interview process in order to maintain objectivity. Though I have extensive experience in the field of crisis intervention, it certainly was not exhaustive. While I expected some mental health professionals would report experiences that mirrored my own, I expected some had experiences that would be unique. At the onset of the research I wondered whether some participants in this research study would have had less than positive experiences conducting crisis interventions and may have entered the research interview process with some negativity. Further, I considered the possibility of “burn out” with the likelihood of some resentment toward crisis work as a whole. I anticipated that the crisis-weary participants would reveal rich information because of their ability to accurately describe the pitfalls of crisis work. To my surprise, the cynical crisis worker did not materialize. Overall, the positive outlook toward suicide intervention was shared by nearly every participant. This was a sample that appears to have chosen, through a process of self-selection, to remain in the field of crisis work. Only the professionals who can survive the rigors of crisis work were available to be interviewed.

Member checks with each participant confirmed the accurate and complete reports of both the positive and negative aspects of their crisis intervention experience. During the second phase of the research process, I checked to ensure that all aspects of the participants’ experience were accurately reflected, to the extent that they were
comfortable sharing the information. I also contemplated that it was possible that participants could have experienced secondary trauma based on their crisis intervention experience. This could have resulted in guardedness or even withholding of information on the part of the participants. This potential problem would have been outside of my control. Again, this was not evident based upon the responses from the participating clinicians.

**How Clinicians Assess Suicide Risk and Lethality**

When I began exploring dissertation topics, I was drawn to the notion of increasing the validity of a specific suicide assessment instrument. In light of the findings presented here, I experienced a sigh of relief that I was persuaded to explore other avenues of research. This is largely because the process of suicide assessment revealed by participating clinicians was largely confirmatory when viewed in light of the preponderance of the literature. There are key elements that all suicide assessments must consider in order to be considered complete. These will be explained next.

In the literature, and confirmed by participating clinician interviews, there was an overwhelming agreement that certain key elements must be present in order to assess suicide risk potential with a high degree of certainty. First, one must identify the way a client plans to attempt suicide. Next, one must determine if the client has access to the means of attempting suicide (i.e., if the person plans to shoot themselves in the head, do they have access to a gun and do they have at least one bullet?). Then the clinician must assess if the client has a real intention to die. Finally, the clinician must consider if there are prodromal factors that have driven the client to consider suicide now, such as an
irreversible loss or recently being diagnosed with a terminal illness. These are spelled out as a standard of care in an article published in 2011 (Joint Commission, 2011). According to the Joint Commission, these are risk factors that clinicians should always investigate when assessing a client’s risk of committing suicide. This list of risk factors was mentioned by nearly all participants of this research study, particularly those with more experience who had committed them to memory.

It is important to note that the more experienced participants in this group reported the lowest level of anxiety when approaching crisis situations. This may be a product of increasing confidence after conducting multiple suicide assessments and receiving supervision during and after those interventions, but it may also be a product of ongoing training through workshops or peer consultation. Unfortunately, the specifics of this point were not explored in detail, but may be of interest to other researchers.

While experienced clinicians do not rely exclusively on any one assessment paradigm, they do utilize a common set of elements to adequately assess suicide risk. These common elements appear to be a nearly universally accepted standard of practice. These essential components of a complete and reliable assessment of suicide risk are questions about future orientation, questions about a means of committing suicide, questions about circumstances that may increase a client’s predisposition toward committing suicide (such as an irreversible loss), questions about the client’s mood, questions about substance abuse, and questions about the client’s current support system.

Noteworthy, while there are many suicide assessment tools available to clinicians such as the S.L.A.P. (Morris, 1998b), which is scored by the clinician after interviewing
the client; the Beck Depression Inventory (Beck et al., 1961), which is scored by the client or the clinician; and the Reasons for Living Inventory (Linehan, 1993), which is scored by the clinician and the client in a collaborative manner, none of the participants in this research study relied solely on any one of these or any other suicide assessment tool exclusively. The panel of participants felt collectively that no one instrument offers a complete assessment of a client’s risk of suicide without the clinician’s ability to interpret the results. Instead, the participants in this research considered these tools a guide. The most senior clinicians in the study demonstrated a strong tendency to view every suicide assessment tool with degrees of skepticism, questioning their reliability and validity. In light of this perspective, one cannot help but wonder if this effort is wasted on the very clinicians who are intended to be the primary consumers of these tools. Considering the extensive overlap that is present among currently available suicide assessment tools, only a truly innovative type of instrument, with a completely new set of questions, would seem to offer any promise of being innovative. Even if such an instrument could be constructed, it would seem that it would have to include some prompts that have been well covered by the cannon of assessment tools that are currently available to clinicians today. At this time, such an instrument seems unlikely to appear on the horizon soon.

**Effects of Suicide Assessment on Clinician’s Clinical Practice**

The three most common responses to questions about the changes in clinical practice resulting from engaging in client suicide assessment were disruptions of the therapist’s daily schedule and the therapist’s associated feelings of both anxiety and depression. The time necessitated by crisis management resulted in their other clients
facing inconvenience and disruption in their lives because their prescheduled appointments were delayed or abruptly cancelled. Participants were concerned about the inconvenience to their clients, specifically, leaving some clients waiting to be seen for an excessive amount of time or having other clients with no alternative to rescheduling at a later date. Participants were anxious knowing their other clients were left with unmet needs. A larger concern voiced by some participants was the possibility of concurrent suicidal clients, with the needs of one left unmet while attending to another. The notion that there could be unmet client needs or needs of some clients being met inadequately was a significant source of anxiety for participants, many of whom see themselves as having to meet the needs of all of their clients all of the time. The pressure to be all things to all people clearly was another source of anxiety to participants. By necessity, crisis intervention has to become a clinician’s top priority when facing a suicidal client thus relegating other tasks to secondary status. This possibility alone appeared to fuel some of the anxiety that was widely reported by most participants. It appears that the widely reported increased level of anxiety experienced by clinicians is created by a combination of four factors: (a) practice disruption, (b) concern for the safety of the client, (c) concerns about unmet client needs because of the possibility of concurrent crises, and (d) fear of the eventual death of the client should the client choose suicide in spite of the efforts during the crisis intervention.

**Therapists’ Perceived Confidence in Clinical Training**

Perhaps the most surprising result of this research is the reported lack of training that participants received as graduate students in their mental health studies. Only one
participant in this research study reported taking any coursework in their academic training that specifically mentioned suicide assessment. The others reported a paucity of training specific to the identification of people at risk of committing suicide and minimal training about how to conduct a comprehensive suicide assessment. Many participants reported feeling inadequately prepared for the challenges associated with suicide assessment upon graduation from their academic program. This feeling abated with additional post-degree training opportunities and experience. Another criticism leveled by participants was a lack of training concerning the management of emotions associated with the process of suicide assessment and how to cope the loss of a client who successfully commits suicide.

Huh and his colleagues (2012) found that attending a 6-hour workshop provided a measurable improvement in the assessment skills of participants. Participants in my research reported they learned the process of suicide assessment from targeted training offered by employers or by attending post-graduate professional education workshops. These reactions appear to confirm the findings by Huh and his colleagues indicating that attending professional workshops specific to suicide training is helpful to professionals and that it is done routinely.

Finding research that specifically addresses the effect that a client’s death by suicide has on a therapist was exceedingly difficult. In a related field, psychiatrists were studied by Knox et al. (2006). This may give us ideas about training for non-medical therapists in the mental health field. The authors found that the death of a client is a devastating experience for a psychiatrist trainee and one that requires intervention to
address the needs. Of these needs, paramount was for the therapist in training to process the loss but only when and where it is comfortable for him or her. The authors felt it was worthwhile considering the clinician’s beliefs about suicide and how his or her work is affected after the suicide occurred. The therapists in training who participated in this research reported recognition that the suicides took place amidst considerable suffering on the part of the client, thus was not a sin or a sign of weakness. Notwithstanding the effect a suicide has on a clinician in training, further training into effective suicide risk assessment was not among the recommendations made by Knox and his colleagues.

The Effects of Engaging in Suicide Assessment

The process of assessing suicide is impactful on clinicians both personally and professionally. It is noteworthy that therapists who work with suicidal individuals on a daily basis reported significantly less anxiety than was reported by clinicians who face suicidal clients only sporadically. There was a clear difference in emotional response between hospital and community mental health-based clinicians and clinicians in private practice, with the private practitioners reporting significantly more emotional impact when conducting suicide assessments. These sentiments were echoed by Deutsch (1984), who reported that participants in her research found clients with suicidal behaviors the most stressful aspect of their work as clinicians. This is a response that was mirrored by participants in this research who endorsed a combination of feelings of anxiety and depression more frequently than any other emotional response. This is particularly so when it feels there were no other clinicians available to offer assistance, such as when assessing a client in the middle of the night. While crisis workers in hospital or
community mental health settings were able to utilize other clinical staff such as nurses or security personnel, independent practitioners do not have that option. One respondent said that he felt he could not relax until he knew a client was admitted to an inpatient treatment setting.

Participants in this research reported they find the process of suicide assessment can cause them to feel depressed as well. The participants identify negativistic thinking on the part of the clients they interview and this saddens them. This was reported by participants as being manifested in a depressed mood on the part of the clinicians following the interaction with suicidal individuals. One reported crying in her car on the way home from an assessment, while another reported being so disturbed that she could not focus on the topic of a meeting at her son’s school. These feelings are reflected in the literature as well. Of their participating therapists, Pope and Tabachnick (1994) found that the most frequently endorsed focus of discussion was depression and general unhappiness, which was mentioned by 1 out of 4 of their respondents. The results of the present research would appear to confirm this aspect of Pope and Tabachnick’s study.

Another significant discovery was the frequency that a feeling of anger was mentioned by 11 of the 17 participants in this research. There were several reasons why they felt angry. While the disruption in their work day was mentioned with some irritation by several participants, a greater source of anger lay in the effect the client’s suicidal behavior would have on the bereaved family if the suicide attempt were successful. One participant was chagrinned by his emotional response, recognizing he was not helpful to the treatment process when he demonstrated anger toward a client.
Stoval and Domino (2003) were among the few researchers to identify the potential feelings of anger a clinician could have for a client following a successful suicide. Their participants stated the level of anger they had for a client who committed suicide during the treatment process was intense. This finding was certainly reflected by the comments made by participants in the present study.

The underlying sense of anxiety likely is a significant contributing factor when one considers why some therapists turn to a wide variety of coping mechanisms with a goal of allowing them to endure the stress associated with the suicide assessment process. These coping mechanisms were reported as including mindfulness techniques, exercise, meditation, prayer, and consultation with colleagues. While it is no surprise that interacting with suicidal people is stressful, it makes sense to alleviate as much of the clinician’s stress as possible when he or she faces people in crisis. Despite the stress involved in suicide assessment, it is clear the participants in this study are passionate about work and see it as a valuable part of their practice. The stress involved is often a product of a desire to do the best possible assessment of suicide risk while being mindful of time constraints.

**Change in Worldview as a Result of Engaging in Suicide Assessment**

The majority of participants expressed that their worldview had been changed as a result of engaging in suicide assessment. This was often a product of being able to see their own life through a lens of their client’s problems. Participants reported feeling that their own problems paled in comparison to those of their clients. Among the participants, many shared a view stating that the act of suicide is an option that is “always available”
to clients, even when the act of suicide is in direct opposition to the personal beliefs of the clinician themselves. The code of ethics of the American Psychological Association and the American Association of Marriage and Family Therapists state that clinicians must do everything in their power to prevent a client from taking his or her own life.

Notwithstanding this, participants demonstrated an ability to look at the act of suicide in pragmatic and empathic ways that I found deeply moving. Furthering this notion was the idea that clients were capable of autonomous decision making. Often a client’s decision about committing suicide falls outside the sphere of influence of therapy. While this was a humbling notion for many of the participants, it appeared to be a pragmatic way of looking at the actions of clients. It is clear that many participants recognize and respect the free will of their clients even if they were not comfortable with their client’s choice to commit suicide. Regardless of their own viewpoint about the act of suicide, most participants were able to look at the suicide as a way of ending the suffering through a seemingly intolerable situation for some clients.

Within a phenomenological framework, clinicians identified that their clients have the freedom to make their own choices with a sense of autonomy. Clients have the freedom to do as they wish, including committing suicide. One participant noted that for some clients, suicide is their way to “escape from hell.” She explained that suicide is a potential consequence of the disease process, with the disease being depression. Another participant felt that mortality must be accepted in order to fully understand the relationships he has with the living. He noted that if we accept that everyone is a living being, each of those living beings must experience a death. At times death occurs in ways
that he neither agrees to nor fully understands. Sometimes the most misunderstood of deaths happen by suicide.

A common response among participants was a feeling that they were always listening with some degree of vigilance any time they are interacting with others. They find it difficult to hear jokes about suicide and are constantly aware that there may be underlying thoughts when suicide is casually mentioned in social gatherings. One participant mentioned she is no longer any fun at a party. She stated that such interactions are simply too stressful. Instead she would prefer to observe others in such gatherings thus avoiding the difficulty she had with interacting. In my research I was unable to uncover any specific reference to this feeling in the literature. Instead, this may be addressed in some writings by Frankl and by Ericksen, who discuss being a therapist as very much of a process accepting one’s own contribution to the change process.

Coming full circle, these observations have helped this author understand the very event that led to this research—the death of my friend during my early college career. I knew long before we became friends that she had once attempted suicide. One evening we spent several hours in her parents’ basement rec-room talking about life and her previous suicide attempt. When she successfully completed suicide during my sophomore year of college, I blamed myself, erroneously believing I could have said or done something that would have prevented her from committing suicide. Today, of course, I understand things differently than I did as an 18-year-old college student. I know that her death was part of a disease process that was far more sophisticated than I could have confronted at that point in my life. Experienced professionals tried to help her and she
committed suicide anyway. Perhaps with better tools, better training, and a different mindset, my friend would have received the help that she needed. At the same time, I can’t help but wonder what the counselor who was treating her was feeling when he or she received the news of her suicide, and I can’t help but feel empathy for that individual.

**Limitations of This Research**

This study had some inherent limitations. It was focused on a small group of participants who were, intentionally, a sample of clinicians who could offer expert opinions on the topic of suicide assessment. All participants either were known by this researcher because of their expertise in the field of suicide assessment or were referred by individuals known to me. The fact that I was trying to gain insights from individuals who had considerable experience assessing suicide presented an inherent limitation in this research. This was a bifurcated sample. Nine participants worked in a hospital or community mental health setting, while the remaining eight participants worked in either a private practice or community funded outpatient practice setting. Some participants conducted several suicide assessments in a single day as part of their job in a community mental health or hospital setting. Other participants conducted only a few assessments per month as part of their private practice. This bifurcation provides some valuable insights into different aspects of crisis assessment, yet it cannot be considered a reflection of all crisis work.

This research does not purport to demonstrate the state of crisis intervention in every part of the country. The study focused on people living and working in midsized cities in Michigan. Remote rural communities and large urban areas of the country were
not represented, nor did this study make any attempt to do so. It is not generalizable outside of the specific area where the research was conducted. Replicating the research in rural areas and in larger urban areas would certainly be an area where further research could be conducted, but that was outside the scope of the present research project.

Ethnic, cultural, and racial differences would be another area of research interest. This study interviewed people who were available and willing to be participants. There was no inclusive or exclusive criteria based upon demographics aside from the required amount of experience in the field of crisis intervention work. As such, all of the participants in this research project were, with the exception of one participant, white, middle class clinicians practicing in the midsized towns in Michigan. It would be very enlightening to replicate this research with a more diverse group of clinicians to see how their experience compares to the participants of this study.

**Recommendations and Potential Areas for Further Research**

As previously stated, this is a research project that is not without limitations, though the researcher has made efforts to address these limitations within reason. This research could address some of these limitations if it were replicated in another location. It would be enlightening to see if similar results would occur if the research were duplicated in a large metropolitan or urban area, or if there would be a different outcome in parts of the country where therapists treat a population from a remote rural background. It would be enlightening to explore this research with a more diverse mixture of participants as well. It is assumed, but has not been demonstrated, that therapists from a more diverse background would be able to offer some useful insights to
the conversation about suicide assessment. Other groups that could offer valuable information would be seasoned mental health care professional retirees and entry-level clinicians.

Another area of research would be to explore the effect on clinicians if they were offered additional training specific to suicide assessment at the graduate level. The results of this research point to a need to implement and require some training specific to the identification of symptoms of suicide risk and how to treat a client who appears to be at risk of committing suicide. Based on the literature and confirmed by the participants interviewed for this study, it appears that weekend-long workshops make a meaningful impact with regard to the confidence level of professionals as they enter the field of mental health treatment. It would be worthwhile to conduct such training and then assess participants’ knowledge and confidence in the area of suicide assessment.

It is noteworthy that every aspect of the process of assessing suicide is anxiety-provoking. If we accept the notion that elevated anxiety is associated with the process of suicide assessment, it seems that the answer may be increasing the emphasis on education specific to suicide assessment so students or professionals emerge from graduate programs adequately prepared to cope with the stress of the assessment process and the associated mood fluctuations inherent in this work. This point raises a serious question: Do universities feel confident in their own ability to offer this type of training? Amidst the statistics, theory, techniques, and history curriculum, it may be worth considering the addition of training specific to suicide assessment to the core curriculum. To test this notion, one could explore the curriculums of counseling psychology (or other programs
that offer training in related fields) to identify those that do offer training in suicide intervention and interview graduates of those programs about their experiences.

The lack of suicide risk intervention training is an educational void that this researcher feels should be filled, not only to moderate the anticipated feelings of anxiety and depression that were reported by participants of this research study, but to offer the best possible counseling to the clients who come to a mental health professional for assistance. Failure to meet this need is failure to follow the suggestions we make as a field. If we, as professionals, experience uncomfortable levels of anxiety and depression when we conduct our work, are we truly able to assist our clientele to live better lives as we face the juxtaposition of our own deficits while failing to get the help we need?

As has been stated previously, at the onset of this research, this author was interested in standardizing the process of suicide assessment. While that task appears out of the reach of this author, it would be worth exploring clinicians’ opinions about how to improve the tools that are currently at their disposal so they could serve a greater purpose than providing only guidance. Exploring the avenues of questioning that are missing from the currently available instruments could prove fruitful. It would also be worth asking if the instruments feel adequate in their present form and are most useful as a guide only. In colloquial terms, if the guides are not broken, is it useful to try to fix them?

The experience of varying degrees of anxiety and depression during the process of suicide assessment was a commonality that was widely reported by the participants. Outside the scope of this research is a possible avenue of inquiry, which is, in the face of such anxiety and depression, what drew people to the field and what keeps them there?
Assuming some of them have considered leaving the mental health field, what experiences have brought them to that degree of dissatisfaction? What do crisis workers find fulfilling about their work?

The reasons why experienced clinicians are now more comfortable conducting suicide assessments are not well understood. Could this be a product of on-the-job training, workshops, peer-reviewed interventions, or a good supervisory relationship? At this time, it is not known but would be worth exploring in future research.

While some of the participants offered their opinions about the act of suicide, this was not a direct question that was asked of them. Several participants opined that the act of suicide is a choice available to everyone and the ramifications of their opinions in their work. This researcher feels the answers to these questions would certainly prove to be as interesting, if not more so, than some of the answers that were recorded in response to the questions about participants’ world view.

**Summary and Concluding Comments**

The experience of assessing suicide is anxiety-provoking yet inherently rewarding to the clinician. One of the primary tasks of this process is to identify the presence of symptoms, including depression and suicidal behaviors in clients. In light of this, it would be necessary to understand the reported sense of anxiety that so many participants described. While there is significant overlap in the suicide assessment paradigms from a content perspective, and clinicians take the results derived from them into consideration, they report that they still rely on their own clinical judgments more than standardized instrumentation.
Anxiety, as it is related to the process of suicide assessment, takes four forms: (a) the disruption of their day, (b) clinicians feel anxiety when they have not yet reached a point where safety of their client is assured, (c) concerns about unmet client needs because of the possibility of concurrent crises, and (d) risk of the potential death of the client should the client choose suicide in spite of the efforts during the crisis intervention.

This researcher suggests the answer stems from an inverse relationship between anxiety levels and experience. The greater the experience level when assessing suicidal clients reported by participants, the lower their subjective reports of stress and anxiety. In other words, if they felt they had an adequate combination of training and experience when facing a suicidal client, they felt less anxiety when intervening in their crisis situations.

The lack of confidence reported by less experienced clinicians is not without good reason. There is a paucity of training in the assessment and intervention process of suicidal clients by graduate level mental health training programs. This is true of psychology, counseling psychology, and social work programs, where this researcher found no discernible differences reported by participants. The training that clinicians have been able to receive largely was gained by attending workshops within the context of their employment. The feeling of depression that was widely reported by participating therapists appears to be a common by-product of interacting with suicidal people. This depression appears to be totally unexpected by many participants in this study. Inexplicably, graduate training programs fail to explain this eventuality to their students. More troubling is the fact that, for this research study, this researcher specifically sought
out the more experienced and seasoned professionals for inclusion. One can only imagine
the degree of anxiety that a less experienced respondent might have reported.

While it became clear that moderate anxiety was an emotion that was commonly
experienced by everyone in this pool of participants, it seems more important to note that
participants significantly resolved their anxiety so they could be of help to their clients.
Nearly every participant who described their feelings of anxiety felt it was a normal and
expected feeling associated with the process of suicide assessment.

To this researcher, the most significant finding in this body of research does not
relate to any of the research questions, yet goes to the heart of the suicide assessment
process. When exploring suicide risk, there is a sense that suicidal behavior is not the
primary focus of attention. Instead, the focus of suicide assessment is to discover reasons
for living and a thread of hope. These ideas are not new. Authors Kenneth Morris
(1998b), Marsha Linehan (1993), and Jack Klott (2012) have advanced these ideas in
their research. What was striking was the frequency that the idea of exploring reasons for
living and hope surfaced independent of the researcher asking specific questions about it.

As has been noted, the S.L.A.P. is an innovative assessment tool because it has a
subscale that explores the resources that a client has available to them in the midst of
their time of crisis. This researcher would suggest that this subscale is of vital importance
and offers us a perspective that could be of great help to people considering suicide,
because it directly answers the deficit in a typical suicide assessment process—the
reasons to live and the resources available to a client.
For people who are deeply committed to ending their lives, there is often little that can be done to stop them from committing suicide. Often these are the people who do not come to counselors for assistance. They tend to commit suicide in lethal ways and without reaching for help. In juxtaposition to this group of individuals are people who face significant levels of pain with a feeling that there are no options available to them. Despite this feeling they come for help. By exploring their reasons for living, resources, and then offering a sense of hope, a perspective of exploring their available strengths and resources can offer a way out of a seemingly insurmountable crisis.

Participants in this research were unanimous in suggesting we must do everything we can to help the client cling to life. Several participants noted that the process of suicide intervention often does not involve a lot of discussion about suicide. Instead, there is considerable discussion that explores the reasons a client hurts. By carefully and attentively listening to the client, one can offer a cathartic effect. Immediate attention to the client and the pain he or she is facing was suggested as being the real work of suicide assessment. Indeed, many participants saw the suicide assessment process as not only an ongoing process but as a beginning of a therapeutic relationship that ideally extends for a long period of time. The establishment of this relationship by actively listening and attending to the client was the key to suicide intervention.

As a group, there was a level of passion and commitment to serving other people that was palpable through every interview that was conducted. Participants were eager to share their experiences using raw and often openly expressed emotions. Every individual indicated a willingness to participate if in some way it could help someone in need.
Without being asked, several participants referred the researcher to their colleagues to further the data collection process. If a similar level of passion and commitment to helping is evident during crisis interventions, this participant group offers ample reason to feel optimistic about the future of suicide assessment in crisis situations.
REFERENCES


Appendix A

Research Planning Table
**Topic:** The clinician’s experience of assessing the suicide lethality potential of patients in crisis

<table>
<thead>
<tr>
<th>Key Concepts</th>
<th>Problem</th>
<th>Purpose</th>
<th>Research Questions</th>
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<td>Research has not addressed the lived experience of clinicians as they</td>
<td>To gain insight into the lived experience of clinicians as they assess the suicide lethality potential of their clients.</td>
<td>1. What is your approach to suicide assessment?</td>
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<td>assess suicide lethality potential of people in crisis situations.</td>
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<td>2. How has your professional practice changed as a result of conducting suicide assessments?</td>
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<td>Suicide risk assessment</td>
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<td>3. How are you personally affected by the process of suicide assessment?</td>
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<td>Crisis intervention</td>
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<td>4. How has the practice of suicide assessment affected your worldview as a person both personally and professionally?</td>
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Appendix B

Research Questions
Interview Questions

The Meta Question

How does the practice of suicide assessment effect clinicians in their professional practice and in their personal lives?

Broad General Questions and Subquestions

1. “What is your approach to suicide assessment?

   a) “What is your conceptual framework when assessing client’s risk of committing suicide?”

   b) “How do you determine the seriousness of a client’s risk potential?”

   c) “Do you use any suicide assessment protocols or standardized instruments and what are they?”

   d) “How valuable are assessment protocols and instruments to your practice of suicide assessment?”

2. “How has your professional practice changed as a result of conducting suicide assessments?”

   a) “What changes in your therapeutic practice have you noticed in the wake of suicide assessments you have conducted?”

   b) “Are there any changes in your daily routine on the day of a suicide assessment?”

   c) “Over time, have you had to make any systematic changes in your practice because of suicide assessments?”
d) “Are there any systematic barriers that hinder your ability to adequately conduct a suicide assessment?”

3. “How are you personally impacted by the practice of suicide assessment?”
   a) “What happens to you emotionally during and after a suicide assessment?”
   b) “Do you find yourself experiencing any change in mood during the assessment or at any time following the suicide assessment?”
   c) “If your mood is changed because of suicide assessment what, if anything, do you do with those feelings?”
   d) “How is the rest of your day and time out of the office affected immediately following the process of conducting suicide risk assessments?”
   e) “Does anything ‘spill over’ into interactions with other clients?”

4. “How has the practice of suicide assessment changed your worldview as a person both professionally and personally?”
   a) “How has your personal worldview been changed by your practice of suicide assessment?”
   b) “Have there been any changes in your practice if your worldview has changed?”
   c) “Have you noticed any changes in your personal life after conducting a suicide assessment?”
   d) “Can you describe the changes you have experienced in the weeks and months that you attribute to your experience conducting suicide assessments?”
Appendix C

Script for Initial Phone Contact
Script for Initial Phone Contact

My name is Eric Macleod and I am a doctoral student in the department of Counselor Education and Counseling Psychology at Western Michigan University. I am contacting you to invite you to participate in a study that I am conducting as part of my dissertation. Choosing not to participate in this study will have no personal or professional ramifications. This study is looking into the lived experience of a clinician’s practice of suicide assessment. I am conducting this study under the supervision of Dr. Alan Hovestadt.

You have been referred as a possible participant by _______________ (insert referral source name) because of your personal interests in both aspects included in this study. My study will focus on individuals who work as therapists and who themselves are currently engaged in suicide assessment. In order to participate in this study, participants will be required to meet the following criteria: (1) You have worked as a clinician providing direct therapy to clients for a minimum of 2 years; (2) You are currently and have practiced crisis intervention for a minimum of 2 years; (3) You have conducted at least one crisis intervention in the past year and you have completed at least 3 crisis interventions in the past 5 years. Do you meet these criteria to participate in this study?

My study will consist of a brief demographic questionnaire along with an in person interview lasting about 45-50 minutes utilizing a phenomenological research approach. If you choose to participate you will be asked to do the following:

1. Complete a brief, confidential, demographic questionnaire that will take approximately 15-20 minutes.

2. Participate in a confidential, audio recorder, in-person interview lasting approximately 45-50 minutes. This interview will take place at a location that is convenient for you.

At this time do you have any questions regarding the study or your participation in it? In addition to or in place of your participation, I wonder if you would be able to provide contact information for others who may also qualify to participate in this study. If so, by passing on this information to me I could contact them to ask them for their participation. If you do not feel comfortable giving me their contact information, could you please pass along my information so that if they are interested they can contact me. I can be contacted by phone at (269)420-3852 or via email at eric.w.macleod@wmich.edu. Please let others know that they may contact me if they are interested in learning more about the study.

Thank you for your time and consideration regarding your participation in this study. At this time I’d like to set up an appointment to meet and conduct the interview portion of this study.
Appendix D

Consent Form
Consent Form

Western Michigan University
Department of Counselor Education and Counseling Psychology (CECP)
Principal Investigator: Alan Hovestadt, Ed.D.
Student Investigator: Eric W. Macleod, MA, L.L.P.

You have been invited to participate in a research project entitled “The Clinician’s Experience of Assessing the Suicide Lethality Potential of Clients in Crisis.” This research is intended to study the experience of clinicians as they assess the suicide lethality potential of their clients. This project is the dissertation project of Eric Macleod.

You will be asked to participate in the following manner:

- Participating in a face to face interview with the researcher, Eric Macleod regarding your own practice of suicide assessment.

- A follow-up telephone conversation to ensure the accuracy of the information gleaned from your interview.

- An optional written statement to clarify any statements transcribed from your interview.

The investigators will provide any postage necessary for your returning of any materials included in this study.

As in all research, there may be unforeseen risks to the participant. One potential risk of participation in this project is that you may experience discomfort or unease during the interview process; however, Eric Macleod is prepared to provide crisis counseling if you should become significantly upset. He is prepared to make a referral for additional counseling if that became necessary as a result of your participation. You will be responsible for the cost of this counseling if you choose to pursue it.

Upon completion of the research you will be offered a copy of the abstract of findings. By participating in this research you will contribute to the knowledge base of other clinicians and researchers in the field. You will have the opportunity to reflect on the impact your work has on your personal and professional life. Additionally, it is anticipated that this research will offer you a beneficial collegial experience as you consider your professional and personal experiences.

All of the information collected from you is anonymous. Your name will not appear on any papers or digital recordings where information is collected or recorded. The digital recordings and forms will all be coded, and the student researcher will keep a separate master list with the names of participants and the corresponding code numbers. Once the
data are collected and analyzed, the master list will be destroyed. Pseudonyms will be used for reporting purposes. All other forms will be retained for at least three years in a locked file in the principal investigator’s office.

Any identifying information will be changed in the final report to protect your anonymity.

You may refuse to answer a question or choose not to participate, and may withdraw from the study at any time without prejudice or penalty. If you have any questions or concerns about this study, you may contact either Eric Macleod at (269)430-3852 or Dr. Alan Hovestadt at (269)387-5117. You may also contact the chair of the Human Subjects Institutional Review Board at (269)387-8293 or the vice president for research at (269)387-8298 with any concerns that you have.

This consent document has been approved for use for one year by the Human Subjects Institutional Review Board as indicated by the stamped date and signature of the board chair in the upper right corner. Do not participate in this study if the stamped date is more than one year old.

Please print your name: __________________________

Please sign your name: __________________________
Appendix E

Demographic Questionnaire
1. Gender: M  F  
2. Age:_______
3. Ethnic Background (please check all that apply)
   □ American Indian
   □ Asian
   □ African American
   □ Hispanic/Latino
   □ Pacific Islander
   □ White
   □ Other ethnicity alone
   □ Multi-racial including something not listed here
4. Graduate degrees (circle all that apply) 
   PhD  PsyD  EdD  Ddiv  MD  MSW  MS  MA  MEd  Mdiv  Other_______
5. Length of time as psychotherapy practitioner: ____________________________
6. Length of time as a crisis intervention practitioner:_____________________
7. Current Licensure or practice credential:_______________________________

8. Please describe your psychological theoretical orientation.
9. On average, how many clients do you see per week in your clinical practice?
   < 5, 6-10, 10-19, 20 >

10. Have you assessed three or more clients for suicide in the past five years?

10a. How many?

11. Please briefly describe your training in crisis intervention.

12. Please circle the number of times per month that you currently assess client’s for suicide risk potential.
   < 5, 6-10, 10-19, 20 >

13. When was your most recent suicide risk assessment?

14. Are there standardized suicide risk assessment tools you use?

14a. What are they?

15. Have you had to involuntarily commit anyone to inpatient psychiatric treatment in the past 5 years?

16. Have you recommended voluntary hospitalization to any of your clients in the past 5 years?
Appendix F

Summary of Individual Interviews
Summary of Individual Interviews

This Appendix is used to present a summary of the interviews with all seventeen individual participants. As a means of ensuring the confidentiality of the participants, all of the names have been changed by the researcher Macleod. The names selected are all common names in contemporary American society. None of the selected names is an actual name of any participant in the study. The names reflect the actual gender of the participant. To further protect the identity of the participants, the order in which they are presented here is different than the order their demographic data is presented elsewhere in this document.
Summary of Participant Interviews

Participant 1: Christine

Christine is a 35-year-old Caucasian woman who was interviewed in the meeting room at her office. She has a master’s degree in social work and has practiced as therapist and crisis intervention worker for the past three and one half years. During the day she works with a population that is seriously mentally ill and contracts as an on-call crisis interventionist during nights and on the weekends. She uses a preadmission screening tool that was developed by her agency when assessing suicide but augments the tool with her own questions.

At the time of the interview Christine felt it was important to note that she had just come from an intervention with a person she feels poses a very serious suicide risk and likely will commit suicide at some time in the future. This is very disturbing for her because, although he poses no immediate threat, she is facing a very real possibility that her client could die by his own hand while in her care. Reflecting on this situation she said: “I think my concept now of seeing someone who’s ready to do it and serious versus someone who’s thinking about it and thinking about a plan and is still kind of on the fence that those two people look very different. And it’s much easier to assess someone who isn’t 100% committed to it.”

For her, significant barriers that interfere with her ability to properly do her job are related to time and multiple crises happening at once. “I mean you are starting an assessment with someone and you need to be present and ready and not have, not be
interrupted by calls and not be thinking there are two other people waiting to be assessed. And it’s an extremely difficult situation to be in, for anybody to deal with that.”

The emotional impact of suicide assessment was particularly poignant at the time of our interview because she had just completed a very difficult shift. She said she is typically a strong person but finds she can be “rattled by especially tough cases, especially when they involve young people.” At times she finds that some cases are so difficult that she cries in her car after the intervention is complete. Sometimes she copes by calling a coworker who will listen to her. When self-care was discussed she readily identified that she does not do enough to care for own emotional needs. While she does talk with coworkers, she thinks seeing a therapist would be a better idea, although she has not yet engaged someone for help. Conversely, she tries very hard to avoid drama in her life and people who tend to become engaged in drama. Explaining this further she said: “My friends are very stable and very down to earth. Um, that’s a welcome relief after a long day at work.”

Conducting assessments of suicidal individuals can be very taxing on Christine personally. “Continuous suicide assessments can trigger some depression in myself. It can be difficult to um, want to engage with others. A lot of times I have my own stuff going on. And it’s hard for me to get up off the couch and turn off the TV to go do things for myself.” Exploring her mood more deeply she said: “I’m really drained. I don’t have the patience I would normally have just from being, you know, kind of emotionally exhausted, you know? You know I can be quicker to get upset or little things bother me more or you know?”
She sees the changes over time having an impact on how she sees the world. This has included her approach to interpersonal relationships.

I think that I worry sometimes. I have a very, well I, my boyfriend suffers from depression. He had told me a couple things last year that worried me greatly, about his, what he was dealing with and I sort of did some safety planning with him (laughs), and you know it affected me more than, obviously than if it had been a client but it sort of sneaks up on you in your personal life when you try to just pretend it doesn’t exist in your personal life. And when it does I think it’s even more hard than when you don’t do this all day. Cause it’s not supposed to happen in your personal life. You’re not supposed to have work related issues when you go home. So….it’s very difficult.

While she takes suicidal thinking very seriously, she does not believe the truly suicidal people are assessed very often. Reflecting on this she said: “I think when I see people who are truly suicidal it’s still affects me emotionally but I, gotta say 80-90% of people I assess are not truly there.” With experience she has found herself less intimidated when asking about suicidal ideation but she is fully aware that some of the mistakes she could make can be life or death errors. This is worrisome as she does not know how she could go on as a professional in the field after making an error of such magnitude.

Looking at this idea more deeply she explained her thinking behind such a loss:

I think I have really high expectations of myself you know? And I’m very hard on myself when I make mistakes. And if there were to be a mistake of that magnitude, even if it’s someone who has been seen by 20 other people, and they all agreed I would still take it in on myself. And I don’t know if I…if I would get over that. To be honest with you.

After considering this statement Christine allowed that she was experiencing the impact of an intervention earlier in the day when she made that statement. Despite that, she felt it was important to have a very raw emotional experience included in this research. “I
thought you might when the topic came up. But that’s okay. I think it’s important for you to, you know, understand. I’m sure you do. As part of your research.”

Christine demonstrated some very raw emotions as part of the interview. At various times she cried and at other times struggled to talk at all. She indicated a full knowledge that such emotions were a real possibility during our interview. Despite this, she wanted to offer her input so others would know how it feels to do the work and experience the emotions it can involve. Her hope was that she could offer help to clients and to therapists who help them.
Participant 2: Eileen

Eileen is a 50-year-old Caucasian female who has worked in the field for thirteen years. She is a Licensed Clinical Social Worker and is employed by a crisis intervention unit where she has worked for a number of years. By her choice, the interview with Eileen took place in her office at the hospital.

She began the interview by talking about some important first impressions of a client when they present in her office for an assessment. “If I am able to talk to that person in the course of their ER visit then they have not done anything very serious. If the degree of lethality is such that they have to be admitted to the hospital then that postpones their assessment until they are medically stable upstairs, then it is very serious.” This distinction is her first means of determining a client’s risk and the client’s intent to commit self-harm. The way the client presented to the hospital (voluntarily or involuntarily) and if there was a suicide note present and a clear intent to die are all important distinctions for her.

Before she meets a client for the first time, Eileen likes to review the chart (when it is available) to gather as much background information as possible. In the process of her assessment she has a checklist of suicide risk factors taped to her clipboard. She feels this is a helpful, if rough guideline, so she is sure she has missed nothing in the process of her assessment. Her view of the actual process of suicide assessment was illuminating.

I learned a long time ago, relatively speaking, that you just have to spell it out and if you spell out exactly what you are talking about they will follow suit. I very seldom have anybody get squirmy or embarrassed or uncomfortable when I use the term suicide. I figure it’s kind of like child rearing. You know you are modeling. I can have a frank, if I can be frank and open and honest with this topic then so can the client.
She feels that the process of suicide assessment needs to be frank and has to be the first thing “you have nailed down” when a client presents for an assessment.

Eileen’s workplace is highly intense at times. She reports she once assessed nine individuals for psychiatric admission in a single shift. This suggested a question about how she cares for her own emotional needs in such situations. She replied: “Probably because of the number of patients we can see in the course of a day, I am usually able to maintain some distance so I don’t get as enmeshed emotionally. I think that’s because I don’t have ongoing relationships with these people.”

To keep herself emotionally healthy, Eileen turns to family and coworkers for support. She has found that her coworkers have been present for her, particularly in cases where she is unable to establish professional distance. Reflecting on this experience she said:

I had probably just reached my limit as far as, you know, what I could handle emotionally at that point in time. I was on overload and I had to pull the door closed. I couldn’t face them. And she did [a coworker stepped in to do her job as a substitute] and it was great. So we covered for each other. So, a lot of venting, a lot of supporting one another. And that helps me too, not having to take it home.

The process of suicide assessment itself has had profound impact on her views of life and how she interacts with other people. Her worldview in the wake of suicide assessments is reflected in the following way:

I guess it has driven the point home with me that uh, this is part of the human experience and it’s okay to just bring it to the open, bring it to the light. Look at it. What we are dealing with. Let’s be practical. How can we address it? And go from there. Whereas I suppose prior to getting into the field I probably felt that some of it was your upbringing. That it, there are some things that you just deal with and you don’t bring them out into the open. Or there are some things that are too personal and you should not be dealing with it with other people.
The ability to ask direct questions and speak frankly about suicide is something she has found to me highly valuable in her work and was a point she returned to several times in the course of the interview.

Over time Eileen has learned a variety of assessment techniques and reports she is now more attuned to body language and other non-verbal cues to what people are thinking in the midst of a suicide assessment. Increasingly she relies on her instincts and subtleties that were not part of her assessment processes when she began her work. She finds asking for direct feedback from clients which helps her to get a better picture of the accuracy of her own assessment. She summarized the interview with the following: “I think this is an ongoing learning process like any job that you do and that you want to do well and one you want to continue to get better at, you want to keep learning.”
Participant 3: Mark

Mark is a 56-year-old Caucasian male who is a Licensed Clinical Social Worker. He has worked in the field as a counselor for 25 years. For the past 20 years he has worked for a large outpatient clinic. In addition to individual counseling he runs several groups and has experience working as an after-hours on-call clinician. He has not served in that role in some time but routinely assesses suicide risk among clients on his caseload. Mark was interviewed at a restaurant near his office shortly after he left work for the day. Mark began the interview by discussing how he begins exploring suicide risk among his clients. He indicates “I have had 90% of my clients in the past seven years say ‘yeah I have thought of suicide’ but I have not lost 90% of my case load.”

A significant problem he identifies is outside pressure to see increasingly more clients over time. The pressure he experiences can affect his interactions with suicidal clients. Mark explains: “When somebody is suicidal and they are crying and I’m thinking gosh what time is it? Or I have somebody out there waiting. So I feel, I feel pressure, to answer your question, to get it done in an allotted hour. Now that, that’s disconcerting to me.”

Over the course of his work he has only known of one person on his caseload to commit suicide. Reflecting on the experience he said:

It was awful. It was a real interesting case. It was a person, I don’t mean this rudely, but he was not the brightest person. So what he did was drank Draino. And I, and I know him well enough where I know he did not know what he was doing. He just, I assume, had problems with his girlfriend. He probably drank it “okay I’ll probably throw up and my girlfriend will feel sorry for me.” He had no idea it would eat through his whole stomach like it did. And he died four days later in the hospital. And I went up to see him in the hospital before he died. He
could hardly talk. It burned all the way down. Yeah, So he could hardly talk. But he held my hand and he died a couple days later. That was awful. And I felt bad because he was kind of a funny guy. He would call in a semi-crisis saying “my girlfriend called me and what do I do?” Well, you need to call her back. And ask her what is going on. “Well, what if she does not want to go out with me?” Well she doesn’t. And we would kind of have these dialogues. And I wouldn’t document this stuff because actually it was kind of humorous. He took the Draino and, you know, died. So I felt terrible about it. He did not want to die. No way. I just think he did not really know what Draino was going to do to him.

Reflecting on this experience he was able to identify nothing he could have done to change the outcome. “I feel I did my job. I assessed him to get an idea and I had to make a clinical opinion.” Based on that discussion, he was able to find nothing that would have led him to believe his client would drink a lethal dose of Draino. To cope with this loss and other stressors, Mark often relies on colleagues for support. “I re-evaluate my thoughts. If it is really disconcerting I am going to talk to a colleague.”

Mark reports an ability to leave things behind at the office when he leaves. This extends to his thinking from one client to the next. “I have developed the skill of when the next person is in the office, I leave the last person behind.” He admits with some embarrassment that preoccupation with a previous client only becomes problematic when he finds a client’s narrative uninteresting. In those situations when his mind drifts: “I kind of start thinking about the other person.”

When Mark was asked to consider any changes in his worldview he responded in the following way: “I think the more I do this the more I realize there are more hurting people in the world than I ever, ever realized. That has been a big eye opener in 25 years and still is.” Elaborating he said: “even bright people, wealthy people, people who seem
to have it all together. They can still do it. And sometimes we miss the boat.” Mark

concluded this line of thinking:

We’re human. And what has changed my world view is when I hear of someone
who has suicided and the community says well why didn’t someone do something
and people are so apt to blame the mental health system that we didn’t do enough
and that really pisses me off. Because sometimes we do things. And I know for a
fact as an agency we have prevented a lot of suicides that people know nothing
about. And I think it is real easy when people say this person was a client of such
and such therapist, or a client of such and such agency. Then all of a sudden we
have to defend ourselves. We’re doing our job. Well you didn’t check on them.
You don’t know the story.

Mark made special notation of the unique experiences associated with young gay
men and women as they make the decision to come out. He notes that there are a lot of
feelings that strait therapists in particular may be unaware of. He is greatly concerned
about the suicide rate among the gay population. “(T)he suicide rate of young gay men
and young gay women is higher than the population as a whole. And so when I have a
young person in my office, who is a teenager, 19 or 20 years old or whatever who’s
finally coming to terms with who they are, I always focus on that.” Mark wants to know:
“How do you, how do you feel about it? Where, are you okay with who you are? Or do
you feel you have to fight who you are? Are you ashamed of who you are? That sort of
stuff.” More to the point of his concern about suicide: “And have you thought of ending
your life because of that? And then sometimes I think that question gets overlooked.” As
he assesses suicide risk he typically explores this question in great detail when
considering the young gay population:

And that’s the red flag that goes off in my head. In other words, do you have a
support system out there? Are your parents okay with who you are or have they
threatened to kick you out? Are you being picked on in school? Who is your
support system out there?
Concluding our discussion he emphasized that his concern for this population is not limited to only the teen population: “Or even people, even in their 20’s or 30’s who have been married for 10 or 15 years who now say “I am really a gay man. I’ve got three kids but I am gay. I’m 38 years old.” You know, that again, that’s when my red flag comes out. How are you coping with this?”
Participant 4: Amy

Amy is a 38-year-old Caucasian woman who has worked as a clinician and crisis intervention worker for 11 and 9 years respectively. She has worked in a variety of positions in her organization but most recently specializes in treating seriously mentally ill individuals with borderline personality disorder. By her request, she was interviewed at a restaurant near her office during her lunch hour. She explains her view of the act of suicide and the process of suicide assessment in the following way: “suicide is a potential consequence of the disease processes of the disease known as depression. Therefore suicide assessment is just another way of just, uh, assessing the symptomology associated with that disease process.” She explains that her concept of this definition was one that took the emotion out of the act of suicide and the process of suicide assessment, a mindset she acknowledges is more of a medical model way of thinking.

Amy finds the process of suicide assessment has impaired some of her sense of humor in counseling sessions: “I think it has made me more sensitive to indicators that may be there and my clients may say I take them a little too seriously. So that they feel that they don’t, they can’t make the joke ‘If I don’t get my way I’m going to kill myself.’ Cause I’m all “Oh really?” (laughs) That it impairs my sense of humor (laughs). A lot of times.”

Amy feels she has grown considerably more confident in her ability to adequately assess and discuss suicidal thinking with her clients. Early in her career, assessment tools were of help to her: “I found when I was a junior baby clinician and had that initial sense of “Oh my God what am I going to do?” it gave me a tool to reach to and do and look
competent and make me feel I knew what I was doing.” She also feels she has improved her ability to ascertain the sincerity of her client’s commitment to keeping themselves safe from self-harm, compared to where she started as a clinician:

I had thought we had made a plan. I did not get commitment, a real commitment. I got a lip service commitment. And when I looked back at the intervention I could see that they weren’t really making eye contact with me. I wasn’t really pushing the issue. They said yes so I agreed to that and I moved on without really checking that out. As well as there wasn’t a change in their affect. When people, I have noticed over time, when people get hope their affect changes, even a little bit.

She has spent some time considering what would happen if one of her clients were to commit suicide:

I see a lot of professionals say “well they could commit suicide.” Well they could anyway. We’re powerless. And, and, and I guess I have done a lot of soul searching through my own sense of answering the question of “why do I do this?” Of why do I do this when I can fail? And what is failure and failure to me is not suicide. You know? I guess that is why I gravitate to a medical model. You can’t tell a diabetic well if your blood sugars go up you’ve failed. It’s part of the disease process.

She believes it is important to be very direct when discussing suicide: “saying suicide, not “taking your own life” or something flowery. Using the words.” Her practice of being direct allows her to be more efficient when assessing suicide risk: “it’s acknowledging the reality that in half an hour you are going to walk out this door and we need a plan.”

Amy has some specific techniques she uses to debrief after a suicide assessment:

I listen to a little bit of music and I try to refocus myself and I breathe deeply ‘cause I notice physiologically I get tense. And it is hard to hold that tension. Now if I have the next widget right there, then I really have to be mindful of not allowing that tension to bleed into their session. And that’s a challenge sometimes because I have noticed there are times after a really rough session where there has been a suicide discussion, the next time I kind of don’t give the next person my full attention.
When asked about changes in her worldview, Amy has invested considerable energy considering this over time. She responded:

I think that I have had to find a sense of spirituality that is okay with death in general. You know, not just suicide, but all kinds of death. And come to some sense of understanding meaning in life. You know that for however long we are alive there is some purpose. So, even when I see someone and they go kill themselves there was a meaning for their existence for however long they did and how they died. And I think that I am kind of, I can understand why people would want to kill themselves and I can understand why people would actually follow through and do it. And while it is sad that they gave up that hope and it’s sad that they did not reach out and all those things are unfortunate I find a way how not to reach back and reflect on my personal failure in that, you know? And I think that is the key to survival. From what I have seen in other clinicians who have had suicides some of them really can’t tolerate that. And it burns them out. ‘Cause they then spend a lot of time trying to prevent things and not just suicide. Trying to prevent everything. And really overwork themselves.

A downside to the types of clients Amy sees has been the quality of interactions with other people. She finds the high risk population exciting, while every day interactions can become routine: “It almost pales in comparison. And I think that’s why I do what I…I work with the high risk population. Cause there is a bit of an adrenaline rush there.”

Amy lost one client to suicide ten years before our interview. Reflecting in that experience she explains:

I was the last person to see this person alive. I talked with him and was trying to get him to the hospital. And then I got called the next day on the weekend and they said hey do you know this person? He killed himself. And I you know, it totally ruins your weekend. And I think I was at a point where for the first time I had to face the, wow! Decisions have consequences. But did I do anything wrong. And when we went through the assessment and the post hospital or post incident review or blah, blah, blah…I did everything right. And he still died. And I went, you know what? This is not going to be about me. This is going to be about people and their choices.

She briefly discussed her graduate program’s training on the topic of suicide. She indicated they were very specific about the risks involved in the work. “They said you
will work with some people who will die and if you can’t handle that you need to get out of this field right now.”

Amy concluded our discussion by discussing her views of suicide from spiritual and world view perspectives.

I think it is interesting to know what you believe at your core about suicide. As a belief system. I know there are people who are Christian based counselors and they believe that is just never an option. I am Buddist-ish. It’s a choice. And after you die there’s…we don’t know what happens and there is no maybe they do go to a better place. I see suffering that I understand. I would make that choice, you know?

She continued by discussing her view of suicide, offering considerable empathy for those who make the decision to end their lives.

I think there are some people where suicide is truly their way out of Hell. And I don’t think we can blame them for that. That’s what I hate about suicide. A lot of blame.

Amy believes her role is to help the client discover the purpose of therapy, which from her perspective is to make meaning out of life and to help her clients decide what aspects of their lives really matter.
**Participant 5: Sally**

Sally is a Caucasian female 44 years of age. She is a supervisor of a program that is geared toward the treatment of children and families. She holds a Master’s degree in counseling and has been working in the human services field for 16 years. She has been involved in crisis intervention work for the past 11 years. She was interviewed in a group room in her office. She feels it is important to assess the suicide risk of every client every time she meets them. She indicates “it is surprising how many times you ask that question and they go “well yeah.” But that was not the presenting issue. That was not why I got called.”

Sally has a very broad approach to the process of suicide assessment:

I look at a variety of things. I look at currently what their state of mind is. Um, are they rational? Is there some psychosis going on? That’s really rare in kids. You have to…You have to find out. I was able to get have they attempted in the past? What their thoughts are like. Do they know anyone who has killed themselves? Especially a friend, a close family member, um do they have a plan? Is that plan doable? You know, cause a lot of kids will say, “oh, I am going to smother myself with my pillow.” You know, it’s probably not going to end up lethal…but then you’ve got the kid who says I am going to hang myself and I’ve got in the woods behind my house. Whole different feel to it.

A significant concern for her is when there are people in the client’s life who do not take their risk of committing suicide seriously: “that gets scary. When you’ve got the parents who say ‘oh, they’re not serious.’ But yet in talking to the kid I think they are very serious.”

When assessing suicide risk, Sally does not see the hospital as her only intervention option: “And if they say I want my pain to go away that gives me an in” to discussing other treatment choices. She elaborates about the choices available to a client
concluding: “Suicide does not have to be your final option.” Conversely, when she begins to feel a child is very serious such as when they state a desire to end their life: “But if they give me a more definite “I want to be dead.” All of that stuff starts adding up. Have they actually made an attempt and failed? They figured out how to improve it?” These factors led her to pursue inpatient treatment options.

At times Sally finds the pressure to avoid inpatient treatment can interfere with her freedom to readily choose the best treatment options to her clients. She recently received a call from someone at her funding source who “said ‘placements are high.’ And I say yeah. Um, and again we never ever want money to play in to our decisions.”

She finds herself very concerned about where things are heading with the country and with mental health services in particular. She has noticed a dramatic increase in the use of her organization’s services:

I think last year was our busiest year and in the program ever and this year is heading in that direction. And the question is why. Why? Is it the economy? Is it stress? Is it families are taxed so they can’t teach their children appropriate coping skills? So, something is going on and I don’t see a change at any time soon unfortunately.

She finds the process of suicide assessment simultaneously an exhilarating and sad experience:

Yeah there is the adrenaline rush and sometimes during the assessment I can get genuinely sad for these kids, and the parent. I mean, I assessed a kid not long ago and he’s telling me about these suicidal thoughts and nightmares about killing himself to the point where he’s afraid to go to bed at night. He’s afraid he’ll stab himself. He’s gone and he’s gotten a knife and he’s held it to himself and his mother is sitting there listening to him with tears streaming down her face. ‘Cause she’s like how horrifying listening to how your child wants to kill himself.
At other times she feels she is sharing the experience with a client, particularly when they relate a very sad story to her: “I will tear up with a client when they are talking.” She finds it is unhealthy to dwell on these experiences: “I don’t hang on to it real long. I think with crisis work it’s the nature of the beast.”

Sally feels she has a realistic view of the practice of suicide among teens: “there is that realistic part of me that knows that most kids do think about it at some point. So and then I think one day with the girls (her own children) how am I going to handle that?” She also takes a broader, societal view of the problem of suicide in children: “I think as a whole what has gone wrong with our society? How do I not let that impact my children?”

Reflecting in completed suicides that have impacted colleagues:

I think about one in particular, just because I know the clinician who assessed that child through another agency and that child went home and killed themselves. And I have tremendous respect for that clinician. Um, and I felt very bad for her and I knew what kind of heat she was taking. I watched her since then and she’s done magnificently with that. And handled that very well. And you honestly think “I hope that never happens to me.”

Sally offers some mixed empathy and anger when considering parents who elect to attempt suicide: “sometimes you get angry. Or a parent who attempts and survives and their child is struggling. And you have to keep that in check because that person is dealing with a whole lot of pain…” She concludes by voicing a concern about complacency in the field “Probably one of my biggest concerns for my team and myself is we do it so often I don’t ever want it to become boring or causal.”
Participant 6: Bill

Bill is a 58-year-old Caucasian male who has been practicing as a therapist in a private practice for 33 years. He has a Ph.D. and sees over 20 clients every week. He was interviewed in his office where he serves a dual role as practitioner and clinical director of the practice. He began the interview by discussing some of the unique characteristics of his practice, and by extension, the clientele of that practice: “The first thing I would say to that is my practice is that I am in kind of a special niche. I am in outpatient but my clients are, you know, private pay, um most of the people who come here are employed.” He continues, explaining how this relates to suicide assessment in his facility: “we’re getting a select group of individuals, most of which would not be sent to us if they were suicidal. They would be sent to the crisis intervention.”

Bill approaches suicide assessment from a perspective of engaging clients in a discussion: “usually my first approach is, again, to start asking them questions. I think it is a positive step when someone is willing to tell me they are having suicidal thoughts.” He feels this is a positive step because it indicates there is a level of trust that allows him to fully explore his client’s suicidal thoughts and plans.

He is very cautious when a client first starts taking anti-depressant medications. He feels they can mix a feeling of worthlessness with a boost of energy that could allow them to make an attempt on their own life. This, he warns, is particularly concerning as are people who refuse to engage in a conversation about suicide. When he encounters resistance on this topic he finds himself particularly worried about the safety of the clients in question.
He indicates he is much more comfortable exploring suicidal thinking now than he was when he started his career. While he still takes suicidal ideation very seriously, it is not the frightening experience it was when he began his work. The difference he identifies is an increased level of confidence in his ability to ask the right questions and to intervene in the correct way based on the way clients answer his questions.

In the wake of suicide assessments he finds he is impacted by these interactions during subsequent sessions later in the day:

And that’s exhausting emotionally. It’s emotionally tiring. You can’t just turn that off and go into your next appointment and be… Everything’s fine. I think it does impact. I don’t think it seriously deters me, but I am not at the same level energetically.

When the need arises, he is greatly relieved to find there are always people in his office who will offer him emotional support. If they are unavailable, he has his spiritual self that he can turn to. “I am not at all embarrassed to say I would call on the Father for a little love and grace and calmness.” This was true when he experienced the suicide of a client. He described the experience in the following way: “I felt bad. But it wasn’t like I felt a personal, how would I say that? I didn’t feel responsible. I have never had anyone that has told me that…told me that they were going to shoot themselves. I’ve never had that kind of cause and effect experience. I think that would be very traumatic, personally.”

Reflecting on the loss of one other client he empathized with her life and her loss in the following way: “(I did not feel) responsible but just sad because honestly, she had a tragic life.”

Reflecting on suicide itself, he responded by saying: “It’s a sad commentary. That some folks see suicide as a way out.” He elaborated in the following way: “In the sense
that I think years ago the pendulum would have been over here where with suicide you
were thought of as kind of an outcast. At least for, only those on the very periphery of
mental health stability would ever go there.” When asked to explain he said:

And I think we have shifted now to so much social talk, media talk and kid talk
and all this psych talk about suicide. I’m going to kill myself, I’m going to blow
my head off, do this, do that, do this, do that, I could just die, you know, just die.
I’ll just give up, I don’t care, I don’t want to live, and we become culturally
desensitized to it. And then these kids think it’s normal. And it isn’t. That’s crazy.
To me it really belongs, that pendulum is now swung out here. And I’m saying,
we’ve got to bring this baby back. You know, talking about suicide lightly or
casually, like it’s an okay thing to do, it cancels out your problems, to me is the
wrong message. Well and you know, in a way, a lot of times you get I think that a
lot of times it is a selfish act. A childish act. An act of someone who doesn’t know
what else to do, you know? A lack of proper parenting or support group.

When thinking about suicide assessments he has conducted over the years he
responded: “I think a certain, certainly they bring out a level of for me heightened level
of sensitivity and compassion.” Bill went on to say how he felt when entrusted with such
personal information: “It’s not honor, but it’s like that. You know that someone would
trust you with the responsibility to tell you that they don’t want to live anymore.” He
concluded by considering the seriousness of the responsibility of suicide assessment: “I
suppose, in a way philosophically, a special place that you have been honored with. Now
that may sound paradoxical but I think there is a certain level, if you take it seriously and
do your job that you have done a great service to that individual. And you know there is
probably a spiritual level to that too if you are a Christian. Because in Christianity the
belief is that God does not want you to take your life.” He said this allows him to open
the door to a way to keep God happy by sparing the person’s life.
Participant 7: Fran

Fran is a 54-year-old Caucasian woman who has been practicing for the past eleven years as a private practice counselor and has conducted crisis assessments throughout that time. She received her crisis training while volunteering at a suicide intervention hotline. She has a master’s degree in counseling psychology (MA, LLP) and is also licensed as a marriage and family therapist (MFT) and as a certified professional counselor (CPC).

Her approach to a client who is expressing suicidal thoughts is to first look for the presence or absence of hope. She looks for hope particularly when it is accompanied by a significant change in presentation, such as a new hairstyle or an appearance of lightness. She is mindful that such changes can reflect relief that an ordeal may be over and could be a sign that the decision to commit suicide has been made.

She finds the best intervention when she suspects a client has decided to end their life is a very direct approach. She has a “chain of questions” that typically conclude with a direct inquiry about a client’s suicidal intentions. She finds this approach is helpful. “Most of them, it’s actually, you see a sense of relief. That someone has finally asked and someone is willing to discuss it without being…without outwardly showing that fear.”

She finds it important to take each and every suicide threat seriously, regardless of what instinct may say to the contrary: “It’s a topic that you always take seriously even if you have that little voice in your head (saying) this is manipulation, this is manipulation, this is manipulation.”
Fran has not lost a client to suicide but she is aware of several colleagues who have experienced this loss. She said: “They are very professional but I have seen the presentation where it looks as if they are carrying extra weight.” Elaborating, she talked about their mood in the wake of the loss: “even discussing with them and them saying I know there was nothing I could do. I know I did everything. There’s still that thing where they are remorseful.” Struggling with a feeling of responsibility seems to be a significant challenge for these people: “they feel accountable at times. (Even though) their professional part will say I’m not accountable.”

A significant challenge for her is maintaining focus after conducting a suicide assessment: “if I have someone on my caseload like that, even though I try not to, other clients are not going to get as much of my attention. They are not. I really don’t think they know. They will not get that focus.” Outside pressures can create problems with the way her day flows after conducting a suicide assessment: “I am going to be trying to squeeze phone calls in between sessions.” To manage the additional stress, Fran uses the support of therapists in her office: “I might be consulting with other therapists. That’s one of the benefits of this practice is the ability to speak with other therapists.” She sees this point as an advantage: “there isn’t the isolation factor that you have in private practice.” Fran explored her own response to suicide assessment by describing the physiological response to the process: “to be truthful, it’s one of the most exhilarating feelings I have ever felt. I am just thinking about the physical response. Your adrenaline kicks in so your pulse is going faster. You are breathing faster. It’s arousal. You’re alert.”
She elaborated about the experience of feeling the sense of exhilaration in the following way:

The person I am thinking of relating to this is a man who had attempted, not completed, sat in my office and told me about it and I started questioning him about the manipulation aspects of it and he was very forthcoming that, yup, that’s what it was. Looked right into my eyes. That span of time for me was very, uh, heightened. So it was like, finally someone, a client is talking about this honestly. I don’t have to do that thing where it feels like I am pulling it out. So I’m thinking of the contact with him. But in that case I was relatively safe because we were not discussing his future plans. We were discussing what he had done. So that was, for me that was quite exhilarating because of the topic. But it was relatively safe and it was an opportunity to learn.

For her the experience of assessing suicide in a person who is considering I acting in the future is very different than someone describing an action from their past: “If it’s someone who is suicidal it’s like uh. Um, kind of like clicking into a very systematic what to do, what to do.”

An intervention like the one she described above is emotionally taxing work for her. While she is able to compartmentalize her clients during sessions, she reports a feeling of “being a little amped up” after a particularly intense discussion of suicidal ideation. She feels this ability to compartmentalize conversations allows her to better focus on client issues as they are present in therapy sessions and offers her the opportunity to model this behavior for people who become preoccupied with stressful events.

When discussing her world view in the wake of suicide assessments she feels she has been impacted in some significant ways: “I recognize the fragility of, of what we all take for granted. Life is going to go on this way so I recognize that, that’s not true. Just like that (Snaps her fingers) be it suicide or be it an accident…anything. A person’s
whole world changes just when they are not planning on it.” Her role as a therapist has impacted her overall view of the world as a result: “I recognize that in my world view….um…actually being therapist has changed me from sarcasm and pessimism to optimism. Forced optimism because I don’t want to feel that way.” She went on to describe her ability to control her own thoughts: “your brain is like a TV. And that you can change the channel, you get to decide what’s playing there.”

Over time her views have evolved in terms of the world and how she conducts therapy: “I would say that having been exposed to people who are suicidal or who have attempted have helped that kick in that somebody in the room has to remain calm.” Continuing, she said: “Someone has to remember…the steps and so I would say over the years I have become not nearly as frightened of it as I used to be.” In the wake of suicide assessments the day-to-day aspects of life can become rather mundane: “So if you are used to that excitement during the day, those things that seem very, um, average or normal…”

Reflecting on the work of a therapist, Fran concluded the interview by describing her struggle to explain the kind of work she does to someone who is outside the field or unfamiliar with the processes inherent in it:

It’s hard to explain this profession to someone who doesn’t do it. They have a good idea but they really don’t quite get it. Not because they’re not trying, but until you do it, you have no idea. I think it’s a very um, spiritual calling if you will. I think it is. So how do you explain it to them? It’s better than a movie. ‘Cause you always want to say something that is very respectful to what I call is a lay person. Because they need to see therapists in a certain way. It’s voyeurism with responsibility. And we must attend. Because there are details in there that can help.
Participant 8: Joe

Joe is a 65-year-old Caucasian male who has been practicing in the counseling and crisis intervention field for the past 38 years. At his request we met in a restaurant over his lunch hour, though the interview actually lasted close to two hours. He has a small private practice and limits the scope of his work to clients who are experiencing suicidal ideation. This gives him a rather unique perspective, by working with very high risk clients yet working only with those clients with the greatest needs. He approaches all clients with the mindset that their behaviors are purpose driven and are designed with specific goals in mind.

Joe enters each interaction with clients with a very specific case conceptualization. He believes there are understandable and treatable reasons for suicidal thinking. “There is a reason why men and women die from suicide and that is usually because they are experiencing some type of emotional, psychiatric, psychological agony that uh, they can’t cope with.” This conceptualization offers him both direction for treatment and hope for success: “I want to find out where they hurt. So, what that means is I don’t spend a lot of time talking about suicide. I spend most of my time talking about who they are, what’s going on in their lives and where do they hurt.”

Joe went on to talk about the initial steps he follows when beginning a course of therapy: “First task of therapy is to discover the locus of the client’s unbearable pain. And that’s what I focus on. I then want to get a sense of what they are doing right now to cope with this pain, and more often than not that is a maladaptive behavior. Um, drug use, self-
mutilation, some other kinds of behaviors that have been shown to them to not be
effective.”

When looking at the act of suicide, Joe has a rather unique view:

Suicide is a problem solving strategy. It is very productive. I never pathologize it.
Never, ever pathologize suicide because you lose the client when you pathologize
suicide because for them in your office suicide is a very productive behavior.

Continuing, he said “(Suicide is a) reasonable, logical, attractive behavior. And I am not
going to get into a debate with my client about the inappropriateness…think about who
you hurt, tada, tada, tada.”

While his primary focus is the pain his clients are experiencing, he does conduct a
very thorough assessment of the presenting problems.

And one of the very first things that I go by is that very often, and data kind of
reveals this, that many people who die by suicide don’t go to counseling. It’s
usually men and women who are ambivalent about suicide that show up in a
counselor’s office. And it kind of is a logical conclusion because if I am talking to
a counselor about suicide; if I mention the word, it means there is a little bit of
ambivalence there.

Elaborating, he indicates many clients seek professional assistance to prevent
their own deaths. “(Clients say I) want people to know I am suicidal. Why do I want them
to know? I want them to do something to keep me from doing it.” He sees this as a very
different mindset than people who have decided they truly want to die.

When men and women die by suicide, they don’t people. They don’t want to be
cought. They don’t want to be stopped. They’re so convinced that is the issue. So
number one, the very fact that they are talking about it means they’re ambivalent.

This is an important distinction because he wants to align himself on the side of the
ambivalence.
When exploring the usefulness of any lethality assessment scale, Joe was unequivocal in his disdain. He describes them in the following way: “there’s not a one of them that’s valid. Unless, unless of course you have nothing but Caucasian middle class middle age males. If you happen to be seeing a culturally diverse population, female population, adolescent population, they are worthless. Absolutely worthless.” He goes on to say that the Reasons for Living Inventory by Marsha Linehan does have some value, but it has the advantage of being validated with women and minorities as part of the sample.

Over time he has had some significant changes in his practice: “I am much more comfortable with the population now. As a matter of fact, in my practice since 1980, that was my specialty.” This vast experience has shaped his view of the act of suicide. He does not think most people he sees want to die: “the overwhelming majority of folks that you see are going to be what we call ideators. They’re thinking about it as a problem solving strategy.” He continued to explain his increased comfort level in more detail: “They rarely, rarely become completers. Rarely. So with that knowledge base I found myself much more comfortable working with this population because the risk factor, as long as they are talking about it, is relatively low. It’s when they stop taking about it that the risk factor becomes elevated.”

The problems he would face when intervening with a client who was using suicidal threats as means of attaining some sort of secondary gain clearly had a strong emotional impact on him. He looked back on some of the interactions he had with clients with not an inconsiderable amount of regret:
And I would say something relatively inappropriate like what do you care? You’re going to be dead. What, are you going to sue me from the grave? I get involved with these inappropriate conversations with my clients in an emergency room at 2:00 in the morning because I was pissed. And then I’m driving home saying Joe, jeeze. You’re supposed to be above this. And yeah, I used to do that stuff. 20 years ago, oh my God! 2:00 on a Sunday morning, 4 degrees outside, wind and snow blowing and here I am in an emergency room talking to you. I could be in bed or I could be at my child’s baseball game right now. And then on my way home thinking to myself, I did absolutely nothing to help that client. Absolutely nothing. Instead what I could have said is “you’re having a tough time right now. I know the hospital provides you with a sense of security and a sense of relief. We need to talk about other ways that you can do that other than going into (the) hospital every other week. I could have done that. And now I do.

Joe described one of the big challenges of conducting suicide assessments is the “carryover” from one client to another. “Part of you is there, but part of you is still with that person from 9:00 in the morning who you have walked out to their car and you don’t know…boy oh boy.” While he is careful to let such clients know he is distracted by events that occurred earlier in the day, he does so without using self-disclosure: “I’ve always been extremely cautious about self-disclosure. To a point where I, right now, I would never ever use it…never use it.” This is because he sees self-disclosure as detracting from the therapy process. “They’ll go after me with “you never answer any of my questions. You always put it back on me.” And I’ll say, yeah, that’s therapy. Therapy is not about me.”

Explaining his worldview, Joe identifies a lot of important issues: “Sharing. Sharing, sharing, sharing. Resiliency hope and friends. And my world view basically on my focus on friendships, focus on hope for the future and a focus on some bad things happen in life.” He went on to describe several things that have happened to him, concluding with, “Some terrible things happen in life. You can cope.” This is the
message he tries to share with his clients. While he sees the act of suicide as a comparatively rare event, he has lost four clients to suicide. One of them was particularly impactful: “I began to develop a perspective of those folks who die, by suicide and leave behind horrific grieverers, it’s pretty narcissistic.” He found himself looking carefully at those who complete suicide, and has tried to understand them: “I began to develop a perspective that there is something characterologically flawed in the men and women who die by suicide.”

Joe concluded our discussion by offering his opinion of how higher education views suicide education:

It is ironic, tragically ironic that one of the more profound dilemmas, human dilemmas that a professional is going to face in their career they are going to learn about on the fly. There are no formal courses, protocols, course curriculum in suicidology in any major graduate program for social work or psychology. Which is abjectly tragic. It’s absurd. The most common dilemma we face! A university has a program in addiction disorders; a specialty program in addiction disorders, but nothing in suicide. Fascinating.
Participant 9: Phillip

Phillip is a 37-year-old Caucasian man who has been working in the counseling and crisis intervention field for the past 15 years. He has a master’s degree in Counseling and has started work on a PhD. His primary role is serving as a crisis intervention and suicide prevention counselor at a large community mental health service provider. He was interviewed in his office where he works. He was interrupted once during our interview so he could answer a telephone call.

Phillip sees his first responsibility is offering hope to the individual in crisis. He feels providing hope is the best way to avoid involving clients in the most intense levels of service. There are three primary questions he calls “the biggies” that he wants to have answered before the end of the first session.

I think for me is are they suicidal, are they homicidal, are they psychotic? Are they able to take care of their basic needs? And I think based on you know, many questions that surround those areas, kind of determine the severity of their illness.

The emotional response to crisis situations is an aspect Phillip clearly likes. He describes himself as an “adrenaline junkie” and says he likes the high stress that is inherent in the work of a crisis worker. This is an aspect that makes him feel a sense of worth and makes him feel purposeful. In turn this tends to improve his mood through the course of the interview and later in the day.

Coping with the stress is an aspect of his work that he feels is vitally important. Among the most effective stress relievers he identifies is laughter with a coworker. He believes people on his team laugh more than anyone in the organization, thought they acknowledge a certain “gallows humor” about their situation. He feels this is essential to
his survival, even though there are people who fail to understand what the amusement is about: “You kind of have to laugh at some of the things that happen so, to someone else who might not be in this field would be like, what are they laughing about?”

A significant frustration for Phillip is the bureaucracy he faces when trying to deliver services: “if the clinician didn’t do the paperwork then they couldn’t schedule an appointment with a customer, but the customer might be suicidal and it might be avoiding a hospitalization. And it’s, you know, really? Come on.” He says these kind of things are aspects of the job he dislikes but it does not prevent him from continuing to work: “So those types of things you know we can certainly run into and that’s a frustration. You’ve got to be willing to, uh, kind of buck the system a little bit and be okay with that.”

Discussing his emotional response to the work of suicide intervention, Phillip made it clear that he likes a lot about the work, particularly the high energy part of what he does: “For me it’s uh, it’s exciting. I love what I do. I couldn’t imagine you know, I have worked in private practice, I’ve done other things and you know. This it more my speed and more what I like to do, but um, I think the more busier I am, the more assessments I do, the more uh, energetic, awake if you will, I feel.” He elaborated by stating that not everyone affects him in the same way: “it really depends on the person sitting in front of you.”

While he enjoys the stress inherent in his work, he finds that some days what he needs most is time at the end of the day: 

(W)hen I get done with work I want to be by myself for an hour, or hour and a half and I just want to kind of separate myself from everything and be in my own world. For me I’ve noticed that on a busy day I just sort of need to pull back and process everything and after that I am back to being normal but you know
especially because of the ‘chaoticness’ of what our days can be like having that hour or so, or going to work out is very important.

This is especially important so he can avoid having the events of one intervention spill over to another: “I think there have certainly been times where I have maybe continued processing what happened with a previous client and sometimes we can be dealing with more than one client at one time, so you know, yeah, it’s kind of hard for it not to.”

He believes his world view has been shaped in significant ways by the work he has done: “Cause no matter how stressful my personal life gets, it’s nothing compared to what the customers we care for are going through on a daily basis, so it kind of puts things in perspective for me a lot.” His level of involvement emotionally has changed over time:

I don’t become as emotionally involved with the customers as I did initially. Because I remember when I first started as a therapist, it would just tear me up with some of these stories that I heard. Now it’s not that it doesn’t affect me, I just, I guess I don’t, I try to separate myself from their stuff. I try to keep it separate from me. ‘Cause I think that sometimes people as therapists, with the transference and counter-transference issues are huge and the more you try and be there with the client and customer and try to relate but at the same time separate yourself from that and not make it your issue then I think the better.

He is cautious not to allow his work to “bleed into” his personal life. He believes the risk of this is a tendency to distance himself from his family. He has found himself distant in the past and is now more cautious about this tendency. Concluding the discussion, he was surprised that there was not more discussion about how he came to the field of work in the first place. He indicates this was an evolutionary process and not at all what he planned. Despite that shift in focus he is very happy in his present role.
Participant 10: Tammy

Tammy is a 34-year-old Caucasian woman who was interviewed at her office in a large community mental health center. Tammy has a master’s degree in counseling psychology and has a limited license to practice. She has practiced as a mental health professional for the past six years and has been in the capacity of a crisis intervention worker for the past year. Her primary task in her current job is crisis intervention and suicide assessment. Tammy was highly succinct and her interview lasted just short of 45 minutes.

When assessing suicide risk, the first thing she focuses on is reasons for living. She has little faith in standardized assessment tools as she finds they tend to be too easy to use as a comprehensive instrument, thus failing to explore the nuances of a client’s thinking in more depth. Over time she has found herself increasingly comfortable exploring suicide risk in explicit terms, finding that she is more confident that she is getting an accurate picture of the seriousness of a client’s suicidal ideation.

Important considerations for her are the client’s age when they first attempted suicide, how many attempts they have made in a lifetime, how serious those attempts were, and did the client have a clear expectation of death. She is interested in the events that have led to the suicide attempt and how those events were significant to the client at the time. She feels this kind of information “can give you kind of an idea of the life stressors and their inability to cope.”

Tammy said the most significant barrier to adequate assessment of suicide risk potential is her own fear. Elaborating, she said:
My own not really wanting to know the answer. Um, I think that, certainly I always think that you know unconsciously I can portray that to someone and I have to be very diligent about how I am asking the question. And making sure my body language is not, you know, indicating to them that I really want you to say no even though you are suicidal.

She feels not wanting to really know if the client is suicidal can be a significant problem for many therapists and it is something she has to be mindful of at all times. She went on to explain that she is very careful about how she asks if clients are feeling suicidal. “I worked with many people who would say ‘you’re not suicidal are you?’ and then shake their head no. So of course they are going to say no.” Instead, she asks “when was the last time you thought about killing yourself?” Tammy feels the latter question produces a much more genuine, and accurate response.

Assessment of suicide is an emotional experience for Tammy. Both anxiety and sadness are prominent reactions for her. She explains her feelings: “there is always some anxiety for me personally because it is an intense moment right?” Discussing the sadness she experiences she stated that the process of assessing people who consider suicide “pulls at your heartstrings.” A highly profound experience for her happened during a crisis intervention. “I was interviewing a client at the hospital and she wrote a really in depth suicide note. It was probably 6 pages long. Yeah. It…the overwhelming feeling of sadness just reading it. It was pretty incredible.”

To cope with these feelings, Tammy reports she has to become very good at distancing herself from the events and has to compartmentalize things. Without this ability, she says her job would be very difficult: “I could do six assessments a day and you know you just have to carry on.” The other potential problem would be an inability
to focus on any one client completely. Despite her coping mechanisms, she finds the task of maintaining a separation between clients remains a significant challenge for her. Tammy reports only a minimal change in her world view in the wake of suicide assessments. The most tangible has been sadness and a realization that many people are suffering. Though this information is not entirely new to her, the degree of suffering is surprising: “I think on one level I knew that before but to encounter so many people on a daily basis who feel that their only option is to kill themselves, um, there is a lot of suffering in the world.”

This viewpoint has changed her view of suicidal people’s motivation for acting as they do: “I think I can wrap my head around it a little bit better in the sense that it is not just someone being selfish. Although that is part of it but someone is suffering that they are in so much pain that the only thing they can do or the only reasonable solution they feel they have is to kill themselves.” This perspective has greatly increased her empathy for people in crisis. “I think I have gotten better at encompassing all the areas and looking at the person as a whole.”
Participant 11: Jennifer

Jennifer is a Caucasian female who is 72 years old. She was interviewed in her office at her place of employment. She has a Master’s degree in Counseling Psychology and has been working in the field for eight years. In her work setting her primary task is to assess crisis situations and assess the suicide risk of her clients. She likes the work and enjoys the fast pace involved. She particularly likes having the opportunity to get to know many of the people she assesses and feels her long term relationship with them gives her a significant advantage over people who have not been working with suicidal clients as long.

She is acutely aware of both the stress involved in her job and the risks involved. She described her interaction with a man she felt was at significant risk in the following way:

(H)e had lost his son and he was giving a lot of signs that he could be a completer. Uh, he was going to the cemetery on a daily basis. His son was killed in a broadside accident by people who were eluding the police. And so we set him up with all kinds of treatment. He saw a psychiatrist on a monthly basis and saw a therapist on a weekly basis. I was seeing him as a case manager. At that time I was just starting out. Uh…I saw him maybe 2-3 times per week. And uh, we thought we had it covered. And we did as well as we could. And the one thing I learned from that experience was he came in the last day I saw him, it was a Friday afternoon and he had this very peaceful countenance. His affect was brighter. And I as an inexperienced case manager took that that we were making some improvements.

For her, the loss of her client was a deeply moving experience that could have had the potential to end her career in the field. The factor that helped her the most was the support she received from her peers. She said: “I got all kinds of support. The people over me seemed to understand, you know, how devastating this can be for, for a clinician and
they came to my aid and said if there was anything at all that they could do to help me. And that is crucial.”

The process of suicide assessment itself is something she derives satisfaction from. She said “I feel some adrenaline.” She went on to describe her mindset going into suicide assessments: “I am going in and I am very alert to body language, voice, um… and then like I said, the other things I use as tools. Um…and also I look for, is there a secondary gain?” She finds reporting the result of her assessment to the psychiatrist of record is a significant responsibility. When asked about her reaction to this role she responded by saying “I am humbled by it. I can say if anything I am humbled by it.” Jennifer reported a number of self-care mechanisms that allow her to deal with the pressures of her job. These included walking her dogs, listening to music and seeking out family support. She indicated she felt very fortunate to have the level of support at home that she does. She has also learned to compartmentalize interactions with suicidal clients so she can fully attend to subsequent clients. She also learned that she had to accept the suicides of two people when they occurred. Reflecting on this loss she said: “(T)hey will affect you. They will always affect you. But you know, you look back and you have got to say I did everything I could. I could not have prevented it. And move on. You have to move on.”

It was very clear that Jennifer is passionate about the work she does. Given the opportunity to reflect on her own worldview as it relates to suicide she responded: “I guess I did not realize there are so many unhappy people. We have seen a big increase (in suicide attempts).” She reports the process of suicide assessment is often an inexact
science and puts it this way: “I can’t see inside a person’s head. I can just go by certain things that I see them do, but in the final analysis I don’t know really what they are thinking.” While unsettling, she indicated that she must accept this reality, the inability to know for sure what a client thinks in order to stay in the field.

Jennifer sees taking every client seriously as one of her primary responsibilities, believing the process of suicide assessment is “serious business. Very serious business.” She concludes by summarizing her experience as a crisis counselor in the following way: “I wouldn’t do anything else. I can’t envision myself doing anything else. Because there’s closure, you know. It’s not. I like to go in and I make the evaluation and get the help they need. And then move on to the next one and get the help they need. You feel like at the end of the day that you have accomplished something.”
Participant 12: George

George is a 63-year-old Caucasian man who was interviewed in a therapy room in his office building. He selected the room stating that he felt it would be a comfortable place to discuss the topic of suicide intervention. He noted that the same room we were using was a room where he had personally conducted several suicide assessments during the time of his employment. George is a licensed master’s level social worker who also has licensure to work with the substance abuse population. He has worked in the field of crisis intervention and community mental health treatment for the past ten years.

George looks at suicide assessment in a way that he learned when he started in the field. He begins the process of suicide assessment the moment it is mentioned by a client. “Something is said, spoken of suicide so that a person is demonstrating that they have the thought. And what I am listening for at that point is any sort of plan to complete that and then the ability of the, of that plan to be carried out. The ability of that person. The reality.” Having established the presence of suicidal thinking and a plan to carry it out, George moved to looking at a subjective evaluation of the likelihood that the plan could be accomplished.

He was careful to point out that suicide threats can be a means of leveraging some control over people or over the system. “The lack of housing, the lack of funds for a person to take care of themselves is the motive to the suicide. Is this really an act of despair or is this a way to sort of leverage against the system to get something a person wants? And that dynamic is always going on and will shade the reaction?” Clarifying, he explores the conditions behind the suicidal gesture. “Motive. The intent is really not to
kill one’s self but to get housing for the night. And that might be the hospital.” These factors would lead him to explore alternate treatment options.

When there is no clear indicator of secondary gain he becomes increasingly concerned. “If there are no factors like that then the risk, and my perception of the person’s risk goes way up.” In order to assess people more thoroughly, he has turned to some standard protocols, though he remains wary of their reliability. “I think that it’s the way a person should learn. A person who’s new to doing mental health work and assessing, assessing suicide risk needs some tools, needs some sort of framework to work within. And it’s always helpful to revisit those.”

Experience has allowed him to develop his own style of assessing suicide and an increased respect for the potential for suicide lethality.

(In 10 years of doing this I have gone from becoming rather numb, not paying attention to, um, realizing how lethal it is. Having my own experiences. How its changed me are the memory of people I have known who have successfully suicided. So I…and you know I can tell those stories. I can relate exactly what happened and now I relive everything that led up to that. And because I was doing community work this was not someone that I only saw in a therapy session or once a week. I knew these folks, some of them, for years. Uh, and did community work with them and um, I the…lethality, I think if that is a word, the lethality potential or mortality risk here is so real to me that’s a piece of what I’m assessing. When I listen to people who say every day that they are thinking about suicide. And I attend. In the past I was much more numb to that than I am now. It’s like I always must be listening and weighing how much risk this person is in.

The practice of suicide assessment has had a significant emotional impact on George. While he has lost some people in the past he is able to consider those losses from an objective perspective. He has several steps he follows with everyone and considers them to be important.
It’s all circumstantial. It’s personal to that individual and their circumstances. Uh, its eliminating as many factors as possible and being able…You know these things have to be written up and I have to be able to truthfully write that I left this person in a state that I want them to say that they are okay and that we have come up with a plan. I’ll do contracts. I think that there’s not…empirical evidence does not support contracts but it doesn’t hurt to get one. Get a safety contract. You know, there’s a big difference between a reporting of history and passing thoughts of considering suicide and someone who truly seems to be at risk. If someone is presenting with some risk, to get to a place with that person where they feel safe, we may be entering into some sort of a contract and planning when we’ll, when we will meet again.

Upon completing these steps he tries to leave the person in as safe a place as he can, particularly in the event that the place is not the hospital. He finds the biggest emotional change has been a shift from apathy to caring, coupled with a shift from inattention to complete focus.

Self-care is important to George. He indicated that he was willing to participate in the research project if for no other reason than to have the opportunity to be heard and to process the events he has experienced. He finds he has developed good coping skills that are process oriented. These are particularly important in the event that a client either is close to committing suicide or successfully completes suicide.

I think that I think that I cope pretty well. I think I found some personal peace and um, I don’t know if tranquility is the right word but peace is a good word. In doing what I need to do. I need to come to that point before I can move on to anything else. The job is not really over until I get to that point. Now if I experience the death of someone than that’s a piece of me that each moment like that significantly changes us in ways that don’t go away. At that point it’s kind of incorporated into who I am. I’m sure that it’s made me a better clinician. It’s increased how much, how carefully I listen and assess situations. It doesn’t make it perfect. People may still suicide and I accept that. I go to the funerals if I can. I’ll speak to the family and I truly feel very bad about it. And kind of those feelings about how precious life is and how temporary it is. It will end and the tragedy of when someone takes their own life and how it is and illness. It’s not to blame.
His ability to cope is a quality that he feels has allowed him to remain active in the field as long as he has.

He sees his worldview as culturally unacceptable at some level, yet highly pragmatic. “I mean it’s perfectly rational, can be, that suicide is an option. It’s, from what I have learned about ancient Greece it was culturally acceptable. It was like this is one of the options that a person always has.” Explaining, he offers his thoughts about his worldview. “That doesn’t fit in our culture and I certainly don’t live or practice that but yes, I do think it and consider it and I can see the reasonableness of that. So it’s in that aspect that suicide and the thought of suicide doesn’t shock me.”

Balancing this worldview about suicide are George’s personal views about life. “In the same time I am holding in my mind, my own worldview, that thought along with how precious life is and that we should um, maintain life but more than that, always be working toward that quality of life as well. I think that’s what my work is about. Joining with other people and working on a quality of life. A better life.” Part of what he believes leads people to suicidal thinking is frustration with their circumstances. Helping people manage the futility and tragedy in their lives is a significant part of his work.

I’m a firm believer in hope and better lives. I think that’s essential to mental health. I joke but it’s also pretty solid research that we need unrealistic optimism. We can’t be um, um, concretely objective because the whole of existence would be rather bleak. So, um, I am thankful that I have that. I do love life and I am able to embrace that and help others as well.

Part of why George is able to accept death as a natural occurrence is because of the work he did prior to coming into the mental health field. “I’ve seen all sorts of tragedy and death and dying. I processed that a long time ago and maybe that’s a big step
personally and makes it unique to me.” He said this shift probably was more significant
than the step toward accepting the suicide of a client.

Getting a hold of that reality with mortality. So that’s, that is probably a bigger
shift for me than mental health has been. With the whole death thing. Mental
health is about relationships with the living. And as I said sometimes those
relationships have gone on for years, professional relationships. And then a
person successfully takes their life.

While clearly painful, he sees this eventuality as an occupational hazard of treating the
seriously mentally ill.

Reflecting on life as a larger entity George said:

(T)he reality of human mortality and how frail we are. And we are animals. All of
a sudden I know the similarities between an embalming room, a surgery room and
the grocery store. And the meat counter. That is just shocking and sort of
revolting. And it’s reality. You know, culturally most folks would be pretty
insulated from that. What we do in life, the exchanges that we have are so
precious and important and maybe I have. I always sort of knew that but I have
learned a lot more about it.

Instead of dwelling on the physical he prefers to explore the spiritual aspect of existence.

He feels that life as we know it inherently goes on for a time and then it is done.

Conversely the spiritual world, as he sees it, goes on in some dimension. That is where he
prefers to contemplate life.
Participant 13: Robert

Robert is a 67-year-old Caucasian man. He has a Ph.D. in Clinical Psychology and has worked in the mental health field for nearly 30 years. He approaches clients from a variety of therapeutic perspectives including experiential, person centered and structurally based counseling. He was seen for this interview in his office in a private therapy practice. This is where he typically works with therapy clients.

He begins looking at suicide from a perspective of exploring a sense of hope or hopelessness. He looks at things from a behavioral perspective so it is important for him to know if the suicidal behavior is an operant behavior designed to get a response from others or if it is a real attempt by an individual designed to end their own life. Either way, he sees the operant behavior as a means of producing a change in the person’s environment. Another important factor to consider is the seriousness of the threat presented. Elaborating, he offered the following example:

There was a guy I assessed who was very seriously injured earlier in his life from accidents and he’s thought very seriously about suicide. He’s a hunter sort of guy and he has guns. So in my report I said if he decides to end his life, he has a plan though he is pretty vague about what it is but I don’t need him to be very specific to be able to fill in the dots. He said ‘I’d go out in the woods and I’d have a gun and that would be that.’ Okay I understand that. So as far as, I take that guy at 100% face value in terms of what he said. He said what he meant and he meant what he says. There is not any game playing going on here. If he decides to pull the plug, that’s what’s going to happen.

Robert sees this situation of an example of a person who has enough volition to end his own life if he becomes serious about doing so. From his perspective, if a person really wants to commit suicide they will find a way to do so.
Conversely, he sees acts of suicide as largely impulsive acts. He believes suicide attempts can often be interrupted by simply slowing people down enough to see things more clearly. He also believes it is important to try to get the person to commit to something in the future as a means of preventing suicidal behavior. “That way it’s kind of in their mind ‘I guess I can’t kill myself on Tuesday because I have to see my doctor on Thursday.’ It sounds funny to say it in those simple terms but it works.” The opposite is true as well. If the individual is unwilling to commit to anything in the future, Robert sees that as a sign that there is a significantly higher risk of self harm.

While he does not utilize a specific standardized set of protocols to assess suicide risk potential, he sees himself having a set of tools that every clinician has in their possession. As he sees it, every therapist has three tools and is limited to these three tools only. Explaining he says the following about this:

We as therapists have three main tools. The first one is our brain, how we think. Second one is what we say and our facial expressions and so on. And the third one is where we move. How we position ourselves. Our bodies. Where we stand, where we sit, where we are. Those are the three main tools we have in dealing with a person who’s really upset, whether they are coming in to raise hell with the office staff or whether they’re thinking I’m going to end my life. Those are the three things we have and basically that’s all we have.

While he does not see any utility in the suicide assessment tools that are currently available to therapists, he indicates it would be nice if such a thing were developed. The tool he does find helpful targets disassociation, a problem that he feels is more difficult to identify and target than suicidal ideation.

Robert is very respectful of the autonomy of the clients he treats. “I think of suicide as a choice. So we as therapists need to respect it as a choice.” Elaborating he
described his understanding of the thinking process that could lead a client to consider suicide: “you have to understand suicide is an escape from psychological pain when a person sees no other escape.” He went on to say “in that sense it (suicide) is an operant, an operant behavior. It’s a way to end the pain when there is no other way out.” Concluding he explained “I say it’s important for us clinicians to respect their choice. We can’t prevent them but we can convince them.”

To address this sense of hopelessness he utilizes some tools as a means of refocusing a client. These include consideration of the effect suicide would have on a client’s family, planning things a very short time in the future and even distracting them from suicidal thinking by recalling childhood events and pets. He considers the latter a “bottom of the deck” intervention but has found it to be remarkably effective because it forces the client to consider something in their life that was positive.

Robert has a long history of working with a male population so some of his interventions are specifically targeted to address the things that evoke a response in men.

I’ll say are you going to be okay? Are you thinking of harming yourself? Well okay, now before you leave I need to know. I need to have a clear answer. If they say okay I’ll be all right. And typically this works best with men but also works with women. I will look them in the eye and say do I have your word on that? Most guys want to feel if they have nothing left in this world, they want to feel that their word is good. So if they give me their word, and I’ll say I’ll take your hand. And if they shake my hand, then I feel okay with them walking out the door. And so far I haven’t been wrong.

He feels the relationship between the therapist and client is essential in order to affect a good intervention with a client. While this relationship does not have to be long, Robert believes it does have to be genuine. “The longer you keep them talking, the better chance you have to stumble on what I call a hook. You know you have some sort of a hook and
you can pull them closer.” Explaining he said: “I am also checking all over the place forward and backward for what resources do I have to call on? Uh, things like that. So I’m really focused in on it. Afterwards, then I’ll kind of replay it and see if I did everything right.”

As a world view Robert sees suicide assessment as an integral part of his treatment process. It occurs with any client and with every client. “(In) my mind it’s all one in the same. So I am not conducting a suicide assessment. I am seeing a client to deal with their problems. The problems they bring when they walk in the door. And a suicide assessment is part of that. It’s an integral part of what I do when they walk through the door for the first time, and as I say, it’s always in the back of my mind.”
Participant 14: Sandra

Sandra is a 53-year-old Caucasian woman who was seen in an office located in her private practice. She has been in practice for 6 years as a licensed professional counselor and licensed family therapist (LPC/LLMFT). While she does not work in a practice where crisis work is the norm, she has seen several people over the years she felt presented very serious risks of self-harm.

During her first appointment with any client she looks for suicide risk by considering “family history of suicide, if they themselves have ever attempted suicide, if they have passive suicide ideation. I look for any history or any reporting of any impulsivity disorder.” She is also careful to see how much depression they report and uses a 1-10 ranking scale to gauge the severity of their risk. Of paramount importance is determining if the client has a plan for self-harm in place.

While she does have a book that has a step by step assessment process that she can use to determine suicide risk potential, she find that it is awkward both for her and for the client. “I have book often open on my desk but it’s not like a check list. It is in my head that I am looking at.”

Sandra is a very spiritual person and finds that prayer is very beneficial when she is dealing with the stress associated with suicide assessment. Clarifying she said: “that’s my personal support. I do find, yeah, my anxiety goes up. My heart speeds up. It’s serious and I know it’s serious. I use that facilitative anxiety, hopefully, to keep me sharp. And yeah, I’ll admit those are cases that when I drive home I think about.”

Her view of suicidal behaviors has changed with time.
As younger clinician I was very nervous about that (assessment of suicide). I am less nervous now and frankly have quite a few people with that axis II on my caseload. So I find that I am not as nervous. I am kind of seeing the bigger picture as I was when I first entered the field.

Despite that, she continues to experience a strong emotional response when assessing suicide. “I emotionally do feel some anxiety. Um, I, in the back of my mind I am always asking if I need to get someone else, have another pair of eyes on this case? As backup.”

Going on, she explains, “I find that I can count on other symptoms. My palms get a little sweaty. And just typical symptoms with a little bit of anxiety.”

Her world view has evolved considerably when considering the way people look at suicide. “I really have a deep sense that it’s a mental health issue. And even in my church I have done some, a dialogue with pastors, talked with elders. I am not a part of a faith group that believes if someone were to suicide they would burn in hell, but I am aware that in certain faith denominations that is taught and I am very passionate about getting the word out there that that is not a helpful stance and it leads to so much residual shame and guilt by the survivors.” She uses her client’s faith as a means of helping them through their depression. “It is not my role to change or challenge somebody’s scriptural interpretation, but I consider it very important that I know because um, my experience has been if people have the belief that, um, if they were to suicide, in some ways it acts as a motivator for them.

In the days following particularly stressful interventions she is more attuned to her own needs for self-care. She tries to relax more and diffuse the tension. “A Saturday typically is laundry and cleanup. And I let all that go. I have a relaxation day and just do fun things for my own self care.”
Over time she has gained more confidence in her own ability to manage the crises her clients discuss in therapy sessions. “I feel that I have gained confidence and yet, so I don’t have the kind of anxiety as I did as a new clinician. Um, I have also gained confidence in the team approach.” This allows her to approach her supervisor with problems without fear that she will be seen as incompetent. Now she knows he will not see her as weak, instead viewing him as a resource for resolving problems.
Participant 15: Julie

Julie is a 36-year-old Caucasian woman who has worked in the mental health field for the past six years. She works as a counselor in a school system and serves as a crisis interventionist at a local mental health system after hours and on weekends. She was interviewed by her choice in an office where she works during the school year. She has conducted as many as five suicide interventions in an evening, work she finds both exhausting and satisfying.

Julie uses the prescreen form that her agency developed but augments this in a variety of ways.

I look at so many different factors. One their affect and it’s totally not clinical, but I listen to my gut a lot. It is something that I have learned over the years is what is my gut telling me? Um, though just because it is not scientific at all, it is more often right than my brain is. But I go through everything. I look at how are they presenting? You know I had one recently where I got a call from the hospital saying that she has cuts all over her arms and she’s certainly going to need to be hospitalized. The doctors are incredibly worried about her. And I go in there and she is eating her meal, watching TV, talking on the phone. It was as if I walked in on a regular teenager in her bedroom. There was no anything that made me think what’s going on with her.

While she finds she can get her best information using her own intuition, she finds the prescreen forms are helpful to ascertain that no important information is overlooked during the assessment process. She sees the formatted assessment forms as a template so she is assured that she does not get distracted, nor does she forget to ask every important question. “They are telling me this and they might not necessarily come up with that information on their own. But when you ask them that, it’s when those kind of things come out. So, I find that it helps and it helps me gauge each time the same, in the same format.”
Julie finds that while there are many people she sees who are experiencing a legitimate crisis, very few actually meet the criterion for inpatient hospitalization. “I guess I have gotten more in tune on that, the true suicidal behaviors.” During the process of these assessments she finds herself increasingly focused and better able to focus on details presented by the client. She sees this as an internal gauge to tell her when a situation is truly serious.

In the midst of a suicide evaluation she finds her mood falls outside her own conscience. “I don’t know how to say it other than I really get honed in.” Explaining, Julie indicates “you really have a bit of this constantly telling myself, listen to your gut, listen to your gut. What is your gut saying? Um, and having that…internal dialogue.” The internal dialogue and gut instinct allows her to focus on the situation as she sees it instead of preconceived notions.

I’ve gone in thinking this will be a done deal based on everything that’s been said. I go in and talk to the kid thinking hospitalization is going to happen based on what the parents told me or what the hospital social worker told me. And that’s what I do in thinking. And then I go in and all of a sudden I have that moment of going this is not matching up at all. Where are they getting this from? Am I you know, looking at this in as clear of a fashion as possible? And can I remove everything that everyone else has said to me and hone in on this person first? And get the sense from the particular client and then talk to the parent and see what might else be factoring into this whole thing.

Among the most emotionally taxing events has occurred when she sees very serious symptoms in a child but their parent does not take the threat seriously.

You know that’s when the emotions hit me more and I had a few over the years where you see consistent hospitalizations and not getting better and that can take a toll. That gets very tiring, um emotionally exhausting. Frustration when the parents don’t believe you when you talk about, gosh your child came in today and we talked for an hour and a half and the things they are telling me is telling me you need to come to the school right now and drive them to the E.R.
In the wake of such an event, she finds the remainder of the day exhausting. While this is often self-evident, she once had a neighbor comment about her appearance of physical exhaustion. “He said he could tell. I looked exhausted. You know I can see it on you and he let me debrief. You know, you get drained. Drained is a good word.” Another response following a suicide assessment is some numbness to less serious problems that her clients can bring to her.

If I have dealt with a suicidal student at school and then someone comes in about some girl drama about so and so texted me this and da, da, da, in my head I might be going really? You know? I just talked to someone who might want to end their life, remove their life from this earth and this is your big drama for the day?

Although she recognizes that such a problem is not trivial to the client in front of her, it is difficult to see such events as having the severity that a suicide attempt would, even though she recognizes it is serious to the client. “For that child, that’s their serious, that’s their big thing.”

Julie’s world view has been changed by her work conducting suicide assessments. She is aware of a part of life that many people around her do not see at all. That heightened awareness has increased her own appreciation for facets of life that fall outside most people’s conscience. “I guess it’s an odd term but a special part of life when they’re thinking about ending it you know? Um, special in not a positive way, but it is a unique and special way.” Explaining this further, she looks at things this way:

I feel like I get to see more of, of human nature than other people do. And so I think it makes me respect being, you know, being a human being and respecting life in a different way than others might. Because you see it in the darkest of dark times and but you also see it in good lights too because you see people really come together to support um, people around them. But you can also see signs when there is no support. And you see all of the dysfunction. You know? And there are times when you are doing not necessarily suicide interventions but
critical incident interventions where I start feeling like what is this world, what is this country coming to? Because you only start seeing those things in your job. And so that gets really frustrating as well.

She addresses the frustration she feels by trying to recognize she can only change one person or one family at a time, and only a little each time she sees them. To cope with frustrating times she turns to her kids and her husband. “Sometimes the best thing I can do is just go home and hug them.”
Participant 16: Garrard

Garrard is a 63-year-old Caucasian male who holds a master’s degree in Counseling Psychology. He has been a part time practitioner for the past 18 years in a public mental health outpatient clinic. He sees between 10 and 20 clients weekly. He tends to approach clients from a psychodynamic or cognitive behavioral perspective. Our interview was conducted in his office where he typically meets clients for therapy.

His approach to suicide assessment is fairly typical. He wants to know how active their thinking about suicide has been, the specificity of the plan and the client’s ability to access the plan. A more unique aspect if his assessment process involves assessing the energy level of a client. “If they are really unmotivated in other areas, most likely they are not going to act at this time. But if their energy level is increasing, or if there is any note on their part of ‘everything is okay. I’m all right.’ Then I know they have made a decision already in their mind.”

Garrard feels assessment tools are useful in his practice.

I’m trying to assess somebody like that, my adrenaline starts going because I realize I’ve got somebody’s life in my hand. And if my adrenaline is flowing, I might not be thinking as logically as I might otherwise because I am sensing some urgency or some panic or some anxiety myself, which can cloud my vision. So if I’ve got this tool with the questions to ask so I’m not groping. What should I ask, and just buzz down that, it helps me stay focused.

He finds because he is increasingly aware of the possibility of suicidal thinking, he has more anxiety just when considering the factors that could lead to suicidal behaviors. “I am thinking in those terms of could this person be harboring these thoughts?”
He has a very strong sense of responsibility, particularly for those clients that he sees as posing a high risk during their first session with him. “Generally I try to confer with someone else to make sure that I am not missing anything because I have a strong faith base. I have before leaving for work I’ll have a prayer for that person. So I am much more aware that life is valuable and I have a greater responsibility for that.” Continuing he discussed how he is affected by interactions with those who appear to have the greatest risk of self-harm. “Depending on the severity of that, sometimes it affects me for the rest of the time after I see that client until I see them again. I am very conscious of that. And then there is the risk of my own licensure. You know? I miss it and something happens what will that do to me?”

Among the most significant barriers to conducting an adequate suicide assessment was a factor identified by several other therapists, time. Garrard explained this problem in detail.

Because it’s like on Monday I come in at 9:00 and I’m on the go. I take a ½ hour lunch break and a ½ hour supper break and then at 8:00 when I wrap up I have probably on some days, probably an hour of paperwork to do. And when you are seeing clients back to back to back it makes it really hard to get through that. Plus on our initial assessment when we pick up on that when we see the client for the first time, you’ve got so much paperwork to do when you are doing that first time assessment, that you always feel pressured; how can I cram all of this in? And adequately do justice to it.

Trying to fit everything into his day tends to lead to an increased feeling of anxiety and adrenaline, fueled in part by his sense of responsibility. “Gotta get this thing right because I have this person’s life in my hands.”

To manage this anxiety, Garrard turns to his sense of faith to cope and sooth himself.
Well for me, as I mentioned before, you know, uh, my faith helps me with that because I pray and commit that person to God knowing that I have done the best that I can do, so I suppose for a person that is not faith based, cognitive restructuring. Taking that irrational thought that I am really entirely involved in making a decision that is going to affect this person’s life forever, well, tell myself that, that person has their own choice and I can’t go home with that one. If they are wanting to do it they are going to do it. You know, sort of self-talk stuff.

He finds that fully focusing on the next client can be a challenge.

It’s sometimes difficult after having a session like that where that person is highly suicidal but in the next session, particularly the next session after that you have to keep bringing your mind back to focus on this person is with you right now because you mind wanders to did I cover all the bases with that? Did I do this? Did I do that? You know? Trying to make sure that you did the best assessment that you could have. Uh, so sometimes it’s hard to shut that down.

With some time, however, he finds he is better able to fully concentrate on the needs presented by each of the clients that follow a suicidal individual.

Garrard reflected on the changes he has made in his own worldview in the wake of many years of treating seriously disturbed individuals. He notes the experience has heightened his own value of life. It has also been humbling. “It gives you that sense of your own vulnerability.” He fully recognizes that therapists are just as susceptible to mental instability as the general populace. Underscoring that point, he described the feelings he had when one of his colleagues committed suicide. “If he can fall prey to that, what can bring us to that point?”

This reflection has stimulated some changes he has made in his own life. He developed a “strong desire to practice what I preach.” He described a time when his first wife died. “I made sure I took good care of myself so I did not get clinically depressed. I did my exercising. I did my forcing of myself to be with other people. Not to isolate even though I wanted to do that.” Other things he feels are important include “Eating right.
Trying to get the right amount of sleep. All of those practical behavioral things I tell other people to do.”

Garrard is vividly aware of a risk for therapists, being drawn into the very problem that a client is trying to resolve.

I think when you’re with somebody who is in a panic mode, that if you are not careful, uh, you find yourself slipping that way yourself. Grasping for straws. What can I do to help this person? What can I say? And when they leave there is this whole sense of discomfort within yourself. Like I know if I see someone who has some psychotic stuff going on, but I don’t recognize it, as the session is going on I’m feeling more and more crazy, all of a sudden I am saying “uh oh.” That’s the tip off right there. If I’m feeling crazy, that must be what they are doing. It does rub off on you.

He sees this as particularly true when intervening with a client who is experiencing real desperation. “That is when you have to be self-aware.”

The changes he has made over time have been significant over time. Today he is very cautious about being flippant and being careful that a client really understands what he means.

It’s been 18 years. And I personally have not had a client during that time ever complete. Uh, (long pause), I may be missing your point here but I think of a client I had last year who was sharing with me, some crazy stuff she was doing so I thought I’m going to say something to kind of shock her into thinking more in reality about the decision she was making. And the next week she did attempt. She actually coded and they had to revive her to bring her back. And this was a big wake up call for me after having been in the field for so long you begin to take your skills for granted. And it, maybe not be as careful. And it made me realize to be very, very careful when what I say to people and how I handle that.

Going on, he said that his statements were perceived incorrectly by his client. “Because the next session, after she got out of the hospital, she said, you said that and I thought what’s the use of living?” Garrard found he had no choice but to take ownership of this
situation and learn from it as best as he could. He has learned to be more cautious but to accept responsibility for his own mistakes.
Participant 17: Fred

Fred is a 51-year-old Caucasian male who has been in the field of counseling psychology and crisis intervention for the past 21 years. He was interviewed at his office at his home where he occasionally does some of his practice work. This was his request because he indicated if he met me in his own office he would be too inclined to work more hours at the conclusion of the interview. He has a busy practice, and typically sees at least 20 clients per week. He holds a Ph. D. in Counseling Psychology and uses a combination of psychodynamic and CBT models of treatment.

Fred begins crisis assessments with what he sees as a standard assessment of suicide risk potential involving assessing the client’s plan, ability to access the plan and the lethality of the plan. This he sees as routine. Augmenting these questions is a thorough mental status exam. He explains:

I want to look at family dynamics in the history. I’ll look for, has there been a history of suicide in the family? Recent losses? Their perception of those losses. How they’re managing them. I look for, if I’m really concerned I’ll do a…I’ll look at their support system. People you can access. Um, I’ll do testing sometimes. I’ll do a Rorschach, more of a projective testing to look at their level of pain and how they are regulating affect. And cognition at the times. And I will see if I can secure a contract if they have done that in the past. I’ll look at other factors like, um, are they single? Do they have a support system? How well is their support? And that’s pretty much…I can’t think of anything else.

Augmenting this assessment, he continues by making a determination of the true risk posed by the client.

If they definitively have a plan to do it, to me that’s very serious. If there is a history of suicide attempts that were serious, that is serious to me, particularly if the context of the old situation matches the situation. I also look at them cognitively. How narrow and rigid are their problem solving capacities at the time? Are they inflexible? Do they see themselves as having any options? Are
they constricted affectively? You know? That affected constriction. An obsessive compulsive pattern. Um, I um, and also where has their energy levels been lately? Have they been giving away stuff? I usually like to contact externals. Have there been any odd changes in behaviors? Any tells, any tells that would indicate disturbances? This kind of stuff? And I look at their energy levels too. Usually if there is lethargy, fatigue, they are automatically beginning to get a boost of energy, things like that make me a little more concerned.

While he sees this kind of in depth interview offering significant value when assessing the risk of a client committing suicide, he sees most instruments offering value only when used in conjunction with a good interview.

When faced with suicidal people, he has made some fairly significant changes in his practice over the past 21 years. “As soon as I have a suicidal client, I get a bunch of people in the bathtub with me. I will refer up the hilt.” He elaborated. “I will include externals into that. I will gather external to make sure I’m not alone in this whole thing.” He includes family members, substance abuse interventionists, and medical professionals and has psychiatrists he feels are competent to intervene when serious crisis situations arise.

Fred finds crisis work can be a serious struggle emotionally and because of the time commitment involved in completing a proper intervention.

I get frustrated. I get anxious. I get, you know, like oh no. How long is this going to take? I’m booked for a half hour or an hour all day long. I don’t take a lunch or anything. So I know that I am going to have to cancel somebody or move somebody to the end of the day. So you have to resist. For me, if you want to talk about therapist issues, it’s resisting doing a minimal assessment. ‘Cause you want to grasp onto something, yeah, they’ll be okay. But you have to just say whatever is in front of me, I’m going to have to let go of right now. And deal with it. Or if I have a court demand it’s kind of hard too.

The emotional impact he feels is quite significant. “It will sometimes, ruin your day and you go home wondering and worrying and anxious about it. You feel like you
have done everything but what if? The what if comes up.” Going on, he explained what
he meant. “It gets into fear of the person dying, fearing of losing your license, fear of a
lawsuit, fear of losing everything. You can go into a pit real fast.” He explained that he
can find himself ruminating about these things.

He has changed his view of the people who consider suicide. “Definitely what has
changed is the judgmental aspects of it. I think when you first come into it you don’t get a
grasp of how severely people are grappling with pain. And you kind of say buck up, it’s
not an emotion.” He now sees this view as unhelpful. Reflecting on the emotional impact
associated with having someone come close to completing suicide he shared the
following. “I have kind of accepted, after 21 years you kind of accept that you have a lot
of people with mental health issues and this is what you are going to get. I just…it’s part
and parcel.” Elaborating, he said, “I don’t expect much anymore. It’s always a bear. I’ll
send them to the ER. I’ll send them to a psychiatrist. Try to call in a favor but it’s very
hard. And then the follow-up is very stressful. So say you have somebody on a contract,
you have to make sure you aren’t busy enough to follow up with them the next day. ”

The barriers to proper intervention with a suicidal individual are significant. “I
don’t trust the support system. I was unable to get um a referral that I wanted to get.
Mental health didn’t respond. Those types of things.” If he finds he is unable to separate
from the crisis he has encountered he has identified a simple solution. “I cancel, you
know? I found I’ll be better for you the next day. I’ve found if it’s a bad one, it’s
probably once a year but I just cancel. Or I’ll just tell them I’m not going to do them any
good. It’s a big issue, you know?”
He has made a significant change in his practice when it comes to treating people who are chronically suicidal. “If there’s a chronically suicidal individual with a history, I won’t take them anymore. I’m too busy. The court jerks me around. So I just won’t take them. I’m lucky enough in my practice to pick who I want so I get enough coming in so I can filter. So I just refer out.” He has also identified a way to act proactively as a means of discouraging problematic behaviors.

And then I also, another thing that’s changed is my initial framework for entering a contract with a client. I’ll tell them I’m not an emergency room. I’m not available at 4:00 in the morning to try to talk you out of a suicide. I give them options. If you want me as a therapist, yes I would be happy to work with you but this are the parameters I am working under. So it’s made me more aware, acutely aware of what I need to do up front. To prevent. And I can always say we talked about this in the past. And I can also say if you need more than that then I’m not good enough for you. And we need to extend some individuals into psychiatry.

Part of the difficulty he experiences is the fear he has when people present a serious risk. Homicide risk, suicide risk, sex offender risk, homicide and suicide run about the same for me. The scariness of it. Of course homicide risk is easier to predict than suicide. Cause we have better scales and measures. You can actually; we have for sex offenders scales that are pretty decent. Not suicide as much. Not that I’ve seen anyway.

Fred has made significant changes philosophically in the time he has been assessing suicide. This has included considering his own spiritual background and beliefs about suicide in conjunction with those of his clients.

What is suicide? Schneidman’s work …the issue of what is suicide? The issue is like when someone who I have talked to, it’s almost like they are disassociated, it’s a repetitive action that is outside of themselves. It that, you know, the idea, when I look at early Christianity, I think it was an effort from the church to say you’d better not do that. We tied salvation to it so if you do it you burn in Hell for
eternity right? I’m not sure I buy that. It’s not in me to judge. So that’s kind of changed. ‘Cause when people do it they don’t see themselves as having options. Then you can get into the philosophical, what is suicide then? From a religious standpoint, did Jesus commit suicide as he walked down into, on the donkey knowing he was going to be killed? It is suicide or is it martyrdom? I mean, what is, the whole definition becomes what is suicide? Yeah, so it’s taken me out of that, not to judge, just to do all you can to prevent and then it’s up to them.

Fred has started looking at suicidal behavior as a product of anger. Increasingly he sees suicidal behavior as an expression of anger turned inwardly. He does not see this as a new idea.

The Menninger idea that suicide is I want to kill, I want to be killed and the narcissistic idea that one can determine one’s own destiny. They said Freud’s suicide was about that. He wanted to control. He had mouth cancer. But there’s also a lot of rage directed toward yourself. You want to kill yourself but it should be externalized somewhere. And the rigidity and dissociative aspects are very interesting.

Expanding on this idea, Fred described the difficulty he experiences when trying to stay engaged with chronically suicidal people.

Personally, I have to, when I have a suicidal client; I have to work to remain engaged because I just want to detach myself. First I become vigilant. My pattern is, first I become very vigilant, and I move toward them to try to do everything. Then I set up this scenario where I’m the rescuer. And the rescuer um, I’m the rescuer and they are the victim, then I withdraw and become the persecutor right? So there’s the dynamic that’s set up by suicides. So I’m careful to maintain a boundary within that. ’Cause I’ve had the experience with personality disorders where you chase them and get exhausted and you withdraw and then it’s tiresome. And so that’s when you say you know I could be paid just as much driving a big truck cross country delivering a load somewhere.
Appendix G

Human Subjects Institutional Review Board
Letters of Approval
Date: January 12, 2011

To: Alan Hovestadt, Principal Investigator
    Eric Macleod, Student Investigator for dissertation

From: Amy Naugle, Ph.D., Chair

Re: HSIRB Project Number: 10-12-07

This letter will serve as confirmation that your research project titled “A Qualitative Examination of Therapist’s Perspectives of Suicide Assessment and Intervention” has been approved under the expedited category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note that you may only conduct this research exactly in the form it was approved. You must seek specific board approval for any changes in this project. You must also seek reapproval if the project extends beyond the termination date noted below. In addition if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: January 12, 2012
Date: December 12, 2012

To: Alan Hovestadt, Principal Investigator  
   Eric Macleod, Student Investigator for dissertation  

From: Amy Naugle, Ph.D., Chair  

Re: HSIRB Project Number: 12-12-12  

This letter will serve as confirmation that your research project titled “A Qualitative Examination of Therapist’s Perspectives of Suicide Assessment and Intervention” has been approved under the exempt category of review by the Human Subjects Institutional Review Board. The conditions and duration of this approval are specified in the Policies of Western Michigan University. You may now begin to implement the research as described in the application.

Please note: This research may only be conducted exactly in the form it was approved. You must seek specific board approval for any changes in this project (e.g., you must request a post approval change to enroll subjects beyond the number stated in your application under “Number of subjects you want to complete the study”). Failure to obtain approval for changes will result in a protocol deviation. In addition, if there are any unanticipated adverse reactions or unanticipated events associated with the conduct of this research, you should immediately suspend the project and contact the Chair of the HSIRB for consultation.

Reapproval of the project is required if it extends beyond the termination date stated below.

The Board wishes you success in the pursuit of your research goals.

Approval Termination: December 12, 2013