Wounded Healer or Stigmatized Healer?  
First-Person Experience With Suicidality Among Helping Professionals in  
Suicide Prevention and Intervention

by

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of the Requirements for the Degree of  

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We acknowledge with respect the Lekwungen peoples on whose traditional territory the  
university stands and the Songhees, Esquimalt and WSÁNEĆ peoples whose historical  
relationships with the land continue to this day.
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Abstract

This study sought to explore the experiences of helping professionals who have first-hand lived experience with suicidal ideation or suicidal behaviour and who work with suicidal people.

The research is placed in the context of the wounded healer discourse. Within the helping professions, the term ‘wounded healer’ refers to the idea that a healer’s lived experience of being ‘wounded’, i.e., suffering harm or violence or facing psychological or addiction challenges, is inherently helpful to their healing abilities. While a growing body of literature about the wounded healer concept exists for helping professions with some experiences, such as mental health practitioners who experience mental health challenges, this research project focuses specifically on the under-researched area of suicide.

The study was conducted from an insider perspective. It utilized narrative methodology with a feminist and intersectional lens to analyze the stories gathered from semi-structured interviews with five helping professionals from a variety of professional backgrounds who work with suicidal people.

The findings of the study indicate that, while the wounded healers who were interviewed believe that their lived experience benefits their practice and the people with whom they work, lived experience with suicidality remains a taboo among professionals in suicide prevention and intervention. Certain features of the wounded healer discourse, namely that some wounded healers can become impaired professionals and put the healing process and thus the client at risk, have contributed to this taboo.

This study aims to contribute to the conversation about what it means to be a helping professional with lived experience with suicidality in the area of suicide prevention and intervention, and thus to lessening the stigma surrounding this experience.
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Last but not least, thank you to the wounded healers in suicide prevention and intervention who continue to inspire me. I look forward to creating a more inclusive narrative with you.
But in the end, stories are about one person saying to another: This is the way it feels to me. Can you understand what I’m saying? Does it also feel this way to you?

_**Kazuo Ishiguro**_

I want my words to reflect my way of thinking, being and doing, and it’s difficult at times to balance what I think I’m supposed to write with my sense of self, so I get knotted up inside.

_**Kathleen E. Absolon**_
Chapter One: Introduction

This research project explores the experiences of helping professionals who have lived experience with suicidal ideation or suicidal behaviour and who work with suicidal people. I am interested in the meaning-making that occurs for these professionals as they engage with people who are dealing with suicidality.

The concept of the wounded healer is concerned with the notion that a healer who has been wounded may be better able to help others, as a result of being able to draw on their lived experience. In Western traditions, the archetype of the wounded healer, as conceptualized by Carl Jung for therapeutic practice, has its origins in the Greek myth of the immortal centaur, Chiron. Chiron, who was dealing with severe and incurable pain after being wounded by a poisoned arrow, was known as a great healer and teacher to other healers. (Benziman, Kannai, & Ahmad, 2012; Conchar & Repper, 2014). Variations of the concept the wounded healer are common in Shamanism, as well as Christian, Jewish, and Muslim and other traditions (Benziman et al., 2012; France & Rodriguez, n.d.).

I came to this project wondering why it is becoming more socially and professionally acceptable to be a wounded healer who uses her lived experience with issues such as addiction, mental health difficulties, or trauma, but not the experience of suicidality. I believe that disclosing aspects of one’s mental health difficulties, for example, can play a positive role in one’s work. Despite this conviction, I have never shared my lived experience with suicidality with my clients, or, until I began to prepare for this study, my colleagues, or friends and family. The topic of suicide is close to my heart. People close to me have contemplated suicide and died by suicide, and, while I have never planned or attempted suicide, I have at different times throughout my life felt that continuing to live constituted an almost insurmountable challenge
(Reed, 2017). I am drawn to Hjelmeland et al.’s (2008) term “life-weariness” to describe my feelings of suicidality (p. 22). I struggle for accuracy here as I want to be respectful when I name my experience. I do not want to shy away from aligning myself with those who have planned or attempted to end their lives, and, at the same time, I do not want to take up a position that is not mine to inhabit.

I believe that being a wounded healer has great potential to create common ground in my working relationships in the context of suicide, just as it has in the context of mental health, and suicide prevention has almost always been part of my work. Yet, I have never discussed my thoughts of life-weariness with anyone I have provided services to. In my experience, this is not unusual. It is rare to hear helping professionals speak about their lived experience with suicidal thoughts or behaviour. However, the few times that I have witnessed such stories being told, they have impacted me greatly and have left me interested in understanding how we who provide services to suicidal people navigate our own lived experiences with suicide, the stigma surrounding this topic and the decision whether or not to disclose this in our work to those we provide services to. This is the basis for this project.

**The Thesis**

Following this introduction, I will provide an overview of literature relevant to the topic in Chapter Two. In Chapter Three, I will outline the narrative framework that I have applied in this study, my reasons for choosing this methodological approach, and, in detail, how I conducted the study. Chapter Four will then detail my analysis, first by analyzing individual interviews, then by placing the interviews in conversation with each other. Lastly, Chapter Five contains the discussion of my findings and conclusion, and I also speak to implications of the study, reflections on the research process, limitations, and opportunities for future research.
A Note on Language

At this point, I want to address some of the language used in this paper. I struggle with the use of the term ‘client’ in the helping context, as it sets up a dichotomy between the (well) professional and the (ill) client, and thus denotes a formalized hierarchical relationship (Cvetovac & Adame, 2017). However, I am using the term ‘client’ within this paper as a term that offers the greatest neutrality when describing the people participants work with, thus not identifying individual workplaces.

Given the power of language, especially in an area where people deal with stigma, such as the mental health field, the terms used to describe individuals carry great meaning (Church, 2014; Granello & Gibbs, 2016). There are a variety of opinions about what terms are most appropriate, which has changed and continues to change over time. For this paper, I have chosen to use the terms ‘mental health concerns’, ‘mental health difficulties’, and ‘mental health problems’ interchangeably in combination with person-first language (e.g. ‘people with mental health difficulties’), as it feels most comfortable to me at this time. With respect to participants’ speech, I directly quote the language they are using, unless it would result in disclosing identifying details.
Chapter Two: Literature Review

At the core of this study are the stories of professionals who have first-hand lived experience with suicide and who work with suicidal people. In order to place the study in the context of existing research, I will provide a review of literature in relation to this topic.

The Wounded Healer Archetype

Within the helping professions, the term ‘wounded healer’ refers to the idea that a healer’s woundedness is inherently helpful to their healing abilities in a variety of ways, for example, knowledge of symptoms, diagnoses, and treatment, or increased empathy (see, e.g., Benziman et al., 2012; Cvetovac & Adame, 2017; Jackson & Ta, 2001).

Outside of contemporary Western helping traditions, the concept of the wounded healer can be found in a variety of contexts (Benziman et al., 2012; Jackson & Ta, 2001). For example, woundedness is a deeply imbedded idea in shamanism. It is regarded as necessary that shamans have suffered, either psychologically or physically or both, in order to be able to treat and heal others. Being wounded is thus a required step on the path to becoming a shaman: It is an important part of the training process, as it allows the shaman to gain the necessary skills to be a healer. The presence of wounds is further seen as a sign that the person is chosen as a healer. Variations of the concept of the wounded healer are also common in Christian, Jewish, and Muslim traditions, and can be identified in Arthurian legends and in the Norse tales, as well as in Eastern sources (Benziman et al., 2012; France & Rodriguez, n.d.).

In a Western psychology context, the archetype of the wounded healer was first conceptualized by Carl Jung in his 1951 work “Fundamental Questions of Psychotherapy”. He later wrote in his autobiography that “only the wounded physician heals” (Jung, 1963, p. 134, as
cited in Corney, 2016). Following Jung, the concept was taken up in helping professions beyond analytical psychology.

The origins of the wounded healer archetype are most commonly seen as located in the Greek myth of the immortal centaur, Chiron (Benziman et al., 2012; Jackson & Ta, 2001). Chiron is described as having great skills in medicine, and he was also admired as a teacher to other healers. He was accidentally wounded by a poisoned arrow, which left him with severe and incurable pain. However, he continued to tend to others’ wounds while he suffered. Despite being an accomplished healer, he was unable to heal himself. He only became free of suffering when he eventually relinquished his immortality to Prometheus in order to save him and was so able to die a meaningful death in the service of someone else (Benziman et al., 2012; Conchar & Repper, 2014).

In their retelling of the myth of Chiron, Benziman et al. (2012) stress Chiron’s continued woundedness as an important motif. They also draw attention to this point in their retelling of a story from Islamic culture, that of Abu Bakr Muhammad Ibn Zakariya Al-Razi (ca. 865-925). Al-Razi was a physician who suffered from a severe eye disease which eventually led to him becoming blind, at which point he declined being healed. He ended up writing one of the most important books on eye disease and blindness of his time, and Benziman et al. (2012) note that it is possible that he was mainly able to accomplish this because of his own experience of continued ailment.

While Benziman et al. (2012) highlight the ongoing woundedness of the healer as a positive feature of the wounded healer discourse, other authors stress that wounded healers have to have recovered from their woundedness. This is because, as Zerubavel and Wright (2012) note, “being wounded in itself does not produce the potential to heal” (p. 482), but it is the
“lessons learned that later serve constructive purposes” (Jackson & Ta, 2001, p.2). However, the literature does not clearly define to what degree the wounds of the healer must have healed to allow the healer to have learned said lessons and to be able to apply them in their work with clients.

Cvetovic and Adame (2017) illustrate the broad range of opinions on this matter by pointing to two contrasting viewpoints. They cite Hayes (2002) who suggests that it is not necessarily for a therapist to have fully recovered, as long as they are a step ahead of the client in the healing process. On the other end of the spectrum, they cite Costin and Johnson’s (2002) belief that therapists must have fully left their wounds behind before working with clients. Corney (2016) explores the question of the wounded healer’s recovery process further in his doctoral thesis about how therapists recovering from depression know that they have sufficiently recovered before they return to work, suggesting that insufficient recovery is possible as well.

There appear to be some differences in the way wounded healers are viewed within different helping contexts. As an example, the presence of people who are themselves recovering from substance use issues, and who openly speak about this experience, is common in that area of helping (Jackson & Ta, 2001; Shadley & Harvey, 2013). As Shadley and Harvey note, this may be related to the origins of substance use treatment, when it was primarily people who had lived experience in the area who were willing to support others in a helping role, due to the stigma attached to substance use issues. Similarly, people with lived experience are also represented openly within eating disorders treatment (Jackson & Ta, 2001; Zerubavel & Wright, 2012). Within mental health contexts, people with lived experience are present in the role of peer support workers, though these roles are seen as separate from mental health clinicians, such as therapists and others (Conchar & Repper, 2014; Faulkner, 2017).
While there is no consensus in the literature about the degree of healing that is ‘required’, most authors agree that there is a potential danger to the helping relationship and thus the client, when healers insufficiently deal with their wounds. These healers run the risk of becoming “impaired professionals” (Jackson & Ta, 2001; Zerubavel & Wright, 2012). This dichotomy of wounded healer/impaired professional is widely discussed in the literature, with the impaired professional understood as a healer whose wounds negatively affect their healing work (Jackson & Ta, 2001; Zerubavel & Wright, 2012). It is important to note the terminology used here: Within this dichotomy, and as a result of their impairment, impaired professionals are no longer referred to as ‘healers’.

**The Wounded Healer in Practice**

A number of studies have examined the wounded healer concept in practice, primarily in the mental health context. Conchar and Repper (2014), writing in the United Kingdom, and Zerubavel and Wright (2012), writing in the US, review existing literature about the concept of the wounded healer within mental health, substance use, and eating disorders treatment. The authors critically examine whether therapeutic effectiveness is enhanced if a helping professional has lived experience with the same concerns as their clients. Both texts arrive at a positive evaluation of the concept of the wounded healer, with the condition that the practitioner’s wounds have sufficiently healed, or they are at least aware of and have attended to their wounds.

In Conchar and Repper’s (2014) review, the wounded healer is perceived as being able to provide “more empathic, efficient and effective services” (p. 40). From a client perspective, witnessing a therapist “surviving/having survived mental illness”, is seen as helpful (p. 40). Zerubavel and Wright (2012) note that it is not sufficient for a practitioner to be wounded, and (some) recovery must have occurred because the healing potential for the client is “generated
through the process of recovery” in the practitioner (p. 482). As noted above, the authors also
draw a distinction between the “wounded healer” and the “impaired professional” whose
woundedness adversely affects the therapeutic relationship (p.482).

A separate point of discussion is whether wounds should be disclosed by the practitioner.
Conchar and Repper (2014) only touch on the concept of practitioner self-disclosure in passing.
They refer to Catholic priest and psychologist, Henri Nouwen, who, in the context of pastoral
care, believed that wounds should stay concealed.

In contrast, Zerubavel and Wright (2012) examine the issue of self-disclosure
extensively. They note that the therapist’s motivation for sharing their lived experience must be
the best interest of the client. The disclosure can remain superficial and generic, and supervision
should be sought in this context. The authors cite a number of studies that speak to practitioner
self-disclosure being predominantly well received by clients, and that suggest that it promotes
client healing. Further, self-disclosure may signal to clients that the practitioner is comfortable
speaking about difficult topics and therefore allows the client to share more easily. Conversely,
they also cite other studies that conclude that clients may react in a negative way to the
disclosure because they feel that it takes away from a focus on them in therapy, or because they
wish not to know personal information about the therapist.

Both texts, as well as Jackson’s (2001) overview of the history of the wounded healer
concept, express the belief that the divide between the roles of practitioner and client can be
overcome when the worlds of wellness and illness are bridged by the wounds of the healer
(Conchar & Repper, 2014, p. 40). Jackson, quoting Guggenbühl-Craig, relates the separateness
between helper and client to issues of power: “This sort of experience [being a wounded healer]
makes of the doctor the patient’s brother rather than his master” (p.23). This last point is also
echoed by Zerubawel and Wright (2012), who note that practitioner self-disclosure has the potential to redistribute power in the helping relationship through mutual sharing.

At the time of this writing, I was not able to locate studies that spoke to the experiences of wounded healers specifically in the area of suicide. However, I reviewed a number of studies that exist for other areas, such as mental health difficulties (A. L. Adame, Morsey, Bassman, & Yates, 2017; Cvetovac & Adame, 2017; Davison, 2013; Gilbert & Stickley, 2012; Kern, 2014; Martin-Calero Medrano, 2016; Oates, Drey, & Jones, 2017; Streeter, 2018), and trauma (Zosky, 2013). These studies explore the experiences and beliefs of a variety of helping professionals, including mental health nurses, therapists, as well as social work and nursing students. Their findings speak to how participants’ lived experience interacts with their professional context, and specifically discuss if this experience can be considered helpful in the healing relationship.

Overall, having lived experience with the issue one is tasked to assist clients with is seen as helpful. It is believed to increase the practitioners’ ability to understand clients’ concerns more fully, both “intellectually” and “empathically”, as Gilbert and Strickley (2012) note about the findings from a study examining the experiences of undergraduate social work and mental health nursing students (p.37). Similarly, though less definitively, Zosky (2013) remarks on the possibility of a positive impact of social work students’ lived experience of family violence and other trauma, as it may enable them to show greater empathy towards clients.

In her study of clinical and counselling psychologists, Davison (2013) notes that her participants’ experience as wounded healers varied in this respect. At times they felt that their experience enhanced their practice, while it at other times could decrease empathy towards certain client groups. Having lived experience with mental health difficulties sometimes also presented a challenge to the wellbeing of the professional, especially when work with clients
brought up unresolved or unexamined issues. These findings are echoed in the studies by Cvetovac and Adame (2017), Oates et al. (2017), and Streeter (2017).

The research speaks to self-disclosure as a separate issue, with findings overwhelmingly pointing to self-disclosure being a judicious act that is "exceptional" and rarely used (Oates, 2017, p.476). When and how practitioners use self-disclosure is influenced by beliefs about professional boundaries and relationships (Gilbert & Strickley, 2012), but also by the comfort level of the practitioner related to their wounds (Davison, 2013). Experience with and fear of stigma and discrimination, potentially leading to professional repercussions, is also widely discussed in the context of professional self-disclosure to clients, colleagues, and superiors (e.g. Martin-Calero Medrano, 2016). The nature of the professional’s wound plays a significant role here, as some wounds and their treatment carry greater stigma than others. Cvetovac and Adame (2017) name as examples schizophrenia and bipolar disorder, as well as inpatient psychiatric care.

As noted above, at this time, there do not appear to be any studies that investigate the stories of wounded healers in the area of suicide in ways that are comparable to the literature available for the area of mental health. Rimkeviciene, Hawgood, O’Gorman, and De Leo's (2015) article may provide some insight into one possible reason for this gap. Discussing the findings from their study on the personal stigma that people who attempted suicide feel, they caution against “normalizing” the act of suicide, as the fear prevails that this may lead to more suicides (p. 592). It is not made entirely clear in the text what would constitute the act of “normalizing”; however, the article echoes views that talking about suicide is potentially dangerous and to be approached with caution. Paradoxically and problematically, Rimkeviciene et al. note in the same article that a causal link has not been established between the social
acceptability of suicide, which I assume refers to the above-mentioned normalization of the act of suicide, and higher suicide rates, but that “stigmatizing attitudes [towards people who have attempted suicide] may further perpetuate suicidal thoughts” in people already at risk (p. 597).

As I note in the section on ethical considerations in Chapter Three, research investigating the potential risks inherent in speaking about suicide in different contexts has shown that opening up the conversation in research and therapeutic contexts has more potential benefits than drawbacks for people who experience suicidality (Dazzi, Gribble, Wessely, & Fear, 2014).

**Quantitative Research: Personal Experience With Suicide**

While no qualitative studies about practitioners’ lived experience with suicide could be located, I found a small number of quantitative studies dealing with the lived experience of service providers in the area of suicide. However, this research largely focuses on how their lived experience affects the practitioners’ ability to intervene in clients’ suicidal crises. This can be seen in studies by Neimeyer et al. (2001), and Wallin & Runeson (2003). Additionally, a study by Hjelmeland et al. (2008) examined lived experience with suicidal behaviour in the context of how suicide and suicide prevention are viewed in different countries. This was done with an eye towards creating country-specific, appropriate, and effective suicide intervention strategies.

While Hjelmeland et al.’s (2008) study does not speak to this, neither Wallin and Runeson (2003) nor Neimeyer et al. (2001) find that personal experience of suicidality increases empathy towards suicidal people or the quality of interventions in suicidal crises. In fact, Wallin and Runeson, in their exploration of medical students’ attitudes towards suicide and suicidal patients, hypothesize the opposite, namely that participants’ experience with suicide, and attitudes flowing from this, interfere with their ability to understand the needs of suicidal patients adequately and do not improve empathy (p. 333). Neimeyer et al. (2001) similarly correlate
participants’ personal histories of suicidal behaviours with poorer skills in the area of suicide intervention.

These studies use quantitative methods, such as questionnaires, to gather data, and standardized test inventories to measure competence in the area of suicide intervention. Their focus is on questions of effectiveness, and the voices of the participants themselves cannot be heard. It is difficult to compare this research to the qualitative research that examines the experiences of helping professionals with lived experience in other areas, such as mental health.

Approaching the topic of the impact of lived experience with suicide in practitioners in suicide prevention in this way also leads to a reductionist view on a complex issue (White, 2016). Questions about meaning-making from the perspective of the helper, which are in some form taken up in the wounded healer literature that was reviewed here and that focuses on other areas of lived experience, are not touched upon in the existing literature about suicide.

**Beyond Dominant Discourses in Mental Health and Suicide**

Some of the literature investigating the wounded healer discourse in mental health and elsewhere questions, at least to some degree, dominant discourses of professional helping. However, most of the literature speaking directly to the topic of wounded healers does not critically examine the dominant discourses surrounding mental health and suicide. An exception to this is the above-mentioned study by Adame et al. (2017), in which the authors explore their own identities as therapists who consider themselves psychiatric survivors. However, that study can be considered to fit within the area of Mad Studies. In order to fill this gap, I reviewed literature located in the areas of Mad Studies and Critical Suicidology.

**Mad Studies.** Menzies, LeFrançois, and Reaume (2013) define Mad Studies “as a project of inquiry, knowledge production, and political action devoted to the critique and transcendence
of psy-centered ways of thinking, behaving, relating, and being” (p. 13). This field of study prioritizes knowledge production by people who identify as mad and/or as psychiatrized. Scholars engage in the critical analysis of the current biomedically dominated discourses that medicalize mental distress (Menzies et al. 2013; Ryerson, 2015). Mad Studies is thus a political and social justice oriented field of study. Scholars within Mad Studies, along with activists of the Mad Movement, reclaim the highly stigmatized and negatively connoted term ‘madness’ (Menzies et al., 2013).

Authors writing under the umbrella of Mad Studies often employ intersectional analysis and investigate how medically dominated models of diagnosis and treatment of mental distress affect differently located people in different ways, and how “psychologizing” can be used as a tool of oppression (Chapman, 2014). For example, Merrai, Abdillahi, and Poole (2016) investigate the experiences of racialized people who identify as Black, African, or of African descent, and they name the sanism they face “anti-Black Sanism” (p. 18) to show the intersecting nature of racial oppression and sanism. In his 2014 text titled “Becoming Predator”, Chapman looks at how the psychologizing of caregivers’ aversion against restraining the disabled Indigenous children they cared for led to an apolitical acceptance of the practice of restraining as normal.

Other authors critically investigate the mental health field’s dominant ways of responding to both everyday emotions and mental distress – i.e., “categorizing and problematizing” (Ryerson, 2015). For example, Ussher and Perz (2017) examine women’s strategies in the face of the pathologizing of premenstrual change by contemporary Western medicine. Scholars also highlight alternatives to the often coercive treatment modalities that exist within Canadian
mental health contexts. Clarke (2016), for example, looked at an improvising choir and Hearing Voices Groups as “safe, intentional spaces” (p. 9) for people who hear voices.

Critical Suicidology. White (2016) defines suicidology as the “study of suicide, suicidal behavior, and suicide prevention” (p. 335). In North America, suicidology emerged in the 1950s and 1960s as a distinct area of study that built upon the previous long-existing scholarly study of suicidal behaviours. Traditionally, suicidology has favoured positivist approaches to studying its subject matter, and this continues today (Hjelmeland & Knizek, 2010; Marsh, 2016; White, 2016). As Marsh notes, suicidology makes the claim to be a science, thus primarily relying on the “tools of Western medical science” (p. 19). While research using quantitative methodologies has made significant contributions to the study of suicide, scholars writing critically about suicidology note that a focus on positivist research leaves out the voices of people who directly experience suicidality (White, 2016), and narrows what can be learned about what Hjelmeland and Knizek call “a complex and multifactorial phenomenon” (2017, p. 486-487).

Contemporary dominant suicidology also assumes suicide to be “pathological” (Marsh, 2016, p. 17), with the belief that suicide and mental illness are closely and causally connected underlying much of its research, an assumption that is disputed (e.g., Hjelmeland & Knizek, 2017). Further, as Marsh (2016) outlines, much of the research conducted and published within a dominant suicidology framework represents the view that the reasons for a person’s suicide are primarily located within the individual and that suicide is an individual act. As a result of these assumptions, research with a focus on social justice issues, for example examining the role that poverty or oppression play when people die by suicide, is not given much room within mainstream suicidology.
Scholars engaging in critical suicidology are challenging these assumptions. They offer additional perspectives for the study of suicide, for example showcasing existing qualitative research on suicide (White, 2016) and reviewing quantitative research with an eye towards the need to supplement this research with qualitative studies (Hjelmeland & Knizek, 2010).

Other authors seek to look at suicide utilizing a political approach that takes into consideration “socio-cultural dynamics”, rather than focus on psychology and psychiatry (Button, 2016, p. 270; see also Reynolds, 2016). This includes viewing suicide through a gender lens (e.g., Jaworski, 2010) and in the context of Indigenous frameworks (e.g., Wexler & Gone, 2016), among others. Lastly, and of utmost importance is the inclusion of the voices of people with lived experience with suicide (see e.g. “Part 2 – Insider Perspectives” in: White, Marsh, Kral, & Morris, 2016).
Chapter Three: Methodology

In this chapter, I describe the methodology I chose for this project, along with my rationale for choosing it. I further detail the methods I used for data collection and management and how I analyzed the data. Lastly, I speak to ethical considerations, as well as assessment and evaluation of my research.

Qualitative Methodology

As White (2016) notes, much of the research in the area of suicide has for some time primarily utilized quantitative methodologies and continues to value them as the most applicable and promising for the field. As a result, studies about suicide using qualitative methods are not widely available. This focus is indicative of suicidology’s quest for explanations, rather than understanding, as Hjelmeland and Knizek (2017) write. It also shows a linear cause-and-effect thinking that by itself is not always useful when researchers try to identify why people feel suicidal and die by suicide, as human beings rarely behave in linear and predictive ways. While quantitative methods have an important place in suicide research, focusing solely on positivist knowledge creation limits what can be learned about suicide and thus may not serve those who are affected by suicide. It excludes questions of meaning and related subject matters, which may not easily or satisfactorily be investigated by using quantitative methods, as well as the voices of the diverse groups of people who have lived experience with suicide (White, 2016).

As a suicide prevention and intervention professional, I have read many of these studies, and I have often been left with questions for the people who were the subjects of the research project. For example, I have wondered about how they understood the research questions, what stories prompted their answers, or what else they would rather talk about when it comes to the topic they are asked about. From personal experience as the sometimes object, sometimes
subject, and rarely true participant in the quantitative studies for which I have answered questions, I have often wanted to begin my answers to the questions with “It depends…”, or tell a story in order to have my point better understood. Given these reasons, beliefs, and my lived experience, I have chosen qualitative methodology for this study.

**Narrative Analysis**

After investigating several qualitative research methodologies, narrative approaches seemed to offer suitable tools for this work, and, guided by Fraser and MacDougall (2017), I chose feminist narrative analysis informed by intersectionality to explore my research question.

Over the past several decades, narrative analysis has been taken up increasingly across various disciplines in the social sciences, including social work (Fraser, 2004; May, 2014; Riessman & Quinney, 2005). This has occurred in the context of a turn to language and a greater acceptance of postmodern and post-positivist research methodologies that are open to analysing diverse data resources as well as to non-dominant ways of knowing, and that view personal storytelling as a valid means of knowledge production (Fraser, 2004; May, 2014; Riessman & Quinney, 2005). With its extensive and interdisciplinary appeal, narrative methodology encompasses a variety of techniques and approaches (May, 2012). Riessman and Quinney note that narrative approaches have particular value for the field of social work, due to a shared interest in narratives and relationships.

In this study, I asked fellow professionals in suicide prevention to tell their stories about being a service provider with first-person lived experience with suicidality. Narrative research methods are appropriate to attend to these stories for several reasons. Firstly, these methods prioritize narratives, which are understood as purposefully created texts that contain “plot, characters, actions, and contexts” (Daiute & Lightfoot, 2004, as cited in Fraser & Jarldorn, 2015,
Further, narratives are viewed as ways for humans to make sense of the world by allowing us to talk about experiences (May, 2014), emotions, and “beliefs about how the world should be” (Fraser, 2004, p. 180). They are seen as tools that allow us to organize experiences in a meaningful way and assist us in the creation of identity and subjectivity (Riessman & Quinney, 2005; May 2012). In other words, we use stories to explain “who we are” (May, 2014) as individuals and professionals, which is one of the questions at the centre of my research interest.

When using narrative methods, it is possible to pay attention to the way those telling the story structure extended accounts rather than focus on examining smaller fragments of text, as is common in other approaches, such as grounded theory (May, 2014; Riessman & Quinney, 2005). With this, narrative methodology affords researchers the opportunity to attend to a more holistic analysis of participants’ accounts and thus make space to hear the whole story a person wishes to tell.

In line with Fraser’s (2004) understanding of narrative analysis, my focus in this study is not on solving a problem but on delving into social phenomena. My interest is the exploration of the stories participants have to tell about their experiences as professionals with lived experience with suicidality, the very issue with which they are tasked to assist the people they work with, with the goal to allow for a “plurality of truths to become known” (Fraser, p. 181).

A feminist and intersectional lens. Fraser and MacDougall (2017) further refine and focus their application of narrative methodologies by using a feminist and intersectional lens. This focus is in line with my goal of conducting useful and socially just research, and it provides guideposts for a more in-depth inquiry into the stories I heard.

Fraser and MacDougall (2017) prioritize the feminist idea of linking the personal with the political by viewing narratives as not only located within the individual speaker. They make
visible how power operates in participants’ lives by paying attention to how people’s intersecting identities around gender, class, race, and ability in their relationships affect this process. Practically, they apply an analysis of narratives “across domains of experience”: intrapersonal, interpersonal, cultural, and structural (p. 247; Fraser, 2004). This is a salient point for a research project exploring the personal experience with suicidality in a population of professionals tasked to prevent suicide in others.

Fraser and MacDougall (2017) also reinforce the need for collaborative approaches to research that allow participants active agency. Feminist researchers do not view themselves as separate from participants in the research process. Storytelling is understood as a co-constructive process involving “telling, listening and conversation” (p. 244) between narrator (participant) and listener (researcher). Researchers are asked to stay cognizant of the “role they play in the co-construction process” (p. 244). As noted above, this is particularly pertinent in this study that has the goal to conduct collaborative research involving an insider researcher and her fellow professionals.

Doing research in this way requires researcher self-awareness and opens the door to the inclusion of other valuable sources of data, such as the emotion displayed and felt by both participants and researchers. Making this process conscious and including it as part of the data analysis has the potential to yield valuable information, as Fraser and Jarldorn (2015) have shown in their examination and discussion of their complex and complicated emotional reactions to a research participant’s story of intimate partner violence.

In my case, researcher self-awareness also involved carefully evaluating my insider position and attending to how my stories as a professional with lived experience with suicidality in some ways lined up with and, in other ways, were very different from those of participants. It
was an aspect of the research process I consciously attended to at every step of the project, given the possible (and possibly superficial) similarities between myself as the researcher and the participants. During the analysis process, carefully considering my positionality in relation to participants, helped me not to draw conclusions based on something I assumed I knew about the narrator in front of me.

Fraser and MacDougall (2017) also suggest the analysis of language to show and investigate the normative quality of dominant ideas in the stories narrators tell. Stories are not seen as a mere retelling of the past but as a means to construct reality (May, 2014). Attention to language thus opens the door to a more in-depth analysis and provides means to understand how personal stories affect “the making of socio-political worlds” (Fraser, 2004, p. 197). This in turn offers a way to “contest dominant social practices” (Fraser, p. 180).

**Use of Narrative Methodology in Other Research**

Suicide is sensitive topic that is difficult to speak about. Prior to the start of this project, I reviewed available narrative studies to see what kind of topics narrative researchers attend to. Some examples are Riessman’s (1990) investigation of how men and women experience divorce; Strega, Brown, Callahan, Dominelli, & Walmsley's (2009) study of fathers involved in the child welfare system, and May’s (2008) exploration of women’s perception of (good) motherhood. Other studies have focussed on experiences of abusive intimate partner relationships (Fraser, 2003), distress in childbirth (Fraser, in process, as noted in Fraser & MacDougall, 2017), and youths aging out of care (Martin, 1998).

Looking at the topics represented in this small sample of existing narrative research, it is evident that researchers choose narrative methodology to investigate topics that are difficult to speak about. Narrative methodology offers a space not only for the stories “that ordinary people
tell” (Fraser, 2004, p. 181) but also for the exploration of subjects that were previously seen as unimportant or taboo (Fraser & MacDougall, 2017).

Additionally, several narrative scholars whose work I reviewed have attempted to conduct their research in a way that does not just ask participants to share their stories but to be “active agents” in the research process (Fraser & MacDougall, p. 243). This makes participants powerful co-creators of research insights, rather than passive providers of data. I consider this to be an essential aspect of moving towards socially just research in this project, and it confirms my choice of narrative methodology as appropriate for this project.

**Methods**

In this section, I summarize the methods I used in conducting this study. I begin by describing the interview process. Next, I outline and discuss the recruitment process, and state how I arrived at the number of interviews. I then speak to consent, as well as audio taping and transcription, before explaining in detail how I analysed the data I gathered in the interviews. Lastly, I also provide my ethical considerations for this project and offer criteria for the evaluation and assessment of my research.

**Interviews.** Narrative methods can be applied to a wide variety of texts, for example, oral interviews, written responses to single questions, life stories, history texts, naturally occurring dialogue, direct observation, photographs, and dance performances, among many others (May 2012; May 2014; Riessman, 2005; Riessman & Quinney, 2005).

As the focus of this study is the stories of service providers who have lived experience with suicidality and who work with suicidal people, I chose to conduct interviews. Given the stigma that surrounds feelings of suicidality among helping professionals and the isolation that can result from it, I would have liked to gather data in a group setting and thus offer participants
an opportunity to create community and exchange experiences. However, given the same stigma, I chose to interview each participant individually, in order to guarantee confidentiality.

In the literature about narrative methodology, both oral interviews and written accounts are mentioned as potential sources of data (Riessman & Quinney, 2005; May, 2012). Both have advantages and drawbacks. On the one hand, some people may prefer providing a written narrative in response to an interview question, as they are not as articulate or feel as comfortable in an oral interview situation, especially when speaking about a topic that is sensitive to them. For those individuals, a written narrative may allow for more freedom, as each person can control when and where to write, how much time to take, and what to say. Additionally, the written text can be re-read and amended, should the participant be dissatisfied with their original account.

On the other hand, oral interviews permit a direct engagement between researcher and participants and the possibility of creating a space for an open conversation that may allow for shared intimacy (S. Strega, personal communication, March 28, 2016). This may be the case especially where the researcher herself has experience in the research topic area, as I do. A space of shared intimacy may also help level the power imbalance that can easily be present in the relationship between interviewer and interviewee, particularly when the research touches on a topic that the participant considers to be sensitive.

Another benefit of oral interviews is that they allow for the inclusion of what the researcher can notice about participant as well as researcher emotion (Fraser, 2004). Paying attention to aspects of the interaction beyond words may provide additional data and prevent the researcher from “over-intellectualizing personal stories” (Fraser, 2004, p. 186).
For the topic at hand, I chose to conduct oral interviews, as the benefits seemed to far outweigh the drawbacks, and I ended up recruiting five participants. Due to the geographical location of two of the five participants, we conducted interviews via video call software, while the remaining three interviews were conducted in person. Both interview modes allowed us to see each other and allowed me to attend mindfully to the words being said, the tone of voice used and also to body language and emotions that were displayed by both of us. All of these elements enriched the data analysis process.

To allow participants the greatest level of control over the interview situation, I followed the participants’ lead as to when and where to meet, so long as privacy, anonymity, and confidentiality could be preserved, and how much time to spend. This led to interviews taking place in one participant’s office, another’s home, a restaurant and, as mentioned above, via two different kinds of video call software, FaceTime and Zoom. During the video call interviews, the participants and I were in our respective homes.

The interviews ranged in length from about one hour to over two hours. With three participants, our time together was exclusively spent conducting the interview, while the remaining two interviews occurred in the context of longer visits. In each of the latter instances, the participants and I had previously known each other in other contexts. During these visits, the participants and I first shared a meal and spent personal time together, before we negotiated how we would move into the comparatively more formal research interview context.

I offered participants the option of reading and editing the completed transcripts of their interviews (Fraser, 2004). This was not only meant to correct any mistakes I might have made in the transcription process, but also to give participants the option of editing what they had said during the interview. That way they would be able to amend what they felt did not capture what
they had intended to say, or to take out things they wished they had not included. I again hoped that offering this option would give participants greater control in the interview process. One participant declined reading their transcript when we discussed this at the time of the interview, two participants later declined receiving their completed transcripts, while the remaining two people wanted to have the transcript but did opt not to comment or make edits. I offered all participants the option of choosing their own pseudonyms, which two people did, while I chose pseudonyms for the others.

To create an open space for participants to tell their stories unencumbered by pre-scripted questions, I conducted semi-structured, also called in-depth interviews, which, as Esterberg (2002) explains, can be of benefit when the goal is to explore a topic thoroughly. I asked only one introductory question: “Please tell me the story about your experience as a [participant profession] who has lived experience with suicide and who works with people who are also suicidal.”

I had anticipated that participants would have questions for me following this and was prepared to work collaboratively with each participant to decide the flow of the interview, based on our discussion. One participant, Salal, asked me to rephrase the initial question, which I discuss in the analysis chapter about her interview. The other participants responded to the question without a request for clarification.

To further facilitate the interview process in case we became ‘stuck’, I had prepared a list of prompts with topics that I had considered as related to the research question and that I had anticipated would come up during an interview about this topic (APPENDIX A). There was no expectation that we would cover any or all the topics I had collected. I created this list, rather
than write pre-scripted questions, to allow participants to guide the interview to where they wished to go (Esterberg, 2002; Riessman, 2002).

As a novice researcher, and especially given the sensitivity of the topic and my insider position, I spent considerable time prior to meeting with participants reflecting upon how much I wished to disclose of myself, and how I would respond to questions about me (Esterberg, 2002; Fraser, 2004; Hoskins & White, 2013; S. Strega, personal communication, March 28, 2016). As noted above and based on my desire to engage in narrative research from a feminist perspective, I did not see myself a neutral or objective researcher. I further did not wish to maintain a hierarchy between me as the researcher and the participant and instead hoped to engage in the interview process in a way that decreased the power differential between us. To this end, I found it helpful to think of the interview situation as a research conversation (Hoskins & White, 2013). I agree with Esterberg (2002) that the interview process is a relationship and that the quality of the data gathered depends on whether the participants feel that the researcher, in this case me, is trustworthy. For these reasons, I decided that I would openly share my insider position with respect to the research topic with participants, which I did. In some cases I let participants know of my insider position before the interviews, as I detail in the following section, while we discussed it during the interview in other instances. I speak about this as it becomes relevant in the analysis chapter of this paper.

Recruitment of participants. Contrary to quantitative methodologies, where random sampling and the selection of large numbers of participants is preferred, qualitative research approaches use a purposeful selection of participants who can speak knowledgeably to the research question at hand (Creswell, 2006).
There is significant stigma surrounding the topic of suicide, particularly when helping professionals who work with suicidal people have lived experience with suicidality (see, for example, Zerubavel & Wright, 2012), creating a barrier for people to participate in research. Based on personal experience and through anecdotal information, I am aware that there are many professionals who would fit the recruitment criteria for this study. However, given the culture of silence created by the stigma, I anticipated some difficulty recruiting participants for my research. Early on I therefore spent some time thinking about what I would do should I not be able to recruit participants, and I decided that, in that case, I would conduct a study investigating this silence.

To reach potential participants, I leveraged connections that I had in the suicide prevention and intervention community: I reached out to previous colleagues in various organizations, as well as other helping professionals I knew who work, either fulltime or as part of their roles, in suicide prevention and intervention. I sent each individual an email with a description of the project and an invitation to participate that was not directed at them but that I asked them to forward it to their professional contacts, for example through alumni networks and others, as well as to other organizations that they are affiliated with (APPENDIX B/C & D). I hoped that my personal connection to each professional and their sharing of the information would enhance my credibility and assure potential participants that it was safe to reach out to me. The project information and invitation included my contact information so that any potential participants could contact me directly and confidentiality was thus protected. The professionals I contacted were asked not to forward the information to clients of theirs, even if their clients were fellow professionals in the field.
The response from the professionals I contacted was, except in one case which I will discuss in Chapter Five, neutral to positive, and my information and request for participants was distributed throughout community organizations and personal and professional networks.

I had also hoped that initial participants would refer other professionals to me who they knew would fit the selection criteria. This process is known as snowball or chain referral sampling and is seen as helpful when sensitive topics are the focus of the research (Esterberg, 2002). However, only one participant let me know that she had spoken with a friend about the research who was a suitable candidate and that she was going to follow up with them after our interview. In the end, I did not hear from any new potential participants after the initial round of interviews.

While, as I have described, considerable thought, time and effort went into a recruitment strategy that was responsive to the sensitive nature of the topic and that I believe reached a relatively large number of people, only one participant reached out to me after having received the invitation from a third party. Another participant was one of the professionals I had contacted to forward my project information and invitation to others. She did this and then also decided to participate, as she, previously unbeknownst to me, fit the recruitment criteria, and was interested in speaking with me. This participant specifically noted that she only came forward as she had previously known me and trusted me.

The three remaining participants found out about this research project in conversations with me that were unrelated to the recruitment process. While speaking with me about the project, they informed me that they fit the recruitment criteria and were happy to be interviewed. I had known one of them from a previous workplace, while the other two participants did not have a prior personal connection with me. I met both individually at a professional development
event and in conversations shared my plan and goals for the study, as well as my personal connection to the topic. As a result, both identified themselves as suitable candidates and agreed to participate.

I have learned from this experience that the recruitment process for a project like this depends on establishing trust between participants and researcher, further validating my choice of methodology, as well as my decision to be open about my insider position with respect to the topic.

**Number of interviews.** Within narrative studies, the number of participants can vary significantly: Rimkeviciene, Hawgood, O’Gorman, & De Leo, (2015) interviewed eight survivors of suicide attempts while Martin (1998) included 30 young people in her research about youth in care. Similarly, Fraser (2004) recommends keeping the number of participants under 50, while May (2014) notes that a small number of participants is preferable to allow for a close reading of the texts. Given my position as a new researcher, that the scope of this study is a Master’s level project, and my desire to be able to engage in the close reading of texts that May mentions, I decided to keep the number of participants small. Following Fraser’s (2004) caution that “even studies with relatively few participants are liable to produce many more stories than can be possibly analysed in one article, report or thesis” (p.186), I planned to conduct approximately six interviews, a number which I was prepared to modify, depending on the nature of the interviews. In the end, I received five responses from suitable candidates who all agreed to be interviewed.

**Consent.** To ensure informed consent before the start of each interview, I prepared and discussed with participants a consent form, based on the guidelines set by the Human Research Ethics Board at the University of Victoria (APPENDIX E). Following these guidelines, the form
provided information about the study’s purpose, objectives, and importance, potential risks and benefits, as well as about the researcher and how participants were selected. The form also explained that participation was voluntary and that individuals should consider not participating in the research if they anticipate that engaging in the interview process may be in any way harmful to them. Further, it provided details about how anonymity and confidentiality is maintained, including information about limits of confidentiality and the disposal of data, and how the results of the study would be disseminated. The form provided the participants with contact information for me, my supervisor, and the Human Research Ethics Office at the University of Victoria, in case of concerns. I also provided participants with a list of resources, specific to the geographic location where they resided, should they feel emotionally affected by the interview process, which we briefly discussed in the interview.

Audio tape and transcription. With the permission of participants, I audio taped the interviews to allow me to have access to the entire conversation after the interview. For narrative methodologies, using a verbatim transcript of the interview is preferable over the summarizing of participants’ accounts and allows for the above-mentioned close reading of texts that I intended to do (Riessman & Quinney, 2005; May 2014). I also kept an audio journal and took notes on my observations beyond what was spoken during the interviews, e.g., the surroundings and emotions present, among others (Esterberg, 2002; Fraser, 2004).

While it is time-consuming, the literature on narrative methodology notes that transcribing one’s own interviews is preferred. It increases the researcher’s familiarity with the data and leaves transcribing decisions, for example, about how to record utterances, silences, and incomplete sentences to the researcher (Fraser, 2004; Riessman, 2002). Furthermore, as I am working with a sensitive topic, I would have had to brief and debrief transcribers (Fraser, 2004),
as well as address issues of confidentiality. Based on these reasons, I decided to transcribe the interviews myself.

To protect participants’ confidentiality, I kept consent forms, audio recordings, and transcripts in a secure location that only I had access to. Once I began transcribing and writing about the interviews, I changed participants’ names to pseudonyms which they had either provided to me or I had chosen for them, and I disguised identifying details (Esterberg, 2002). In general, I provided limited details on each participant to avoid that they could be recognized by readers of this thesis who may come from the same professional community. As a measure of ensuring the security and privacy of the recorded interviews, I utilized a stand-alone digital recorder that was not connected to the internet. This allowed me to transfer the interviews directly to my secure computer, without storing this sensitive data in any cloud-based services.

**Data analysis.** As mentioned above, narrative research is an open and adaptable research methodology that is used across disciplines in a variety of different ways; there are no fixed rules or definitive guidelines for how to proceed with data analysis. However, May (2014) notes that most studies approach narratives holistically, that is, they observe the sequencing of themes and focus on the narrative as a whole. They further do not emphasize content – *(what is spoken about)* over form *(how it is expressed)* but pay attention to both. Riessman (2002) similarly speaks about analysing both a narrative’s structure and its content and suggests that one begin with the former so as not to get lost in the latter.

As a novice researcher I chose to follow Fraser’s (2004) seven-phase model for narrative analysis as a guideline to assist me with the practical details of data analysis. In the following, I outline how I worked through this process.
**The interview – listening to emotion.** The first phase of Fraser’s (2004) model is both the actual interview and the process of listening. This includes listening to the story itself but also paying attention to different dimensions of emotion. Fraser and MacDougall (2017) propose looking at emotions and their possible meanings that were present during the interview, as well as at the time of the event about which the participant is speaking. In line with my goal to conduct this research as a self-reflective researcher, I also paid close attention to the feelings the interviews evoked in me.

I further kept track of other details from the interviews that cannot be heard in the audio tapes for additional information. Fraser (2004) notes that keeping a journal alongside the audio recorded transcript can be helpful here, and I kept both an audio journal and written notes, which assisted me in remembering additional details from the interview in later phases of the analysis process.

**Transcription.** Transcribing the interviews, Fraser’s (2004) second phase, is considered a part of data analysis because of the many important decisions that are made when interviews are transcribed, as noted above (Riessman, 2002; Fraser). To prepare for the process, I learned and practiced touch-typing. As this was a new skill, in which I was not yet very proficient, I spent considerable time listening and re-listening to the audio tapes, while I slowly transcribed each interview. This led to an experience I cherished as I analysed the interviews: I was able to hear the participants’ voices in my head, even as I worked with the written transcripts. It also allowed me to be deeply immersed in the data as I came to know the interview conversations well. I found this closeness to the data very helpful, particularly in the later stages of the analysis process when I considered the experiences of my participant group as a whole.
I first created a raw transcript of the interview that I then reviewed repeatedly to correct errors and began to add appropriate punctuation, remove identifying details, and add pseudonyms instead of the participants’ real names. I then removed “uh”, “uhm” and similar utterances for easier reading but decided to keep participants’ speech otherwise intact, that is, I did not remove stops and starts and similar speech patterns, as I wanted to preserve the structure of the original interview.

**Interpreting each interview.** In phase three, each transcript was interpreted on its own. Following the close reading of the data the transcription process had afforded me, I named each interview to capture its essence, or main theme, before moving on to identifying individual stories in each interview. I deviated from this order in the first interview that I looked at, Salal’s, and identified stories first, as it helped me to identify what I considered to be the interview’s essence. I derived the title of each interview from a quote by the participant. The interviews are called: ‘You’re there to work through what you’re going through’ (Salal), ‘Maintaining a relationship with hope’ (Michael), ‘There is still a part of me that knows what that feeling is like’ (Hollie), ‘If you’re helping other people, you should be okay, too!’ (Lila), and ‘It’s given me permission to let people know that I really care’ (Nina). By naming the interviews, I viewed each interview as a whole narrative that was presented to me in response to my initial question, which then contained stories or “segments of narratives”, as Fraser calls them (Fraser, 2004, p. 189).

I then attempted to break up larger amounts of talk and to identify the individual stories that participants had told in the interviews. While narrative scholars provide definitions for what can be considered a narrative, as I have noted above, less is written about how to identify individual stories in interviews, though both Riessman (1993) and Fraser (2004) acknowledge the challenges this process can pose. Fraser cautions that stories may not be immediately visible,
as individuals may use different indicators for the beginning and end of a story. In my participant group, Nina used often easily identifiable stories throughout our interview to illustrate the points she wished to make, once even signalling her intent to tell a story by saying “Oh, okay, let’s tell you a story!” In contrast, both Lila and Salal began stories they then abandoned, only to return to them at a later point, making the identification of start and conclusion points less straightforward.

To complicate matters further, Michael and Hollie each told fewer stories, but had nonetheless much to say about what it means to them to be someone who has lived experience with suicidality and works with suicidal people. Hollie specifically noted in the interview that she had thought much about the topic of this study since she had initially heard about it, and she shared her thoughts with me, both in storied and non-storied form. In both interviews I thus struggled with what to do with the textual elements that were not immediately part of the storytelling, but that were still important pieces of what the participants wished to say. Riessman (1993) calls these elements “non-narrative” and notes that they make up the majority of text, for example, “question and answer exchanges, arguments, chronicles, and other form of discourse” (p. 58), and I assume she discards these pieces.

I question whether these elements should not have a place in the narrative analysis process, perhaps by viewing the interview in its entirety as a narrative. On the other hand, this may take away from a focus on analysing narrative elements, that is, the stories contained within the interview. In the end, it seems I naturally held the entirety of the individual interview in my mind as I went about the analysis process, and I believe I thus never quite let go of all non-narrative text elements that were part of my conversations with participants.
After identifying stories, and as Fraser (2004) suggests for this phase, I numbered lines while keeping participants’ sentences intact and titled each story for better recollection. Again, I derived the title of each story from something the participant had said in the story. I then copied and pasted each now anonymized story into a separate document, printed it, and put it up on the wall in my home so that I could read and contemplate the stories at once. This process helped me to (literally) see the stories better and group and re-group them.

Throughout this phase, I was often left feeling unsure whether I had ‘correctly’ identified the stories that were given to me. Looking at my reflective notes from this part of the data analysis process, I can see how I wanted to honour participants by doing my best to hear what they had meant to tell me. At the same time, it also seems to me that I struggled to leave behind internalized positivist ideas of knowledge creation, namely, that there is a right and wrong answer, or a right and wrong way of doing narrative research, and that there is one truth hidden in the interviews that I needed to uncover (Hoskins & White, 2013; Fraser, 2004).

I eventually shortlisted the stories that spoke about first-hand experiences in relation to participants’ professional lives, and then looked for themes, contradictions, and meanings that showed up in each interview. Following Fraser (2004), I did this by considering the stories across different domains of experience, beginning at the intrapersonal level and then gradually opening up to include interpersonal, cultural, and structural domains. Overlapping with this, I used a feminist lens to “[link] ‘the personal with the political’” (p. 193). I focused on investigating dominant discourses that have shown up in the data and how these discourses have impacted the participants’ experience as well as my interpretation of the stories told. This was done with the intent to complete research that examines social phenomena beyond the purely individual and to look at data through an intersectional feminist lens.
Interviews in conversation with each other. In phase six, though this had occurred at different times throughout the process of analysis, I broadened my view from the individual narrative and explored the interviews as a group. Considering the interviews as being in conversation with each other, rather than focusing on comparison and contrast, helped me to not set up unnecessary dividing lines between participants, and between interviews (S. Strega, personal communication, May 28, 2019). Through this analysis, I identified the main themes Empathy and Deeper Knowing, Sharing One’s Story, Making Meaning of Suicide, and Stigma.

Academic narrative. Finally, I set out to write the “academic narrative” (Fraser, 2004, p. 195), in this case this thesis, which is the seventh and final phase of Fraser’s model.

Ethical Considerations: Speaking About Suicide

In any research project involving human participants, their safety and wellbeing are of paramount concern. Given that the interviews in this study were about suicide, I carefully considered the potential risks and what preventative measures needed to be put in place to protect participants.

As a service provider in suicide prevention and someone who is consulted on how to engage with individuals who are (potentially) at risk of suicide, I am well aware of the concern that exists that asking people about suicide may cause them to feel (more) suicidal. As someone who regularly speaks with people who think about suicide, personally knows people who have dealt with suicidality in the past or do so currently, and as someone who has experience with thinking about suicide herself, I believe that this is an unfounded fear. My experience-based belief is confirmed by several research studies on the potential risks inherent in talking about suicide that were conducted in the past 15 years. In 2014, Dazzi, Gribble, Wessely, and Fear, carried out a review of published literature in the area (e.g., Gould et al., 2005; Reynolds,
Lindenboim, Comtois, Murray, & Linehan, 2006) and found that participants who had been asked questions about suicide had in many cases not reported an increase in suicidal ideation and in some cases even experienced a decrease. Additionally, participants noted they felt positive about taking part in research with the goal of affecting change in the area of suicide, whether or not they had experienced a decrease in suicidal ideation or distress. In my study, this was confirmed by Hollie who explicitly noted upon hearing about the project that it was her intent to participate in order to help with research she considered important. It was further implicitly confirmed by the willingness of all study participants to openly speak about this topic with me.

As I prepared for each interview, I also compiled a list for each participant containing resources specific to the geographic location where they resided, should they feel emotionally affected by the interview process. This was likely an unnecessary precaution as all participants were helping professionals who work in various capacities in the area of mental health and suicide prevention and were familiar with available resources. While I had been prepared to make recommendations for additional resources that were available to participants, if needed, this was not necessary, as none of the participants indicated to me that the interview process had emotionally affected them in a way that would require reaching out to other resources. Additionally, each of them also had access to their own mental health care.

Evaluation

While there is a well-established set of criteria or for what constitutes ‘good’ quantitative research, namely validity, reliability, generalizability, and objectivity, a single framework does not exist to evaluate qualitative research (Tracy, 2010). Different researchers argue for different sets of criteria, some with the intent to mirror those of quantitative studies, while others reject this idea and demand that criteria for qualitative research must be entirely separate (Fossey,
Harvey, Mcdermott, & Davidson, 2002; Tracy, 2010). Similarly, there is no agreement on whether the same standards should be applied to all qualitative studies (Tracy, 2010), or specific criteria ought to be developed for specific research methodologies (Creswell, 2007, as cited in Tracy, 2010).

In the absence of a universally accepted framework for the evaluation of qualitative research, I evaluate the research I conducted for this project based on the following criteria that are in line with my goals for this study and my values as a researcher.

**Striving for social justice and usefulness.** Following Potts and Brown (2015), Strega and Brown (2015), and Fraser (2009), I made a commitment that I would aim to conduct research that is socially just and done from an anti-oppressive perspective. While it is doubtful that my small-scale Master’s level project will create large societal change, it has the potential to create change in my life and in that of participants, for example by starting conversations about being a helping professional with personal lived experience with suicidality, thus combatting some of the stigma that surrounds this experience. By extension, breaking some of the silence around the topic of suicide in one area might open the door to further conversations in other areas, thus creating the possibility of further change.

In practical terms, striving for a socially just approach to research has meant that I have made every effort to conduct research *with* people, not *on* people. I have positioned myself on an equal level with participants as much as possible and approached the process of knowledge creation as a collaboration between the participants and me (Potts & Brown, 2015). I have further attempted to break down some of the stigma and the resulting separateness during the interview process: I have done my best to be a transparent researcher by sharing my personal
experience with participants, and I have shared, without identifying details, some of the experiences and insights that came up in other interviews.

Striving to conduct socially just research has also meant that I chose a topic that situates me inside my research area. This choice has allowed me to recruit participants who are fellow professionals, thus moving away from creating yet another research project with a focus on marginalized groups of people and instead looking in on service providers themselves (Potts & Brown, 2015).

**Reflexivity, honesty, and transparency.** Connected to my goal to conduct socially just research, I have aimed to be a present and visible researcher, rather than the distant and objective researcher figure that is familiar to me from positivist research methodologies. I have done this by sharing my personal connection to the topic in the context of the recruitment process, with participants, and with the readers of this research.

I have made every effort to approach the project with self-reflexivity, honesty, and transparency. I have kept a journal, sought feedback from others, and shared my reflections in this paper. My goal throughout this process has been to be cognizant of and investigate the prisms of my multiple locations through which I view the world, as well as the assumptions that accompany them and that I am often unaware of. I have done my best to see and to show how who I am has affected everything from the design of the study to how I have interpreted the data (Hickson, 2016).

**Coherence, understandability, and trustworthiness.** This last set of connected criteria is about attending to the practical aspects of the research process, both the actual ‘doing’ and the communicating of the work. Firstly, I have done my best to choose, understand and apply a methodology that matches the research question well, and to back up claims I make with the data
from my study (Tracy, 2010). Secondly, I have attempted to show how I have done this by writing an academic narrative, this thesis, which at the same time functions as an audit trail, a tool which shows the steps taken by the researcher as she works through the research process (Carcary, 2009). Only if I have done the second part in a way that allows the reader to follow along and understand the research process, will they be able to assess whether they accept the analysis I have provided of the data I collected.

Naturally, readers of this thesis may not agree with how I interpreted the data, but that is the nature of a qualitative study that does not make claims for objectivity and has an author who brings much of herself into the research. However, letting readers know who I am in relation to this project allows them to consider this information when they think about whether what I have written is worth their trust or not.
Chapter Four: Analysis

In this chapter I provide my insights, observations, and analysis of the interviews conducted for this study.

I asked five helping professionals who identify as having first-hand lived experience with suicide to tell me the story of their experience working with people who are suicidal. This is a topic that is not often spoken about, and it was my goal to offer participants an open space to talk about their experience in any way they chose.

As I have detailed in the previous chapter, I followed a framework for narrative analysis outlined by Fraser (2004). I focused on the narrative elements contained in the interviews, that is, the stories that participants told me in response to my initial interview prompt, and in particular on those that connected their personal lived experience to their professional lives. In the following I will detail what I learned from these stories.

I begin by telling the story of each interview, before I outline the themes that emerged when I regarded the interviews in conversation with each other.

Salal – You’re There to Work Through What You’re Going Through

Salal and I have known each other for a number of years and have worked together in several workplaces. For the interview, we met at Salal’s home, which is in a different city than the one I live in. Therefore, we had agreed I would stay overnight.

Salal had immediately offered to be interviewed when I first told her about the focus of the study I was thinking of conducting in my Master’s program, thus identifying herself as someone who had lived experience with suicidality. Up until that point, I had not known this about her. Similarly, I only realized during our interview that I had never told her about my longstanding feelings of deep hopelessness either. It is a sign of the stigma that surrounds the
topic of suicide, and even more the acknowledgement of one’s own feelings of suicidality, that, despite having worked together in a suicide prevention context, we had never spoken about our personal connection to the topic.

In her current job, Salal works in a non-clinical capacity with individuals who have self-identified as having a history of serious suicidal ideation and/or attempts. She is a white woman who identifies as queer, and she has experienced suicidal ideation and has attempted suicide.

Before the interview began, I was not sure if our pre-existing relationship would be a hindrance, as having a recorded research interview is very different from our ordinarily occurring conversations among friends. However, as we began the interview, I felt that it was fairly easy for us to talk, despite the recorder, and I believe that our pre-interview trust relationship, as well as our shared experiences in a work context were helpful.

I noticed that Salal seemed to consider us to be on the same page quite often, for example, when she used “Right?” at the end of a statement, and I often felt the same. I am aware, however, that having shared or similar experiences created challenges for me during the interview and analysis process, when I tried to hear Salal clearly and not substitute my own experience for hers.

After I posed the initial question Please tell me the story about your experience as a [redacted job title] who has lived experience with suicide and who works with people who are suicidal, Salal asked me to rephrase it. I had anticipated that participants would have clarifying questions following my initial prompt to tell me their story, but I had not expected that someone would ask me to rephrase the initial question entirely, and I was caught by surprise. I had not prepared an alternative statement or question, and so I rephrased focusing on one of the areas that I was hoping the study would cover, thus narrowing our interview starting point: “So, what
interests me is how your experience with suicide affects your interactions with people who have experience with suicide as well.” Since listening to the tape and transcribing the interview, I have repeatedly thought back to that moment. While I was not initially aware of this, at the outset of this project I seem to have focussed on whether being a helping professional with lived experience with suicide is helpful to clients, and this is what I thought about when I presented my rephrased statement to Salal. This is not surprising to me, as much of the literature that contributes to the wounded healer discourse focuses on the question of whether being a wounded healer is helpful or harmful to clients in the helping process. Given that I am a person with lived experience who works in a helping profession, I am interested in the answer to this question, and I am also emotionally invested: I want my lived experience to be helpful.

It has since also occurred to me that I was much less concerned with the experience of the helping professionals themselves, despite asking for stories about exactly that. Only during the analysis process, when two of the other interviews revealed participants’ stories about how their relationships with clients who are suicidal impact them (Hollie), and how important their work was for them as they dealt with periods of suicidality and depression (Nina), did I realize this. This realization points me to an unexamined blind spot in myself. I subconsciously had held on to the view that the interaction between client and professional is a one-way-street. In doing so I internalized current dominant ideas about professional helping relationships, in which clear lines are drawn between the ‘client’ and the ‘expert’. One of the features of this discourse is that the expert is responsible for caring for the client, while she is simultaneously being expected to keep a separation alive between her and that client, that is, not care so much that it affects her. These ideas show themselves, for example, in a focus on individual wellness, self-care, and ‘doing the
work’ on the part of the helping professional, with the goal of not becoming too affected by witnessing the difficulties in clients’ lives.

Through her stories, Salal makes two main points about her experience as a person with lived experience with suicidality who works with people who have also experienced suicidality. Firstly, she often uses her lived experience to inform her work with clients. It helps her to empathize with people from a point of having been there, and it informs her thinking when she considers how to assess a client’s suicide risk, and if and how to intervene. Secondly, she thinks about what she finds helpful when she is in the role of the client and uses it as a model for when she is in the role of the helping professional. In her stories, these points are closely connected.

In Thank You For Just Talking To Me, Salal notes that she believes that the decision to die by suicide lies with the individual contemplating suicide, and any meaningful help will be based on listening to the person, allowing them to talk about their thoughts and feelings, and providing optional resources. Her belief is based on both her own lived experience and on what she has heard from clients:

But honestly, like, if someone really wants to, then they really want to. And it doesn’t matter what kind of stuff you go out to do for that person, if they’re gonna do it, they’re gonna do it, right? So, honestly, if you just talk to them and let them know what’s there, if they want it, but just talk about it. For the most part, that’s what people want. I’m not a psychologist [laughs] but that’s just how I know I felt and that’s how I feel a lot of my clients have felt, too. ‘Cause they’ll call me back and just be like: ‘I’m really sorry if I, you know, scared you.’, or: ‘I’m really sorry that I said that, you know, but thank you for listening.’, like: ‘Thank you for just talking with me.’
(Thank You For Just Talking With Me; lines 20-25 of 25)

Salal does not believe that “over-helping professional[s]”, as she calls them in this story, who force resources and interventions on people will prevent suicide. She uses an example from her own life to illustrate this further. She tells the story of how, in the past, it was not helpful to her when her family wanted to immediately spring into action when she told them that she felt
suicidal. Instead, she would have preferred if they had listened to what she needed in that moment, for example, taking her pet for a short time, so she could fully relax without having to deal with that caring responsibility. She connects her family’s actionism to the kind of professional approach that is always “ready to go”. With this, she feels, professionals signal to those seeking help that all that matters is that the person stays alive while under the care of that professional (“You’re not gonna die on my watch!”), rather than listen to what kind of help the person might actually want. In those situations, risk management and liability questions take precedent over person-directed helping.

In *Finding That One Thing To Fix*, Salal tells the story of two of her own treatment providers who have failed to address the concerns with which she had come to see them, and instead focussed entirely on something they had decided was “wrong with [her]”. Salal connects this to how suicide interventions are often focused primarily on the prevention of death, while not helping the person to deal with the underlying reason for their feelings of suicidality:

And if you just talked to that person for longer you’d find out why they’re feeling suicidal and try to fix that thing, not the suicide piece! Not: “Okay, I have to stop you from committing suicide!” But: “Oh my goodness, you are feeling overwhelmed, why are you feeling overwhelmed?” Right? “You’re feeling overwhelmed because you had, I don’t know, you had a brain injury last month. Well, is that why? Is that why you’re feeling overwhelmed? Okay, well, what kind of things have you been doing to not feeling overwhelmed?” And kinda, like, dial it back instead of focussing on the suicide piece. Pull it back and talk about the other stuff. Yeah.

(*Finding That One Thing To Fix*; lines 69-74 of 74)

While her expertise, which originates from her lived experience with suicidality, is useful to her, it can at times be at odds with the professionally acquired expertise of the clinicians she works with, whose “speciality is […] suicide prevention”. It is of note here that I only assume that their expertise is professionally acquired, and not also based on lived experience, as Salal
and her clinical colleagues are not sharing information about their personal backgrounds with each other.

In *Spidey Sense*, Salal believes a client is struggling and needs additional support. However, the clinician she discusses this with assesses the situation as less urgent and declines to become involved as an additional resource for the client. The client then attempts suicide¹, and Salal is left feeling frustrated by being overruled by the clinician:

> And that was really frustrating for me because—because I… I have a spidey sense and if somebody tells, like-like, I can kinda tell and I was really frustrated in that situation ‘cause that person’s full-on expertise is on suicide prevention. *(Spidey Sense; line 5 of 25)*

Salal’s frustration seems to stem from her expectation that her clinician colleague, using their clinical expertise-based knowledge, should have arrived at the same conclusion she did using lived experience-based knowledge; it appears that she sees both of these knowledges as equal.

Salal did not tell me if she had ever spoken with her clinician colleague about her lived experience with suicidality, and I did not ask her about it. However, as Salal had never shared her lived experience with suicidality with me when we were working together, I do not believe that her workplace would be aware that she brings this knowledge to the table. Even if they knew, given how much her employer values clinical assessments and similar tools, it seems doubtful that her intuition honed by lived experience – her “spidey sense” – would be taken as seriously as a suicide risk assessment based on a catalogue of risk and protective factors.

In the story I have named *Spidey Sense (II)*, Salal again interacts with a clinician. This time, the situation is reversed and her colleague is convinced that a client is at risk of suicide, and

¹ The client survived.
that there needs to be an intervention. Salal, meanwhile, believes that the client’s explicit threats of suicide are just that, threats. She calls the threats a form of “revenge suicide threat”:

They didn’t like the way that something was going […] and was [sic] basically like: ‘Well, if you’re gonna call me out on that or criticize me on that, then I can just feel, like, I can feel the knife in my hand now. [Edited during the interview by Salal: These are not the actual means discussed by the client.] And the more you talk I can feel it cutting through the top layer of my skin. You know, I can feel the blood coming out now, because you’re criticizing me.’
(Spidey Sense (II); lines 8-9 of 38)

While suicidology and many suicide prevention campaigns would suggest that an objective assessment of suicide risk is possible, Salal’s story offers a glimpse at the messiness of suicide interventions and touches on the complex and complicated discourse of what gets taken into account in the assessment of the seriousness of a suicide threat (Marsh, 2016). In reality, people who voice suicidal ideation are not always taken seriously. Sometimes people are not believed to be suicidal because they have never attempted suicide before, because they are seeking help, or because they have previously been in contact with the mental health system, especially if they were assigned a personality disorder diagnosis. Other times they have previously attempted suicide, but it was deemed ‘attention-seeking behaviour’, perhaps because they chose a potentially less lethal method, such as pills rather than a firearm, or because they called for help after initiating the attempt. In many respects this is a gendered discourse, as Jaworski (2010) outlines. She goes on to explain that certain ways in which women engage with suicide are seen as “reactive, manipulative and attention-seeking”, for example, when women choose to overdose with pills (p. 48). In contrast, male engagement with suicide, for example, when they use a firearm, is seen as “serious and wilful” (Jaworski, 2010, p.48). And, while some requests for help in a suicidal crisis fall on deaf ears, the opposite reaction can also occur: When someone voices suicidal intent and practitioners or organizations deem it necessary to manage
risk to avoid liability, suicide prevention efforts can quickly escalate to intervention at all cost, up to coercion and forced hospitalizations.

In *Spidey Sense (II)*, a version of the latter occurs, as the clinician believes the client to be at risk of suicide, and they act. Salal, however, disagrees with this. Based on her lived experience with suicidality – she has personal experience with what she calls “revenge suicide threats” – and her familiarity with the client’s circumstances, she doubts that the client will attempt suicide.

In this story, Salal also uses clinical risk assessment tools, in addition to her lived experience based knowledge. She looks at protective factors, specifically the life plans the client has recently made, which in suicide intervention practice would indicate that they are thinking about the future, and thus theoretically are at a lower risk for a suicide attempt:

> And then they’re, in other aspects of their life, they’re displaying drive, you know. They’re going back to university or they’re, you know, making plans for something. *(Spidey Sense (II); lines 33-34 of 38)*

However, she looks at this protective factor in a nuanced way, that is, she critically evaluates this tool from the viewpoint of lived experience. She notes that she has used making plans for the future to make herself feel better while actually being acutely suicidal, calling into question the formulaic use of risk and protective factors in suicide prevention:

> And I make plans for things, too, when I’m suicidal because it helps kinda get-make me push through stuff […] *(Spidey Sense (II); line 35 of 38)*

As I engaged with this story, I felt conflicted about Salal’s reading of the client’s reasons for bringing up suicide. Her reading seems to touch on the aforementioned narrative that some people make threats of suicide, not because they are at risk of killing themselves and are looking for help, but because they are said to have an ulterior motive. However, she discusses the
statements about her client in the context of not only her relationship with the client, but also her own lived experience with suicidality.

While Salal does not believe that forceful crisis intervention is generally helpful, she works within a system where those interventions are common. In *Crisis Line*, she tells the story of a client who was forcibly taken to hospital by police after he called a crisis line and the staff there felt he was in danger of hurting himself:

> [...] took him into hospital and he didn’t have his ID, and he didn’t have his phone, and he didn’t have his shoes. And they handcuffed him to a chair, and he said he sat there for eleven hours. And then he didn’t even see a doctor! And he was discharged with no phone, no keys, no wallet, and no shoes, and then had to walk home. So he told his psychologist what had happened, and his psychologist gave him his personal phone number and said: ‘You know, next time you’re feeling suicidal, call me. Just call me and we can talk about it and we can talk it out.’ ‘Cause he was, like, traumatized after. And this is, like, an older man-an older man who was-who was incredibly embarrassed ’cause it was in front of his, like, his, his, neighbours and everything.  
*Crisis Line*; lines 7-13 of 24

As a result of this experience, the client told her he would no longer call crisis lines. While she considers the negative impact of the intervention, she also accepts that the crisis line’s procedures may require them to call emergency services, though perhaps not in this case:

> And I understand that they-they have certain protocols in place and that’s fine but there should also be more of an understanding when someone’s just calling to just share how they’re feeling, right?  
*Crisis Line*; line 24 of 24

Similarly, in her personal life, Salal called 911 when an ex-partner with whom she was no longer speaking sent messages containing suicide threats to her, and she felt she had no other option. They then also ended up in the hospital against their will. In both cases, Salal wished there had been a different outcome than police taking people to hospital; however, she did not feel there were alternatives to involving emergency services. Despite questioning the validity of
some of the currently dominant ideas about suicide and suicide intervention based on her first-hand lived experience, Salal still operates within systems that are governed by those same ideas.

A main point Salal has derived from her experience in the role of the client is that she does not want to explicitly disclose her lived experience with either suicidality or mental health difficulties to her own clients. As noted above, she bases this on what she considers helpful for herself. In *The Whole Point Why You’re There*, she notes that she found it engaging and even useful when a facilitator shared their personal experience in the area of mental health and suicide during a workshop she attended. However, in a one-on-one context, she considers such disclosures to be out of place:

But when you’re seeing, like, a treatment provider and you’re only seeing them for an hour, like, and you can only get an appointment with them for an hour every two to three months or every month, you don’t wanna—you don’t wanna focus on, like… to take away from that time by worrying about that person. Like, I don’t wanna be worrying about the person.

SH: Oh, I see.

You know what I mean? And then feeling like: ‘Oh my god, like, I’m so sorry.’ Like…

SH: Do you feel you can’t tell them about— you feel that you would burden them if you felt that they have a lot going on, kinda thing?

Well, not burden them but you just start thinking about them and their situation and the whole point that why you’re there is to work through what you’re going through. (*The Whole Point Why You’re There*; line 21-27 of 27)

In the same story, Salal also sets the professional helping relationship apart from a friendship where a give and take between the parties would be the norm. In *Comfortable Sharing*, she describes the rapport she has with her treatment providers, which was jointly established through small talk and sharing of some information about their respective lives. Having this rapport makes her feel comfortable enough to be open in therapy. In contrast,
another treatment provider she is seeing is unwilling to engage with her in rapport-building, even though she initiates this repeatedly:

And I will walk in the room with him and I’ll be like: “How is your day?” And he won’t respond. I will go in and be like: “How is your day today?” Nothing. And then he’ll just look at me and say: “How are you?” I’m like: “Okay. I’m good. How are you?” And then he’ll just move on the next question. Like, there is no rapport-building whatsoever and I need that.

(No Rapport; lines 4-8 of 8)

While Salal is interested in feeling comfortable with her treatment providers, she wants the relationship to stay superficial and not based on mutual sharing beyond small talk. This protects her from having to care about them, and to her, this keeps the focus on her.

During the interview I found myself surprised by Salal’s views on sharing lived experience in helping relationships. I had anticipated that she would appreciate and practise self-disclosure, at least to a certain degree. Due to our pre-existing relationship I know we hold similar views on many other subjects, and thus I had assumed that Salal’s practice would be similar to mine, where I have shared with clients details of my own struggles with mental health difficulties and how I deal with them. However, having uncovered and dissected some of my previously unexamined views on helping professionals as experts, as detailed earlier in this chapter, I am seeing parallels between Salal’s and my views. We both subscribe to, or at least accept, dominant ideas about helping relationships in our respective work contexts. These relationships are not based on mutual sharing, but instead they mirror practitioner-patient relationships that exist within the medical model, where specialized medical professionals are tasked with treating a patient’s physical illnesses. No matter our respective and changing viewpoints of this, it is important to me to make this visible, in order to make an honest decision about who I want to be as a professional and how I want to engage with people I work with.
Additionally, it is also important to pay attention to the different subject positions Salal and I inhabit, despite the similarities between us. I am a middle-class, white, cisgender, heterosexual, and able-bodied woman who deals with ongoing mental health difficulties. Some facets of my positionality, for example, being a woman interacting both internally and externally with a gendered mental health discourse, mean that I am affected by discrimination based on my gender. However, in other aspects of my identity I am dominantly located and mostly protected from discrimination. This extends to my mental health difficulties, which are such that I can manage them with private outpatient treatment (psychotherapy) that I have easy access to because I can afford to pay for it. I am not dependent on referrals to psychiatrists and have been able to choose not to take psychiatric medications. Thus, I have not depended on the medical system for services and had to wait for them, and my mental health difficulties are, to my knowledge, not noted in my medical records, other than those my therapists have kept. My mental health difficulties, anxiety and depression, are also no longer as stigmatized as they may have been in the past, likely due to more open conversations about the prevalence of these issues. Thus, the risk of my disclosure is relatively small. This is different than if I, for example, had been diagnosed with schizophrenia or a personality disorder, or had spent time in a psychiatric hospital, all of which carries considerably more stigma, especially for women and/or racialized people (Meeria et al, 2016).

In contrast to Salal, I also identify as heterosexual and thus inhabit a less scrutinized position than an openly queer person in a predominantly heterosexual space does. It may be preferable for a person who openly identifies as queer not to want to share additional identities that locate her as someone who is easily discriminated against.
Another privileged space that I have inhabited when my disclosures have taken place is a workplace in which I had strong union protection and supportive supervisors. These supervisors agreed with me that it was positive to share my ‘wounded healer persona’, that is, I modeled someone with mental health difficulties who succeeds in the workplace. While my visibility may have been helpful to others who may have taken comfort in the fact that they were not the only ones dealing with mental health concerns in the workplace, I am aware that this also supports the ableist discourse of ‘successfully overcoming’ or ‘working despite’ a mental health issue.

Lastly, I am also in a financially stable position and live with a partner who would be willing and able to support me, should the need arise to leave a work situation that was no longer sustainable. Whether I have been conscious of them or not, all of these points have influenced my decisions to speak about my mental health difficulties with clients, colleagues, and supervisors. This is especially visible to me when I contrast the above with the fact that I have never disclosed my lived experience with suicidality to suicidal clients. Speaking about a history of suicidality makes me feel vulnerable in a way that speaking about mental health difficulties does not.

**Michael – Maintaining a Relationship to Hope**

Michael was one of the facilitators at a conference I attended. During one of his workshop sessions, he told a story about his prior lived experience with suicide and depression after his divorce some years ago. We had already briefly spoken about my research project prior to this session, and he was immediately open to being interviewed for this study when I approached him at the end of the day.
Michael lives in the United States, and we connected via Zoom from our respective homes. He works as a therapist, a clinical supervisor for an organization that serves the transgender and LGBQ communities, and he teaches in a social work program.

Michael began his response to the initial interview prompt by defining his lived experience with suicidality. He explained that he has never attempted suicide but he had felt suicidal ideation in the context of his divorce several years ago. At that time, he drew on the help and support of his friends, and he also attended therapy with a psychiatrist. With this description of his own suicidality, he puts suicide in the context of outside factors which can cause distress and despair for a person and lead them to feel that they want to end their lives. He picks up the topic of suicide again in the story *Murdered By Transgender Oppression*:

I’ve had-I’ve had a trans client kill themselves and they’re honored there is an annual event – it just happened Saturday. [...] But it’s a day that honours and acknowledges all the trans folks who were murdered that year across the world and each person is named and they talk about how they were killed. Very intense. And one the people that is acknowledged was my client, and this is years ago. And they killed themselves but if I didn’t contextualize, like, their killing themselves was a response to the incredible amount of transgender oppression they experienced. They were ostracized by their family, their wife was able to successfully petition the court so she couldn’t have a relationship with her kids. So, it was in response to that that led to the suicide so, like, in some ways it makes sense that they didn’t see much options and so suicide became, like, I almost… So, I-I talked about it as that they were murdered by transgender oppression. *(Murdered By Transgender Oppression; lines 6-13 of 18)*

Here Michael outlines his understanding that suicide is not solely an issue of the individual. His client may have killed themselves, but Michael connects their death to a social justice issue, namely the oppression that transgender people face. He thus considers this to be a death by murder rather than by suicide. Michael’s view provides a counter narrative to the suicide prevention discourse in which suicide is framed as a preventable problem located within the individual person and connected to their mental health (White, 2016). He adds a political
dimension that is missing from this discourse by considering the structural issues that affect people’s lives.

At the time he experienced suicidality, Michael did not share openly that he was seeking mental health treatment. In *A Personal Affair*, he remarks about going to therapy as a mental health professional: “It’s still something that’s, you know, a struggle.” He tells the story of attending a therapy appointment in the same building where he and some of his former students worked. When he met a former student, he hid the reasons for his presence:

> It’s still something that’s a, you know, a struggle because I remember that around that time I did go to therapy, as I said, and I have a health insurance called [insurance company name], and I used to work at [insurance company name], and also a lot of my students and ex-students, they work for [insurance company name], once they graduate, or they’re, you know… yeah, mainly when they graduate, or they’re in their social work program. It’s, like, their practicum. I went to therapy and it’s local, I’m in the same community, and I was in the lobby and I realized, like, I looked over at the list of providers and about half of them were my students, previous students. And one the students came out or, you know, colleagues, ex-students and ‘Hey [participant name], what are you doing here?’ And I said I was there for a field visit, rather than being honest as to why I was there. So, so there is—there is that, you know, sensitivity about it. And then also… or personal affair. *(A Personal Affair; lines 13-19 of 29)*

During the interview and as I first worked with this story, I felt myself nodding and completely understanding the sensitivity of the situation, especially in light of being confronted with the possibility of seeing a former student as a therapist. However, as I have learned throughout this project, whenever I feel easy agreement, I should pause. Quite often, these instances alert me to the presence of a dominant discourse that I am so familiar with that it has become hard to see.

Indeed, I see in this story the dominant discourse that helping professionals should be well and not in need of therapy themselves. The need for help becomes thus a sensitive and personal affair, as Michael notes. This discourse pathologizes seeking help to get better. Given
what helping professionals do, this is not without irony. I wonder, should we not instead advertise our own engagement in therapy or other helping contexts as a testament to how helpful it is? Instead, acknowledging that we as professionals need help with the problems that we are tasked to help our clients address seems to disrupt the idea of the expert who knows what to do, and this disruption is, more often than not, seen as negative. This is curious, given what Michael discovered during his therapy:

> What was interesting is, the person I saw […] And her specialty was working with mental health professionals who have mental health problems and suicide thinking and depression. That was her specialty. […] Yeah, she said about half of her caseload were mental health professionals: psychiatrists, psychologists, social workers.  
> *(A Personal Affair; lines 20-27 of 29)*

Within the wounded healer discourse, Michael’s embarrassment about meeting a former student as he accessed therapy for himself hints at the fear of being seen as an impaired professional whose own issues may hinder their work with clients (Jackson & Ta, 2001; Zerubavel & Wright, 2012). Michael notes that this episode occurred in the more distant past, and it is possible that he at earlier stages of his career felt less able to be open about his lived experience, for fear of professional repercussions.

In the present, Michael is open about his lived experience with suicidality, depression, and with having sought out therapy himself. For example, he speaks about his lived experience with suicide with students in his social work courses and, as I experienced, as a workshop facilitator. He also shares his personal experience with suicidality and how he dealt with it in therapy. In *Maintaining A Relationship To Hope*, he tells the story of a long-time client who sporadically consults him and who experiences suicidality:

> There is somebody that I’ve seen on and off for years and they come back and consult me now. Not on an ongoing basis but… And they were doing well, they’d gone through so much but they were doing well and then all of a sudden they just… some severe suicidal thinking and they came to see me and I thought, you know, they… that I, because they
came to see me in response to the suicidal thinking, that it didn’t—didn’t fit what what they wanted. They were still able to maintain some relationship to hope. So, in that context I remember I did share my experience and, you know, my-me reaching out was a testament of maybe, like, still maintaining some hope. [SH: Hmhm] So, that’s—those are situations where I’ve done it.

(Maintaining A Relationship To Hope; lines 8-13 of 16)

It is my reading that with this openness Michael counters the artificial divide between therapist and client and levels the interaction between the two. Additionally, as time has passed, Michael no longer considers his experience in therapy a personal affair. He is now using the healing of his wound with the help of another professional as an example of what is possible. By doing this, he offers a reading of the client’s story in which seeking help can be seen as a sign that the client’s relationship with hope remains stronger than that with suicide. He bolsters this reading with some evidence, that is, the therapist’s lived experience with suicidality and how he lived to speak about it.

Hollie – There Is Still a Part of Me That Knows What That Feeling Is Like

I met Hollie at a professional development event. She lives in the United States and works as a newer mental health therapist for an organization that primarily serves the LGBTQ community. She offered to be a part of this study as soon she found out who I was seeking to interview, telling me that she would like to help. Hollie experienced chronic suicidality from childhood into her mid- to late 20s.

Throughout the interview, Hollie continued to talk about a client who was foremost on her mind when she thought about our subject matter. At the time, they were the person with whom she had worked the longest out of all of her clients. As I read our interview and thought about Hollie’s stories, I realized how much we had benefitted from this person being a part of our shared narrative, as they helped us to talk about theoretical concepts and our beliefs in both a more concrete and a deeper way. I feel grateful to them.
When I first reached out to Hollie to set up an interview, several of the people she was working with were dealing with active suicidal ideation and suicide attempts. She requested that we postpone our interview but still wanted to participate in the study. We eventually found a suitable date and met via Facetime in our respective homes.

Not surprisingly, our conversation jumped off from the recent events at her workplace and the impact these had on her, and Hollie openly shared her ongoing reflections about how to integrate her lived experience in her work in a way that feels right to her. Hollie identified her lived experience with suicidality as something that gives her an extraordinary amount of empathy for her clients who also experience suicidality, an amount of empathy that at times feels draining:

I mean, I think it’s hard sometimes. Recently I think I have just been pretty exhausted and a part of that is because, as I mentioned to you, I’ve had a couple of clients in the hospital with pretty intense suicide plans and an attempt a couple of weeks ago and, I mean, as much as I think that I’ve done a lot of my own work I think there is, like, still a part of me that knows what that feeling is like and that-and that amount of empathy, I think – as much as I try to uphold emotional boundaries – can be pretty draining.

(It’s Hard Sometimes; lines 1-3 of 10)

Throughout our interview, Hollie not only spoke about her empathy for her clients, she also expressed that she cares about them and works thoughtfully to create connection and trust in their interactions. However, she also noted how she grapples with feeling “emotionally drawn in”, when confronted with her client’s suicidal crisis, and how this can make it difficult to “uphold emotional boundaries”:

[…]the emotional draw is-real and I’ve been trying to identify what it is that gets-that keeps me, like, drawn in in a way that doesn’t feel as, like, as boundaried emotionally as some of my other clients. And I think that just the chronic suicidality is something that I experienced for a long time in my life from, like, childhood until probably my mid- to late 20s. And so, I think… yeah, I just-I think that really plays a role in-in me trying as a newer clinician – I’ve only been doing this work for a year – in me trying to learn how to uphold the kind of emotional boundaries that can keep me in this work in a sustainable way.
Here, Hollie touches on the discourse of how helping professionals ‘should’ be that has also shown up in Salal’s interview. While professionals are expected to possess empathy, we are also asked to set ‘appropriate’ boundaries. Complicating matters further, we must watch for diminishing empathy as a sign of burnout, or compassion fatigue (see, for example, Coetzee & Laschinger, 2018). It seems that in order to be successful professionals, we are required to care just the right amount, the Goldilocks definition of empathy.

Hollie’s workplace allows for openness when it comes to mental health difficulties. Her colleagues often discuss their mental health concerns with one another, and her supervisor has been open with Hollie about her own mental health difficulties. Yet, speaking about her familiarity with suicidality remains difficult for Hollie, which she links to the stigma surrounding this topic:

[…] I think stigma plays a pretty strong role in why I don’t disclose that both with my clients but also in supervision. And I suspect that my supervisor would be pretty understanding, but there is still something holding me back from sharing that piece. (There Is Still Something Holding Me Back; lines 4-5 of 43)

She notes that she does not have role-models in her professional community who have provided examples for how to speak about one’s lived experience with suicidality:

[…] an interesting thing that I’ve been thinking about in leading up to talking to you about this because I think it’s something not only that we don’t really talk about with our clients but that we don’t talk about with our peers, and also that I don’t really talk about in supervision […] (There Is Still Something Holding Me Back; line 2 of 46)

Additionally, Hollie feels anxious, though she is unsure if this is justified, about disclosing her lived experience with suicidality, and how it affects her in relation to her work with her long-time client, to her supervisor. She fears she might be thought of as someone who is not ready to be a therapist:
[...] the anxious part of me is maybe afraid of what she’ll—what she’ll think—about—yeah, I don’t know—about about my readiness to be a therapist or my having done enough—enough of my own work, but in reality I don’t think really that she—she would say or think that... She is pretty supportive and I think—she hasn’t talked about her own suicidal ideation kind of experience but talks about her own mental health stuff pretty openly, so, I—I don’t really think there would be any repercussions when I’m thinking about it logically, but there is still sort of an anxious part of me that’s like: ‘Oh, this might bring up so much of my own, like, stuff that she’ll think that I’m not ready to be doing this work.’

(There Is Still Something Holding Me Back; lines 18-20 of 46)

No matter Hollie’s feelings about how helpful the disclosure of her lived experience with suicidality could potentially be, the decision to disclose cannot be made without considering the fallout for herself. As a new therapist, Hollie is working under supervision, and it is important that she is not seen as an impaired professional whose wounds are endangering her clients’ healing (Jackson & Ta, 2001; Zerubavel & Wright, 2012). Her professional future is dependent on her being evaluated as “being ready to do this work”. Within her workplace, the stakes seem higher for some forms of lived experience than others: As noted above, it appears to be more permissible and normalized to share one’s experience with mental health difficulties with colleagues, supervisors, and clients than that of suicidality.

To an extent, Hollie has internalized the stigma surrounding suicide, and she notes that she “[doesn’t] necessarily think it’s appropriate to talk about it with [her] clients or [...] just, like, around the office”, which is different from other difficult subject matters, such as mental health issues, which are discussed between colleagues and sometimes shared with clients.

However, she also adds that another reason is her fear of the reactions her disclosure might elicit:

And I think, you know, some of my own fear is— and maybe this is true for you, too— is just what other, you know, what other people will think or if—or I, like, fear that they’ll feel like they have to caretake or do, like, do something to change that when there’s not anything anyone can do or say, right?

(There Is Still Something Holding Me Back; lines 45-46 of 46)
Despite her hesitance and worry that there could be professional repercussions, Hollie once made the decision to disclose her lived experience with suicidality to her long-time client, when they expressed shame around their suicidality. She talks about this in a story I named *Uncharted Territory*:

I think I’ve shared it with one client, that client that I have kind of talked to you about, it’s the client that I’ve been seeing the longest… who has really chronic suicidal ideation and I-I didn’t share much about it. I don’t even remember exactly what I shared – I think just that, like… I think they were just expressing a lot of shame and were like: ‘Ugh’, like, you know, like, ‘Nobody really thinks like this, why am I thinking like this?’ – like, a lot of, like, self-designating as ‘crazy’. And I was like: ‘Actually, you know, a lot of people experience this, especially people in the queer and trans community but-but other people too, certainly. You know, there is suicidal… suicide, suicidal ideation – I mean, just like addiction – is, you know, something that people across race, class, gender, sexual orientation, right, a lot, you know, a lot of people experience it.’ There are higher rates of suicidality amongst certain-certain people… But I think-I think I, you know, I have shared it one time in the-in the interest also of normalizing but it’s something that I don… I have lots of clients who… both are chronically suicidal and… Or even who are just, maybe I wouldn’t say chronically suicidal but experience a lot of passive… suicidal ideation they don’t always talk about but I-I don’t share that typically. I think I just felt compelled to share it with this-with this one person on, like, one particular day in one particular context but… but, yeah, it’s not really something that I-that I share.

(*Uncharted Territory*; lines 2-10 of 38)

In the interview, Hollie notes that she does not remember much else about the disclosure, and we marvel at how unremarkable the event was, given how much meaning it held as the only such disclosure. Upon reading the transcript, I noticed how much less fluid Hollie’s telling of this story was than others she had shared. It is difficult to tell the stories for which we do not have an established form, and there is none widely available for the disclosure of suicidality with a client (yet), at least not one where the disclosure itself is allowable. It seems to be a difficult to express and maybe even forbidden narrative.

In *Multiple Layers Of Feelings*, Hollie tells the story of her long-time client’s suicidality and the balance she tries to achieve between her belief that suicide in the end *is* a choice and her wish for her client to continue living, while being respectful of the context of her client’s life:
One client I have, the one I’ve been seeing the longest, who had some quite serious attempts, like come-come very close several times. And when I think about the context of this person’s life and what they’ve been through and hate crimes and abuse and all, like, all sorts of things I have never had to deal with in that way. And it makes a lot of sense that that a) like, be an escape phantasy but also that that a person would get to points in their life where they feel like they don’t wanna do it anymore. And, yeah, so I think there just are a lot of different types of thoughts and feelings and emotions that go along with-working with someone who experiences chronic suicidality in a… Yeah, I feel like it for me, sometimes it’s a balancing act for me, like, working to help people safety-plan and, you know, think about what’s worth living for and what brought them in to talk about suicide versus actually, you know, going out and acting on those thoughts. Which all of those things are important and also, like, a part of the ethical obligation that I have to help people see that there are other choices, but also, like, balance that also with the knowledge that, like: ‘This might happen!’ And as much as I fear it happening and I don’t want it to happen for lots and lots of reasons, it’s actually this person’s choice. And that’s—yeah—it’s just kind of, like, a fine line to walk. Yeah, and I don’t know that I’ve found a perfect balance of working with that but I’m working on it. (Multiple Layers Of Feelings; lines 17-24 of 24)

With this story, Hollie offers a counter narrative to the earlier mentioned dominant suicide prevention discourse in which suicide is viewed as preventable and inherently individual. Like Michael, she thinks about her clients’ engagement with suicide in a way that is responsive to their lived reality, for example, as marginalized people who face oppression.

Hollie further integrates her professional ethical obligations as a therapist, while not betraying her deeply held beliefs about choice and bodily autonomy:

Like, on one hand, like, I obviously really care about my clients and have a stake in helping them choose life over other options. And on the other hand, I also believe pretty strongly that people should have full autonomy over their own lives and their own bodies and so suicide is a choice. And as much as I don’t want to see my clients make that choice – both because I care about them, and because it would have an emotional impact on me, and, you know, possibly cause investigations and things that would be stressful in my work, right, that like, all of that aside, like, people… [Sighs.] Yeah. People have the right to choose suicide if that is what they decide to choose. (Multiple Layers Of Feelings; lines 13-15 of 24)

The narrative Hollie offers gives voice to a feeling of ambiguity that is always present for me when I think about the prevention of suicide, whether it be mine or that of a client. On the one hand, I strive to remain hopeful, and on the other hand, I understand and appreciate that there is a
level of pain that can cause a person to see death as the solution. However, this ambiguity appears to be absent from the dominant discourse of suicide prevention, and runs counter to campaigns that declare suicide entirely preventable (see, for example, “Suicide is Preventable”: https://www.suicideispreventable.org/ and “Zero Suicide”: https://zerosuicide.sprc.org/)

**Lila – If You’re Helping Other People, You Should Be Okay, Too**

Lila is a white woman who is a trained counsellor and works as a clinician specializing in suicide intervention. We have known each other for a number of years, both in a work and in a private context. At Lila’s request, we met at a restaurant where we found a quiet spot in the far back of an enclosed patio, away from other tables. We had a meal, during which we caught up on each other’s lives, before starting the interview.

I believe that first having a meal together helped us feel comfortable with the interview situation. As noted in Salal’s interview, entering into a research relationship with someone with whom I have a pre-existing relationship has had its challenges and its advantages. Adjusting to the change in tone from a casual meandering conversation about this and that to a research interview focused on a specific topic is one of those challenges. However, as Lila made clear towards the end of our interview together, our pre-existing relationship and the fact that she trusted me were what prompted her to want to participate in this study:

> Yeah, like, I knew that I could open up to you and feel comfortable with you, like, most people that wouldn’t have been the case, so…
> *(The Cat’s Out Of The Bag; line 42 of 42)*

Lila began to respond to my initial prompt by telling me the story of her lived experience with suicidality. She connects the beginning of her suicidality to a crisis that occurred when she was in her mid-twenties, and also to longstanding feelings of hopelessness and pessimism throughout her life, and she has continued to have feelings of suicidality since that time.
And I’d say, probably the first like real clear suicidal thoughts started in sort of that breakup time. I think I probably always have had a bit of a pessimistic view of the world and my place in it. And I have probably always sort of felt this weird sense of hopelessness but I-I don’t recall really ever seriously thinking about suicide until this kind of first time. And… it was just – I was just in so much pain, so sad. I felt really alone and… I-I started thinking about it. And luckily, I had lots of friends who were also helping professionals – I just started-I think I just started my Master’s program around that time.

(Thoughts Of Death And Dying; lines 15-20 of 85)

Like Salal, Lila had not shared her lived experience with suicidality with me before, even though we had known each other for a number of years. I had originally reached out to her to ask her to forward my invitation for this study to her professional networks. In response to this, she let me know that she wanted to participate. Not knowing about her experience, I was unsure whether there had been a miscommunication, and I contacted her to clarify her fit with my recruitment criteria. During the interview, we spoke about this. Lila noted that she feels embarrassed about her history of suicidality in light of the work she does, and normally hides it:

SH: […] we’ve never had that conversation and I may have well misunderstood, right?

I think because I probably downplayed, like: No, but, I do this for a living… no, no, no, but: I [emphasizes I] help people.

SH: That’s right.

And that’s, that stigma. It’s like I couldn’t be because this is what I do every day.

SH: That’s right.

So, yeah, fuck, am I embarrassed? For sure! Do I feel embarrassed about it? Yeah.

(Thoughts Of Death And Dying; lines 68-76 of 85)

With this exchange, Lila also introduces one of the main themes of the interview, namely what makes a ‘good’ therapist. Lila subscribes to the idea that therapists have a responsibility to attend to their own difficulties and become well, prior to attempting to assist clients with theirs.

So, coming here [Vancouver] I knew that was the-the area I wanted to get into but I was still drinking and doing drugs, like, but it was in the program where I was like: ‘Shit, I
maybe need to stop that. I maybe need to stop this. If I’m gonna be a therapist, I probably should to get my shit together.’

(Getting My Shit Together; lines 14 of 34)

Lila sees this as a matter of authenticity:

Hm hm... I just I felt like I can’t be, it would be very, like, double standard if I’m going home and drinking my face off and trying to help somebody who’s going through that, you know? It was like, I needed to be true to who I was and what I was experiencing in order to help somebody else. So, I started going to counselling and stopped drinking as much and... [Pauses]

(Getting My Shit Together; lines 19-20 of 34)

Attending therapy while becoming a therapist was also encouraged in her program:

But I-I didn’t, like, I’d never gone to therapy until I was in my Master’s program. [...] They didn’t make us, but it was, like, strongly recommended that you also engage in your own therapy to sort it out. [Laughs.]

SH: What did you call it: The dark corners…?

The dark corners of our minds.

(Getting My Shit Together; lines 30-34 of 34)

While Lila believes that being well is important to her work with clients, she also sees the downside of this expectation, which comes at her from both external sources, such as the general public and clients, and internally from herself. Being expected to “have your shit together” does not allow her to be open about her own struggles, for example her dealings with depression, and having internalized this expectation makes her feel as though she is lacking:

[...] I would never, like, [publicly at work] share my story about depression and being a mental health professional... like, I would never! You know, like, I just, I don’t know, that’s, like, a no-go zone for me. [Laughs.] [...] Because I-I would feel embarrassed! ‘Cause I do think that there is that expectation that you have your shit together, like, if you’re helping other people, you should be okay, too. Like I-I-I-I think I think that, plus I think other people think that, so...

SH: You think that-you think that, too?
Like, not... like... I have that stereotype, or not stereotype but that, like, in the back of my head. I don’t actually think that, like, 'cause I know that isn’t the case, like... [Chuckles.] I-I’m a living embodiment of that, so I know it’s not that but I think in the back of my mind there is, like, a little voice kinda that’s always, like, you know?

SH: Do you think... so you... do you feel like you should be ‘okay-er’?

Yeah! [Answers without hesitation.]
(You Should Be Okay, Too; lines 36-44 of 55)

Lila grapples with what she sees as the expectations of others, both inside and outside of her profession, for how a helping professional should be. Even though Lila does not directly speak to this, I also wonder how the wounded healer discourse with its warning of the impaired professional whose impairments pose a potential risk of harm to clients plays into this. Lila does not want to be of disservice to her clients, and she was taught when she became a counsellor that the healer must first heal themselves before helping others, thus leaving her few options of how to engage with her own ongoing difficulties. Not being “okay-er” brings shame and can easily be understood as a lack of skill as a professional.

Lila extends the expectations that she has for herself to her own treatment providers. She illustrates this through a story about her current treatment provider who, in her mind, embodies the ideal of a therapist who has experienced struggle and has successfully dealt with it:

I do like my counsellor that I see now. The first time I went to him, he very briefly spoke about his own experience with x, like... – I think he was sort of explaining all the different treatment modalities that he uses and said, like: ‘I’ve even been through blablablabla.’ So he didn’t, like, go into detail but, like, expressed that he has struggled with his own stuff, and that he has done the whole treatment thing, and that he found that really helpful and then, you know... So, that was interesting. [...] Well, and to hear somebody who clearly struggled, yet is presenting himself to be very capable and very well-versed and knowledgeable and, like, engaging therapeutically, that felt good. Even though I know he’s struggled with all this other stuff, like, to me that didn’t put me off or anything, like...
(Being An Example; lines 1-4; 17-18 of 32)
In this story, she also shares some of her beliefs around the disclosure of the helping professional’s lived experience with clients, when she notes that the counsellor “didn’t […] go into detail”, of which she approves. Based on her training, Lila believes that sharing personal information of any kind is only done in a “tactical” way, that is, for a purpose, which is what her counsellor has done:

So I just… yeah, so for me, like, I can remember my practicum: I know I shared things but it was-it was-it was tactical. (SH: Okay.) So, that’s kinda what I mean.

SH: So, by tactical you mean you made a dec… – you had a goal or something.

Yes, like, like I-I chose something specific that I shared because I thought it would move the treatment or the therapy in a direction that I thought it should go or, you know, like, it was a tactical sharing.  
*(Outside Of Here We Could Be Friends; lines 16-19 of 30)*

Resulting from her beliefs, Lila does not disclose her lived experience with suicidality or mental health problems to her clients, as she feels it would shift the focus of the therapy away from the client, which she does not consider to be useful to the client:

I just don’t think it needs… I don’t-I just don’t think it nee…-it should be about me. Like, in those conversations, like, for some maybe hearing someone else, maybe that could help them feel differently about their circumstances, but I just don’t ever want it to be about me, like…

SH: So you have a really strong sense of: I’m there to help them, this isn’t my-it’s not my gig.

Yeah, yeah, yeah – no I don’t think I would ever cross that.  
*(It Was Like I Was Talking To Me On The Other Line; lines 34-37 of 37)*

Even if done with a purpose, Lila believes that the sharing of personal information by the therapist can amount to “crossing the line”, and she provides an example of this in *Outside Of Here We Could Be Friends*. Here, she tells the story of her experience in the role of a client seeing a therapist who disclosed information about herself:
Like, I can remember my therapist sharing a lot of her personal life with me. (SH: Right.) And I always felt there was just a little bit of a weird, like, it was a bit crossing the line, like, I know she was trying to, sort of, show that it’s like: ‘It’s not just you’; like: ‘This happens to other people’; ‘In my experience, I have also ditditditdit…’, so…

SH: […] it bothered you?

I think because I felt like in general she was very, like, I think she wanted to be my friend, (SH: Oh.) and I kinda got that sense I find that when people find out that you’re a counsellor or that you do this kind of work, it shifts the dynamic, (SH: Yeah.) and I think she – because, you know, we have maybe slightly more insight than other people that don’t do this work, and, you know, maybe we’re able to talk differently than other people and so it’s maybe-maybe it’s more engaging or it’s… – but she used to always say like: ‘I really enjoy talking with you’ and ‘I know outside of here I think…’ like, she said once, like: ‘Outside of here I think we could be friends.’, and I was like: Oooooooh…

(Outside Of Here We Could Be Friends; lines 3-8 of 30)

In her relationships in which she is not the helping professional, Lila has shared some details about having depression, taking medication and seeing a therapist. She also shared that she is dealing with depression on social media during an awareness raising day and was surprised by the positive response. However, this sharing remains superficial and she is not sharing the true extent of her difficulties, partly because some of the reactions to what she has shared in the past have been dismissive:

So, I could-I can, like, I could share things, like, I could-I could say I’m depressed but I won’t show you! If that makes sense? Like, you’re gonna get the façade, the mask, not the – what I look like when I go home at night, you know what I mean?

[…]

So… I just think with suicide, like, it’s like – [Pauses.] I think people would be shocked, I think, to hear that from me. I think people have been shocked when they’ve heard I’ve got depression and then to, like, say ‘I’ve thought about killing myself’, I think they would be, like, shocked. And I think, like, I-I have gotten the ‘But your life is so good!’

SH: Oh... when you have said that you have depression?

Yeah, even from family, like: ‘But what do you have to be-what do you-you have a nice house and you have a car and you have a nice boyfriend and you have friends and… Why-why are you so depr…-like, why could you be depressed?’ Like, people just don’t get it, right? And so, I think it’s-I mean, even my family, like, I don’t go into detail about my depression, like, they know I take medication and sometimes I see a counsellor and… but I’ve never, like, gone into detail.
As she notes in this story, she sees a difference in speaking about having depression and speaking about suicide, with the latter being even more difficult for her. Shortly before our interview, she began cautiously sharing her lived experience with suicide with one colleague, when a situation she could relate to arose with a client. She also told another colleague that she was participating in this study, thus implying that she had experience with suicidality.

Even though she is not sharing that she has lived experience with suicidality with her clients, Lila believes that having this experience is beneficial and has allowed her to feel empathy with suicidal people:

I mean, I think I’m probably very accepting, like, I think it probably helps in a positive way.

SH: When you say accepting, what do you mean?

Like, I-like I said earlier, like, I get it, like, when someone is talking to me about suicide, I’m not, like, shocked by it.

SH: Oh, I see.

You know, where maybe some people are, hopefully not in our field but, like, I-I-I, like, when they’re talking to me telling me the story, it’s like, I can-I can put myself in their shoes and be like: ‘Yeah.’ And so, my reaction to them or what I say or how I say it may be slightly tempered by that, like, I’m-I can easily acknowledge, hear them, there is no judgment, there is no: ‘Yeah, look at all the great things that are going on in your life!’ Whereas other colleagues of mine that I know would say something like that. Like, I can really empathize.

(Its Helps In An Interesting Way; lines 3-10 of 39)

However, she feels that it is important to remain cautious and focussed on the client:

And I don’t think I’m somebody who underreacts, like, I-I think I’m-I’m good at, like: Just ‘cause I’ve been there doesn’t mean that my experience is your experience. Like, I can see the similarities or… but I still don’t – I’m not you – I still don’t know what you’re feeling.

SH: So you don’t automatically assume that what is true for you is true for other people.
Right, no, I definitely don’t do that. So, yeah, I think it helps actually in an interesting way.

(It Helps In An Interesting Way; lines 12-15 of 39)

Being a counsellor with lived experience had a particular impact on Lila when she worked with a client who reminded her of herself, and she felt the after-effects of that interaction:

[…] I remember there was one [client] that, like, just, like, touched a nerve: Like, she was similar to my age, you know, similar backgrounds, like, she just… it was like I was talking to me on the other line and that was particularly difficult. I was like: Fuck…

[…]
SH: That woman who was so similar to you, did you do anything different when you talked to her than you do with other people?

I don’t think so, I think, just… no, I don’t think so. I think I just really, like, I felt like that was me in that moment. Like, usually, I can, like, separate, like, the circumstances are so very different than mine and it-I can empathize but it’s like: Different life, different….

But this girl was, like, so similar to me in so many different ways, it was just like: Huh! I thought about what I would write [in a suicide note]. I almost got up in the middle of the night and wrote it one time but…

(It Was Like I Was Talking To Me On The Other Line; lines 6-7; 13-19 of 37)

[…]
SH: How did you handle that?

Just I think like I did with any other, like: Asked the questions, followed up with what she said and asked probing questions and, you know, ensured her safety and offered resources and, like, I think I was able to h… I mean, I think that’s how I could have handled it but I’m subjective, obviously.

SH: But it was – was it more difficult for you?

It just – when I got off the phone, I was just uuuuuugh…

SH: The aftermath was more for you than for her?

Yeah, like, that was one I needed to, like, process, yeah.

(It Helps In An Interesting Way; lines 27-32 of 39)

As is her process, Lila did not tell this client about their shared experience. Instead, she attempted to engage with her as she would with any other client, as she believes is the right thing
to do. However, the similarities between her life and that of the client deeply affected her, and it
took time for her to process the fallout from this interaction.

**Nina – It’s Given Me Permission to Let People Know That I Really Care**

Nina contacted me by email after she had received an invitation to participate in my study
from one of the professional contacts that I had asked to forward it through their networks. She is
a counsellor in private practice, an educator in a counselling program, and speaks about mental
health in both volunteer and paid capacities.

Nina told me she is married to a man and the mother of two school-aged children. At this
time, she is the primary caregiver to her children, while her husband is the primary breadwinner.
She described herself as belonging to the Indian community and as active in her faith
community, though she did not tell me what faith she belongs to, and I did not ask her. Prior to
meeting in person, we emailed back and forth to make sure she fit the criteria of the study and
felt comfortable participating. Nina had at first requested that we meet in a coffee shop but had
then reconsidered, given the sensitivity of the topic, and we settled on meeting at her counselling
office.

This was my first and only interview with a participant I had never met. All of my other
interviews were with participants I was more or less familiar with and had met in person before.
The latter had created its own sets of unknowns about how each situation would unfold, but I had
at least had some familiarity with each person. This time, I was almost completely in the dark
about what to expect. I prepared extensively by going over my notes and thinking of possible
questions and scenarios that could come up, none of which alleviated my nervousness, and I
made note of this as I arrived at Nina’s house. We had agreed to meet at her home office on a
weekday around the lunch hour, when both of her children were at school, and her husband was
at work. Her office was located in a bright and welcoming space at the back of her house, overlooking a backyard. I settled in an armchair, and she made herself comfortable on a couch opposite me. On the wall she had a sign speaking to her belief in the importance of story in a person’s life and this, along with Nina’s warm, open and welcoming demeanor put me immediately at ease. I believe this was the same for her, as we immediately and easily dove into a frank conversation about what it means to her to be a therapist with recent first-hand lived experience with both suicidality and depression.

Responding to my initial prompt, Please tell me the story about your experience as a counsellor who has lived experience with suicide and who works with people who are suicidal, Nina began by telling me the story of her experience with suicidality. Several months before our interview, she had started to experience acute suicidal thoughts, after being prescribed anti-depressant medication. She had received this medication to deal with an intensive period of low mood and other difficulties she identified as likely connected to a depressive episode.

As the suicidal feelings had grown more intense, she had made a plan to kill herself. One day, while her family had been out at their place of worship, she had decided to put this plan into action. As she had been getting ready to kill herself, she had remembered that she knew that some anti-depressant medication could play a role in people experiencing suicidal feelings. She decided to reach out to trusted family members to find someone to talk to. However, almost everyone was out to worship like her husband and children, and she was not able to talk to anyone for some time, until she reached a relative to whom she is close. This person continued to talk to her until her family was back at home. Nina describes this as the most intense episode of suicidality she has had, though she also notes that she has had thoughts about killing herself prior to and after that day.
When Nina talks about feeling suicidal, she expresses strongly the ambiguity she felt towards living, and how the amount of pain she was in overwrote the positive elements in her life that otherwise sustain her, or what in the language of suicide prevention is referred to as protective factors: her children, her husband, and her career.

And I was really con…, like, really confused and torn in both directions, like, it would be an easier way—it would be easier—and it didn’t matter that I had kids, and it didn’t matter that I have a loving husband, doesn’t matter that I have a career—it was like, I was in just-in so much pain.

(*I Was Just In So Much Pain*; line 47 of 87)

Nina also describes how, as she was living through her most difficult times, when her mood was at its lowest, she did not feel life was worth living. This feeling stayed with her, even when she considered that the pain would not last forever. At these times, the thought of suicide brought “some relief”:

And at some point I’d stop being able to, like, get up when he’d [husband] get home and so we just, like… I basically camped out in my living room. Like, we have a futon in my living room, so I’d just like set up a bed in there and I would just, like, be watching TV and, like, I couldn’t even go upstairs. Like, I couldn’t even, like, muster it. And so, when I was thinking of the suicide, I actually felt, like, some relief. […] I remember saying to my sister […], I said: “If I have to live like this for, like, even two years, I, like, I can’t do it! This is not a life!”

(*This Is Not A Life*; lines 46-51 of 51)

Nina was able to obtain a cancellation appointment with a psychiatrist a month after she had put her suicide plan into action, and her medications were adjusted several times, which provided some relief. While she continued to think about suicide, by the time we met for the interview, her feelings of suicidality had not returned to the same degree.

During her episode of depression and feeling severely suicidal, Nina continued to work, and she considered her work with clients important for her own wellbeing:

[…] and I was seeing clients, actually, in the depths of all the pain. And I felt like… when, you know, my husband was, he was like: “How can you do that?” And I think it’s because when I was with a client, my own stuff wasn’t, it wasn’t in front of me, right? I
could move it to the side and actually be fully there with their problems, and not really have to think about mine.

*(I Was Just In So Much Pain; lines 19-21 of 87)*

But… the meaning, like especially people who work in jobs that have real meaning for them and they’re making a difference and they’re making impact. Like, being a mom was not meaningful enough for me - imagine! It’s being a therapist that was the meaning that I-that got me up. At least once a week having a shower, at least once a week talking to another human being besides my family. Like, that’s what…

[…]

But it was… it… but again, like, seeing the transformation in people and being able to witness that, even in the depth of despair, that was profound for me.

*(Needing Others; lines 59-60; 70 of 70)*

As she notes here, her clients were Nina’s motivation to get up, seeing them allowed her to shift her focus away from herself, and it was her work that proved most meaningful while she was unwell. With this Nina offers a perspective that remains largely absent from the wounded healer/impaired professional discourse, namely that she also benefitted from the being able to work while she was struggling with mental health difficulties and suicidality. Outside the helping professions, it is common to recommend to people who are experiencing mental health issues to remain connected to their workplaces in an effort to help their recovery, for example, through connection with their social systems and meaningful routines. Thus it should not come as a surprise that a helping professional who seeks meaning in her work would find it beneficial to continue to work.

At the same time, speaking openly about working while acutely wounded is not common. In fact, during our interview I asked Nina if there ever was a point when she felt guilty that she had continued to work throughout the worst parts of her low mood and suicidality. She responded emphatically:

No, never! Never, never, never, never.

*(Needing Others; lines 62-63 of 70)*
That I thought to ask this question, indicates to me how deeply rooted certain features of the wounded healer discourse – for example, that an acutely wounded healer at least potentially presents a danger to their clients – are in my understanding of what it means to be a helping professional.

Not all helping professionals who experience mental health difficulties and suicidality prefer to stay in the workplace while they deal with their own crises, though many likely have to, depending on their financial situation, the availability of disability insurance or assistance, or the danger that their private practice will lose clients if they are absent for too long.

Nina was able to make a choice about how she wanted to and was able to work. This ability to choose was also contingent on her already part-time practice: She explained to me that the income she gains from this work is not necessary for her family’s financial survival. Additionally, she runs her practice out of her home. These factors minimize the stressors that she may have felt as a full-time employee in the public sector and/or as a therapist whose practice is the main family income.

In the story *Needing Others*, Nina also unsettles the dominant discourse of being a ‘good’ mother, when she explains that it was her work that provided the most meaning to her during times of crisis, not her children:

Like, being a mom was not meaningful enough for me - imagine! It’s being a therapist that was the meaning that I-that got me up.

*(Needing Others; lines 57-58 of 70)*

Current discourses of (good) motherhood presuppose that mothers see children as positive factors in their lives, or, if this is not the case, will sacrifice their own wellbeing for their children because they feel that it is in the children’s best interest that their mother stay alive. These discourses leave out structural issues that negatively affect mothers, for example a lack of
financial, emotional, and medical support, and that may be important factors in mothers’ mental health or suicidality crises. Such discourses permeate suicide intervention contexts just like any other part of society, and it is common for suicide intervention professionals to assume that mothers who are, like Nina, predominantly the primary caregivers of their children, consider their children as reasons to stay alive, and themselves as a positive force in their children’s lives, even as they struggle. While this may be the case for some mothers, Nina’s openness points to the need to consider that it also may not be a reality for women who experience suicidality.

Throughout the interview, Nina expressed just how much she feels that her lived experience with both depression and suicidality has changed her practice as a therapist, her teaching, and how she speaks about these issues in general. In *I Could Speak To Him In A Totally Different Way*, Nina notes that her first-hand experience with suicide allows her to feel more equipped to work with people who are acutely suicidal:

> Like, I had somebody walk in this room… During that whole time, he was probably my most challenging client because I didn’t… I, two years ago, if I had met him, I would be like: “I’m sorry, I have to refer you.” Like: “You’re just, it’s beyond my paygrade, I don’t know how to help you.” He walked into this room and I had to have him, like, shake my hand and make a contract with me that he wouldn’t kill himself before next session. (SH: Hm hm.) Like, it was that int… like, he was coming here and his next goal was, like, the bridge. Like, he was that… this was, like, the final frontier. And it was a stranger, somebody who found me online. But having the exp… like, going through what I was going through, I could speak to him in a totally different way, you know?

[…] He just had his graduation session a couple of months ago, and he wrote me a card and he said: “You saved my life!” And I know that. I know that!

(*I Could Speak To Him In A Totally Different Way*; lines 2-9; 15-17 of 17)

In contrast to how she would have approached this encounter in the past, Nina does not refer the client elsewhere because she feels the situation is beyond her professional capacity. Neither does she involve emergency services, despite his acute suicidal thinking and planning. Instead, she
negotiates next steps directly with the client, trusting his assurance that he would not kill himself but instead come back to see her the following week.

Nina notes that this change from her previous way of working with suicidal clients is primarily due to her new learning in the wake of her own crisis, which made her feel more comfortable with a client who expresses acute suicidality. However, it is important to consider this in the context of Nina’s work in private practice, which gives her greater freedom. It is less likely that she would have been able to work in the same way with an acutely suicidal client in a public setting, if she had been under supervision, for example as a new therapist, or if she were working in a jurisdiction where therapists can be sued for their clients’ death by suicide.

In *I Was Just In So Much Pain*, Nina describes how her relationships with clients who are suicidal or depressed changed after she experienced depression and suicidality herself. In response to her own experience, she began to move away from the expectation that people need to be or can be “fixed”. Her focus shifted from fixing to empathy and a different way of engaging, which is rooted in a feeling of “I get that!” and influenced what did and did not help her in the midst of feelings of suicidality and depression:

> And I think what was the most surprising to me, is, I have such a different relationship with my suicidal clients now, like, I – or depressed clients. Before, when people would tell me they were depressed or suicidal, I saw that as a problem to be fixed, right? Like: “Okay, you’re depressed but you don’t always have to be depressed and you can get better!”, like, that’s how I thought. Now, when somebody comes to me and they tell me they’re depressed or they’re suicidal, I get that. I, like, I can empathize with them in such a different way and I’m not trying to fix them. Not to, like, get them out of it! [Snaps fingers.] I’m just, like, ready to join them and, like, take as long as it takes, and not say those, like, canned expressions, like: “Oh, you know, it will pass!”; and: “There is light at the end of the tunnel!”; and: “Just hold on to hope!” Like all that bullshit, I don’t say that anymore ‘cause that’s the stuff that was said to me that was so not helpful. (*I Was Just In So Much Pain*; lines 64-71 of 87)

Nina’s previous focus on fixing problems is related to her training as a counsellor, where she learned that, as a helping professional, she is the expert in the relationship, a dominant
narrative in helping relationships. Conversely, Nina’s ‘lived experience-induced’ counter-model involves moving from professional distance towards care and showing that she cares. This has allowed her to step away from internalizing the role of the expert who should not be known by her clients, and she can now ask the question: “How can I help?”

Nina outlines how she now prioritizes being “authentically empathic”, which involves a willingness to have “things touch [her]” over upholding professional distance. Rather than having to fix things, she now attempts to help clients to make peace with where they are in that moment:

Like, I have a client right now who just can’t wash her hair; she just can’t get in the shower, and I’m like: “Oh yeah, I know that. Like, that was me six months ago. I know that and I’m not gonna force you to wash your hair, right? So, how can we help you make peace with where you’re at right now? And slowly, when you’re ready, take that step?” ‘Cause for me a lot of it was about, like, making peace and accepting what was happening to me. It felt like something was happening to me that I had no control over, and I was mad about that! You know, I was like: ‘What… like this shouldn’t happen to me – like, of all people! – but it did! And I’m – I’m getting through it.

(Being In The Middle Of It; lines 31-39 of 39)

Nina connects the ideal of professional distance within helping discourses to dominant Western psychology approaches, and she critiques this model, based on her own experience of what she found helped for herself. Resulting from this shift in thinking, she notes that she now feels she is permitted to care and also voice to her clients that she deeply cares for them:

And I think… that professional distance, I think, does a disservice and maybe it’s just, like, western psychology and the way we do it here, in the west or whatever, but, like, I-I felt most supported when people said to me: “I don’t know how to help you but I love you!”, right? “I care about you!” [Tears up.] And I think it’s given me permission to, like, really let people know that I really care. And I’m not gonna just be this, like, clinical professional that’s, like, distant from you. Like, I actually deeply care about what you’re going through. And I can’t fix it – I’m not here to fix it – but I’ll hold your hand, right, and we’ll do this together.

(Permission To Let People Know That I Care; lines 33-38)
However, Nina also wonders to what extent what she calls her “new philosophy in counselling” is permissible within currently operating dominant discourse of caring for clients:

And in the past I would be, like, I would internalize it and feel like: Okay, I’m the expert and I’m going to tell everybody this. And now it’s like: ”Here, this helped! Maybe this will help! Maybe this one!” So, the resources are coming a lot more easily and I’m not worrying about all of that, like: ‘They shouldn’t know me and I should…’ I just feel like: ‘No, I’m this person, I’m not perfect, and how can I help?’ That’s my new philosophy in counselling [laughs] and maybe it’s, like, disallowed but that’s how I’m doing it now. (Permission To Let People Know That I Care; lines 33-38; 41-45 of 45)

Nina not only uses her lived experience to gain further insight into how she wants to work as a therapist, she also shares it with her clients. She regards disclosure as an act of caring that is about “connection and compassion”\(^2\), and meant to “plant seeds of hope”:

I had a client just last week sitting on that couch and she, like, she’s had a baby three months ago and she knows she has post-partum, like, she knows that, that she has PPD but she can’t–she doesn’t know what to do about it! And she’s seeing a psychiatrist and she’s at this, like, she’s in this support group and she’s doing all the things but she still feels shitty, right? And so for me, like, for her – and I made eye contact with her and I said, like: “I know.”, right? And: “If you’d seen me a year ago, like, I could have been on this couch. And today I’m on this side of the couch only because I had, like, hope. A little bit of hope that a few people planted in me, right?” And I said: “If I can even, like, help you plant that seed of hope even just one little seed, then we will have achieved what we need to achieve in this room.” (Permission To Let People Know That I Care; lines 25-31 of 45)

To her, disclosure also represents an offering to her clients that decreases the inequality in the interaction:

And if I’m asking people to be real with me, I don’t think it’s fair that I don’t be… that I get to wear this, like, mask and be perfect and I’m asking them to be vulnerable. That doesn’t make sense to me anymore, right? (Being Authentic; lines 19-20 of 45)

Lastly, being open about her own difficulties within and outside of the counselling office is an expression of Nina’s desire to reduce stigma about mental health difficulties and suicide:

I think I’m role-modelling now about how to be, how to have this challenge and not be ashamed of yourself. And not trying to hide it. And not try to, like, feel like everything is

\(^2\) In We’ll Walk Through This Together
fine. Like, no, it’s like: This is part of what I’m going through, and other people go through it, and look, you can be… Like, I said it on the stage one time, I was like: “I have depression. Maybe I don’t look like somebody who you would assume has depression because I’m wearing these nice clothes and I have this make-up on, and I have this mike on, like, that I’m but…”

SH: But this is also all I can do today…

That’s right! And I’m gonna go home and crash for a day or two after this. And I’m telling people that. And I think that now I can see how that’s a service. And if-if stigma reduction is what I’m really passionate about, I have to live that. *(Being In The Middle Of It; lines 1-12 of 39)*

Initially, Nina experienced anxiety over how she would be seen as a mental health professional with lived experience. Like Lila, she was concerned that she would not be taken seriously as a professional who cannot overcome the difficulties with which she attempts to assist her clients:

The other thing, I think, is… so when it was happening, when I was, you know… I’m talking about it now on the other side, but in the middle of it, I felt so worried that people are not gonna take me seriously anymore as a mental health professional. […] I assumed they would think: ‘Well how are you gonna help anyone, you’re struggling with the same things!’

[…]

I gave this talk on childhood trauma at the public library a couple of months ago and I said it there, like: “I’m someone who lives with clinical depression.” And it just flowed off my tongue, right, and didn’t feel like a big deal to say that at that time, right? But it took me months to get comfortable to say that and feel confident that people wouldn’t… judge my capacity as a clinician because of my mental illness. *(Being Authentic; lines 23-28; 43-45 of 45)*

This is not surprising, given the professional discourse that she exists in, in which the ‘well’ professional is preferred. Nina unsettles this discourse when she recounts the story of a new client who only felt comfortable reaching out to her after she had found out about Nina’s lived experience:

And people have said that to me, like, there is this one woman who said: “You know, up until this year I didn’t really know if I could trust you.” Like, she-she Facebook-messaged me that on my public page. And she said: “But now that you’ve walked
through it, can I come and see you?” [Participant: Laughs.] I was like… [pauses] Right? “Cause you’re gonna get me now!”

(Now That You’ve Walked Through It; lines 18-25 of 25)

In addition to positive feedback, it was helpful to Nina as she navigated how to integrate her lived experience into her work to have a (professional) role-model in the leader of the food addiction program of which she is a part. She had thus experienced the impact of professional self-disclosure by someone who is currently struggling on herself as a client:

[…] the other thing that changed for me two years ago is, I joined a food addiction program ‘cause I had a lot of struggles with food addiction and I gained and lost over 500 lbs in my life and I’d been a size 22 before I started the program and…And so, food addiction, too, is like: ‘You can’t tell me unless you’ve been there!’ Right? ‘If you don’t have a struggle with food, I don’t care what you have to say to me. I wanna see that you did what I want to do. Otherwise I’m not listening to you!’ And the founder of that program [name], she–she modelled this for me. Like, the vulnerability, and, like, just watching her little video blogs, and I’ve joined a boot camp, and there is a whole process… And she showed me, like, I trust her because she lived it and she’s a neuroscientist and a psychologist. And yet she is like: “Hey, this is-this-this is what I went through and this is what I’m going...” Today she’s like: “Halloween!”, she’s like: “Halloween was hard, wasn’t it?” Like, she made a video last week and she’s like: “Halloween, it’s gonna be hard. Here is what we’re gonna do, people. Here is what I’m gonna do.” Right? So it’s like that constant... and it just gives-for me gives validity. Like: “Okay, you know what I’m talking about ‘cause you have lived it!” (You Can’t Tell Me Unless You’ve Been There!; lines 1-16 of 19)

Nina experienced this role-modelling within a (food) addiction recovery program. Contrary to mental health and suicide prevention/intervention contexts, wounded healers can be found in both addiction recovery and eating disorder contexts. Especially in group-based programs, such as AA and others, having lived experience is seen not only as a benefit but a requirement, and the sharing of current struggles is not only accepted but often even encouraged (Jackson & Ta, 2001; Zerubavel & Wright, 2012).

Nina was able to make the decision to be open, both with clients and publicly, about her lived experience. The feedback she received was largely positive. However, our conversation also showed the different aspects she considered with respect to her self-disclosure. Nina worried
about professional repercussions which did not manifest. As noted above, her position as a part-time therapist in private practice at this time in her professional life was likely helpful to her, in that it allowed her to make decisions more freely. Had she been the primary breadwinner of her family, she may have had to consider the possible fallout of new clients deciding against seeing her, based on their knowledge of her difficulties (Adame et al., 2017).

Nina is also a mother and thus she could come under particular scrutiny for disclosing her lived experience, especially with severe suicidality. However, Nina is part of a two-parent family and has a stable support network of family, friends, and faith-based community. It is possible that the decision to openly disclose suicidality would have been more difficult and potentially dangerous for a mother in different circumstances. This may especially be the case for a single mother, particularly if there are custody or other contentious issues with the child’s other parent, or if the family had previously had contact with child protection authorities. In these situations a wounded healer may not feel it is safe to openly discuss her lived experience for fear of negative consequences, whether or not she believes that self-disclosing to clients or others is helpful.

**Interviews in Conversation With Each Other**

In the following I widen my analysis from the individual interviews, and I detail the themes that emerged as I considered the interviews in conversation with each other. I have named the themes *Empathy and deeper knowing*, *Sharing one’s story*, *Making meaning of suicide*, and *Stigma*.

**Empathy and deeper knowing.** Three participants tell stories that describe how their lived experience with suicidality positively affects their ability to engage with clients. They believe it increases their capacity for empathy and gives them a deeper understanding of the
issues their clients deal with. Two others tell stories about how they use their experience to instill hope and decrease stigma.

Lila considers her lived experience with suicidality an asset, as it allows her to empathize better, and engage without judgment with clients who feel suicidal. She also credits her lived experience with a greater ability to react in a way that she considers appropriate when clients speak about suicide: She neither under- nor overreacts in crisis situations.

Like Lila, Salal describes using the insights she has gained from being a person with lived experience to inform her practice with clients in several ways. Firstly, she considers what has been helpful to her when she has been suicidal as a useful guidepost for what might help others. This becomes evident when she talks about how she has valued the opportunity to voice feeling suicidal in the moment, and not have others spring into action to prevent a crisis. Instead, they listened to what her needs were. She attempts to do this with clients as much as possible and has had feedback from clients who told her that they were thankful that they could just talk out their suicidality with her.

Secondly, she uses insights she has from her own history of suicidality to supplement the more formal and clinical knowledge about suicide prevention that she also has. She uses these insights, for example, to gauge the severity of a client’s suicide risk in order to make decisions about the kind of follow-up that is needed. As she describes in *Spidey Sense*, her assessment of a situation made in this way proved to be more accurate than that of a clinician who specializes in suicide prevention, and who (presumably) used standardized assessment tools to assess risk and protective factors in that situation.

In our interview, Nina described a recent suicidal crisis and, at the time, ongoing suicidality, making her lived experience with suicidality the most recently emerging of
participants. She, too, feels that her empathy and her ability to engage with clients who are suicidal has increased, and with it her comfort level and confidence. She links her experience of a suicidal crisis directly to her willingness and readiness to work with people who are acutely suicidal, people she previously would have referred on. This becomes visible in her story detailing her work with a new client who came to her when he was feeling acutely suicidal. She notes that after having gone through a crisis of her own, she “could speak to him in a totally different way”. Her experience with something she had previously only witnessed in others from a distance had broken down a barrier between herself and her clients. She fully embraces her “hybrid identity” of suicidal person and therapist (Adame et al., 2017, p. 2).

In their examples, Lila, Salal, and Nina describe how they use experience-based knowledge, as well as intuition and emotion to better understand their clients and guide their work. This runs counter to what Marsh (2016) describes as the fundamental underpinnings of current research and practice in suicidology: Within suicidology’s dominant discourse, suicide is seen as an individual and pathological phenomenon that is best understood by narrowly applying the positivist tools of Western medical science. There is little room for the “expertise by experience” that guides the participants of this study in their work, and that is also a central theme of the wounded healer discourse (Adame et al., 2017, p.8).

A different aspect of empathy shows up in stories Hollie and Lila tell about the emotional toll that carrying a wound that is similar to their clients’ can take. Hollie, who in the past had felt chronically suicidal for a long time, talks about how emotionally drained she is by the amount of empathy that she feels in the presence of a client whose feelings of chronic suicidality are very familiar to her. In this situation, empathy becomes too much, and she describes how she struggles to uphold emotional boundaries, as a way not to burn out.
One of Lila’s stories details how she encountered a client who she experienced as being very similar to herself, and thus familiar. During this encounter, she felt at times as though she was on the phone with either a friend or herself. She could not help but draw comparisons between her own and the client’s situation of suicidality, and she walked away thinking about her own suicide note. The encounter was emotionally challenging for her. As it is her practice, Lila did not share anything about herself with the client. When I asked her, she did not think she acted in any way differently than she would have in other situations that felt more emotionally ‘neutral’ to her, situations in which she did not see herself so clearly reflected in the client.

However, given the emotional impact engaging with this client had on her, she had to work hard to process her feelings in the aftermath.

In both stories, Lila’s and Hollie’s wounds, even though they are not shared with clients in order not to interfere with the healing processes, stay painful and open for the practitioners. When Lila and Hollie address this, they speak about the amount of work necessary to uphold the boundaries that they feel are required in their work. Lila believes that her professional role does not allow for self-disclosure, as I will discuss later. Hollie considers staying “emotionally boundaried” a necessary skill that will allow her to continue to work as a therapist for a long time.

While the wounded healer discourse centres the presence of wounds that keep the healer emotionally engaged, professional helping discourses task them with keeping a safe distance from their clients. Hollie’s and Lila’s stories seem to indicate that there is danger for the professional if we fail to keep that distance, for example, we risk burning out. The responsibility for staying well, so that we can continue to perform – Hollie’s “keep me in this work in a sustainable way” – lays primarily with the individual professional. Hollie alludes to this when
she speaks about “doing [her] own work”. It also shows up in the literature about the prevention of burnout and compassion fatigue, where professionals are encouraged to engage in various forms of self-care, for example using mindfulness or breathing exercises to combat stress (e.g. Newell, 2010).

This is not to say that self-care in and of itself is a problematic concept, on the contrary, taking care of one’s emotional and physical health is important, maybe more so for wounded healers. However, within this discourse the focus is on the individual practitioner, and structural issues that negatively affect helping professionals in their work environment and contribute to burn-out and compassion fatigue are seldom discussed. They are, for example, the poverty and discrimination that impact clients’ lives, or the scarcity of available mental health and other resources that leave many professionals overworked. That these issues are not discussed is perhaps because they are taken as a given in the currently dominant neo-liberal systems that most helping professionals work within.

As I have noted before, what signalled to me that I am engaging with dominant discourses here is that they are so difficult to see. As I discussed in my analysis of Salal’s interview, I came to this project with the preconceived notion that the focus must be on ‘the client’. I bought into the separation that is expected between the individuals involved the helping interaction, and thus I easily agreed with what I heard Lila and Hollie say when they told me these stories. Only when I reflected on the emotional reactions that I had – I recognized the painfulness of their experience from my own work and I ‘felt for them’ – did I notice this. I did not strive for neutrality and objectivity as I engaged with research participants. Instead, I used the emotion that came up as I worked with participants’ stories as a signal, rather than suppressing it, and I thus see emotion as a useful tool. Parallel to this experience, I am wondering
whether some of the emotional exhaustion felt in Hollie’s and Lila’s professional encounters is caused by the emotional work that it takes to uphold (artificial) boundaries between two human beings. Perhaps there is a different and more useful way of approaching the pain that sometimes comes up when we work with people for whom we feel deeply, especially in instances when their pain mirrors ours.

**Sharing one’s story.** All five participants discuss sharing their lived experience in their work context. There is a range of viewpoints with respect to if, how, and how much of this experience they want to and feel able to share, with whom, and what the reasons for this are. Participants also make a distinction between sharing information about their mental health concerns and their lived experience with suicidality.

Lila is adamant that she does not want to share information about her lived experience with clients. As part of her training as a counsellor she learned that any personal information should only be shared for the purpose of advancing the therapy process, as directed by the therapist. To illustrate this point, she provides the example of her current therapist who shared his previous experience with mental health difficulties and the treatment he used to get better. She considers this a positive example. Even though, she notes that boundaries can easily be crossed when practitioners disclose personal experience, and this has previously happened to her when she was a client. Therefore, she does not share any personal details about herself, including those pertaining to her lived experience with suicidality.

Salal does not openly share with her clients and colleagues that she has a history of suicidality, but she will hint or imply to clients that she understands where they are coming from, hoping they will see her as someone who ‘gets it’. As she discusses in *The Whole Point Why You’re There*, it is her own preference as a client to have only superficial knowledge about her
treatment providers, as she does not want to worry about them, should she find out that they have difficulties of their own. With this, she draws a firm line between the helping relationship and a friendship, where she would want a give and take. Like Lila, Salal aims to keep her personal and professional relationships strictly separate.

Similarly, Hollie notes that she does not want to make people feel that they need to “care-take” for her when they find out that she has experienced suicidality. Interestingly, in her interactions with clients this applies to talking about suicide only, as she has shared information about her mental health difficulties without this concern.

Salal’s point that the client should remain the focus of the helping interaction is echoed by all participants. At the same time, for others this does not preclude openness about one’s lived experience with suicidality. In her story *Uncharted Territory* in which she talks about sharing her history of being suicidal, Hollie explains that her goal was to combat the shame that her client felt for experiencing suicidality.

Nina and Michael both tell stories to illustrate why they tell clients about their histories, namely, to show clients that they are not alone in feeling suicidal, and to create hope that seeking help works and one can get to feel better.

Elements of participants’ rationales for sharing or not sharing personal information with clients echo the dominant discourses of good helping and appropriate relationships in the helping context. Both the decision not to share personal information and the decision to share it are made largely with the best interest of the client at heart, based on participant’s training, experience, and what they would prefer as clients. This upholds a separation between the professional and the client, in that it is the professional who knows best, while the client does not have input into this
decision-making process. It is a discourse that sits firmly in the current context of specialized helping within Western medical model oriented practice.

Other factors in the decision-making process have to do with how allowable and safe the disclosures are for participants, based on their individual circumstances and identities as I discuss in greater detail in other sections of the paper.

During the interviews, each of the five participants shared the story of their lived experience with suicidality with me, even though I did not ask about this beyond confirming, prior to the interviews, that the participants met the inclusion criteria for the study. Responding to my initial prompt “Please tell me the story about your experience as a [participant profession] who has lived experience with suicide and who works with people who are also suicidal”, Michael, Nina, and Lila began the interview by telling me the story of their suicidality, while Salal and Hollie talked about it in the contexts of other stories. At first glance, Michael, Lila and Nina’s choice to begin by explaining the nature of their lived experience can be seen as perhaps the easiest entry point to this difficult topic, especially for people who work in suicide prevention. After all, we are used to describing the concept of ‘being suicidal’ in other people. We are trained to tell the story of someone’s suicidality by way of risk assessments in which we list risk and protective factors, reasons to live, preparations and plans made, and a catalogue of other criteria.

Describing their lived experience with suicidality may have also been a sign of respect for others whose experience differed from theirs. This was the case for me when I defined my own lived experience for this project. Suicidality, like a person’s relationship with the mental health system exists on a continuum of stigma, and the experience of hospitalization after a
suicide attempt is vastly different from the feelings of hopelessness and life-weariness that have been a part of my life for many years.

Lastly, telling the story of their relationship to suicide also gave their audience (me) an idea how participants engaged with the topic and provided valuable information about what meaning each assigned to suicide in their own lives.

With telling me these stories, participants provided me with much information about themselves that was useful for me as the researcher in this study. It helped me put into context what participants told me elsewhere, for example, when they spoke about how their own history of suicidality affected what they consider best practice in suicide intervention, or how they make sense of their clients’ suicidality. It also allowed me, as a fellow helping professional who has lived experience with suicidality, to share my experience with them, and so decreased some of my isolation in this respect. I hope the same was true for the participants. It is possible that a similar openness might have the same benefits for our clients.

**Making meaning of suicide.** Another theme that emerged from the stories told to me was how participants make sense of their clients’ suicidality.

Hollie and Michael both work for organizations that serve the LGBTQ communities in their respective cities. Given the life stories of their clients, they construct suicide as a social justice issue. Each tells a story of a client affected by the oppression they experienced throughout their lives. Both make it clear that the effects of oppression, abuse, hate crimes, family estrangement, and discrimination in court and elsewhere played an overwhelmingly large role in the individuals’ suicidality, and, according to Michael, directly led to his client’s death.

Michael makes sense of his client’s suicide by contextualizing their death as “murder by transgender oppression”. Viewing his client’s death in this way also helps him to work with the
painful experience of the loss of a client. Hollie sees the cumulative effect of the oppression her client has endured in their lifetime, and it makes sense to her that the pain this continues to cause could lead a person to “feel like they don’t wanna do it anymore”.

Both Salal and Lila speak to their understanding that life circumstances affect a person’s desire to die by suicide. In this context, Salal further outlines her belief that suicide interventions ought to focus on the issues in a person’s life that underlie their suicidality, instead of “the suicide piece” alone. Otherwise the effort to prevent suicide begins to shift its focus from the suicidal person to the intervener, as expressed in Salal’s mocking exclamation: “You’re not gonna die on my watch!”

Both Salal and Hollie note that they do not believe suicide is preventable, unless the suicidal person wants it to be prevented. Salal believes that “it doesn’t matter what kind of stuff you go out to do for that person”, if the suicide intervention is not led by the suicidal person and they do not accept the efforts being made. Similarly, Hollie acknowledges that one of the reasons why it is hard for her to share her own suicidality is that people want to do something, when “there is nothing anybody can do”.

Indirectly, Nina’s story of her own episode of suicidal crisis has a similar message. It is likely that she would have died as planned, had she not reached out to her close family friend when the thought occurred to her that her desire to die could be related to her anti-depressants, and thus potentially not truly her own: “And I thought: ‘Wait, maybe this is not me!’” Without her decision to reach out and seek help, not even the resources she had in place as a psychotherapist and psychotherapy client, member of a supportive family and friend group, and patient of a doctor who treated her for depression, would have prevented her death.
While Nina’s story gives a vivid example of the despair and pain that is present when people make a plan to die by suicide, this narrative also expresses that people have choice when it comes to suicide. Hollie explicitly states this when she makes the connection between her convictions around people’s right to bodily autonomy and their right to choose to die. It also counters the dominant suicide prevention narrative that suicide is nearly always preventable if prevention efforts are guided by what suicidology considers sound research (Marsh, 2016). That people have a choice in their own death, while at least partially accepted in the public discourse surrounding medically assisted dying, is something that remains largely absent from dominant suicide prevention and intervention discourses.

As Hollie outlines, one can simultaneously wish for people not to die – for reasons ranging from simply wanting them to live, to fearing the professional and personal repercussions that follow the death of a client –, help them safety-plan, and still allow them the choice to die and accept (with sadness) that they might die. This can be difficult, as it requires being comfortable with, or at least open to, ambiguity and uncertainty. It is a challenge that necessitates personal work, as Hollie notes.

Participants’ meaning making about suicide also directs what they consider ‘best practices’ in their work with clients. Nina speaks specifically about this when she outlines her “new philosophy in counselling” which centres abandoning the need to fix, and instead staying with the client throughout their difficulties, with a commitment to deeply caring and letting people know how much she cares. As seen in Permission To Let People Know That I Care, she puts this into practice when she sees an acutely suicidal client shortly after her own crisis moment, and she does not refer him on or contact emergency services but works with him to make a commitment to stay alive and come and see her again.
In my interview with Salal, stories of suicide interventions took up a lot of space. When looking at these stories, what becomes visible is a view that helping people who are thinking about suicide requires a focus on what the individual communicates that they need. Salal believes that professionals should listen to the reasons for the person’s distress, offer a space to talk and resources on a voluntary basis. She values self-determination, patience, and time. Nonetheless, she also tells stories that show that she has little choice but to work within systems that do not share her values. Thus, engaging with clients in the ways both Nina and Salal describe is sometimes more aspirational than possible in the real-life contexts participants work in. Therefore, it is important to also pay attention to the professional locations the participants in this study occupy when discussing this. Michael and Nina have established careers as therapists, teachers and speakers, and Nina works in private practice. It would appear that because of this, both have relatively more freedom to work in the ways that they consider best practice. Salal, Lila and Hollie on the other hand work in public institutions. Here they are faced with clearly defined expectations about how to engage with suicidal clients, for example, when to contact emergency services when a client expresses being suicidal, or whether to disclose their lived experience. In addition, Hollie’s position as a newer therapist comes with its own challenges.

**Stigma.** Nearly all participants tell stories about how the stigma of dealing with mental health concerns and/or suicidality has affected them in their professional lives.

While Hollie is not opposed to disclosing her mental health concerns to clients, colleagues, and her supervisor, she is hesitant to share her history of suicidality at work. She relates this difference directly to the stigma that is attached to suicide, in contrast to the stigma that is attached to having mental health concerns. Of note, we did not discuss whether this openness about mental health in her workplace applies to all mental health conditions, or if some
difficulties cannot be discussed there as well, as they face greater stigma, for example, schizophrenia (Rüschof, Angermeyer, & Corrigan, 2005). My assumption, based on my own experience, is that discussing such mental health concerns as anxiety and depression is permissible, and that this is what Hollie refers to here.

As a newer therapist who is working under supervision, she fears that there could be professional repercussions, should she disclose her lived experience with suicidality. For example, she fears that she would be thought of as not ready to work as a therapist if her supervisor knew that her wound of prior chronic suicidality feels present when she works with particular clients who are actively suicidal. As a result, she has not shared her history with her supervisor.

Hollie is not sure if this fear is necessary; however, she is also unsure how to assess the risk of disclosing her history. The stigma around suicide has caused a silence that is so complete that Hollie does not have any examples, neither from her training to become a therapist nor from other therapists that she knows, that would assist her in deciding how to proceed here.

Echoes of this are heard as discomfort and concern in Michael’s and Nina’s stories, respectively. Michael, who sought therapy help when he felt suicidal and depressed and ran into his former students at the clinic where he went for therapy, lied about the reason for his visit to the clinic. Nina, when she first considered disclosing her own history, felt concerned that it would undermine her professional credibility. However, these are only faint echoes of Hollie’s fear, given her comparatively precarious status as a new therapist.

Lila feels a lot of embarrassment and shame about her history of suicidality and mental health concerns, though she does not distinguish between the stigma around suicidality and the stigma associated with mental health concerns in the same way Hollie does. Lila identifies
feeling ashamed about being a helping professional who has unresolved wounds that are related to the area she works in. She is embarrassed and ashamed that she does not “have her shit together”, even though this is a goal she has had since she first decided to become a counsellor. One of the ways she responds to this embarrassment and shame is to keep the existence of her wounds to herself. I locate Lila’s expectations for herself, which are brought to her from external sources and which she at the same time has internalized, within a dominant discourse of professionalism that finds wounded healers only acceptable if they have healed their wounds. Having unhealed wounds can easily lead to being considered an impaired professional, someone whose wounds negatively affect the healing relationship, rather than a wounded healer (Jackson & Ta, 2001; Zerubavel & Wright, 2012).

Nina considers the sharing of her mental health difficulties and of her suicidality privately, in the professional sphere, and publicly in talks, a tool to decrease stigma. As a therapist in private practice with an established career, she has a significant amount of freedom to do this. However, in our interview, Nina also noted that, while she often shares her lived experience with depression in her work with clients, this is not the case for her history with suicidality, which comes up less frequently. It would appear that the level of stigma attached to each makes the former easier to share than the latter.
Chapter Five: Discussion and Conclusion

Discussion of Findings in the Context of Existing Literature

The aim of this research project was to explore the experiences of helping professionals who have lived experience with suicidality and who work with suicidal people. I conducted semi-structured interviews in which I invited five helping professionals to “Please tell me the story about your experience as a [participant profession] who has lived experience with suicide and who works with people who are also suicidal”. From the interviews I selected stories which spoke to participants’ lived experience with suicidality in relation to their professional lives, which I then analysed, using a narrative framework.

Even though my study and my initial prompt specifically focused on participants’ lived experience with suicidality, all five spoke of having experiences with both mental health concerns and suicidality. Of note, in much of the literature on suicide the areas of mental health and suicide are also linked. Harris and Barraclough (1997), for example, note that based on their meta-study of journal articles between 1966 and 1997, “virtually all mental disorders have an increased risk of suicide” (p. 205). More current available research articles, and mental health information discussing risk factors for suicide, speak to the same (Cavanagh, Carson, Sharpe, & Lawrie, 2003; World Health Organization, 2014; University of Washington, 2017). This creates the distinct impression that a direct link between having a mental health problem and suicidality exists; however, this link is at the same time also highly contested (e.g., Corrigan, Sheehan, Al-Khouja & Stigma of Suicide Research Team, 2017, Hjelmeland & Knizek, 2017, Marsh, 2016). In other areas, self-determined death is seen as separate from mental illness, for example, in the current debates around medically assisted death when a person has a physical illness. Further, suicide rates often rise in times of economic crisis (Chang, Stuckler, Yip, & Gunnell, 2013) and
are disproportionately higher in marginalized communities, such as the LGBTQ2S communities or among Indigenous peoples (e.g., Adelson, 2005; Haas et al., 2011). While these statistics do not speak to how poverty, race, gender and sexual orientation, among others, intersect with mental health difficulties, they show that factors other than mental health play a role here and that suicide is “a complex and multifactorial phenomenon” (Hjelmeland & Knizek, 2017, p. 486-487). It is therefore important to remember that a connection between mental health concerns and suicidality is not a given, even if people report the presence of both.

Through my analysis of participants’ stories, the themes Empathy and Deeper Knowing, Sharing One’s Story, Making Meaning of Suicide, and Stigma emerged. My findings are somewhat congruent with the literature on the wounded healer discourse that exists for areas other than suicidality, such as studies that investigate the lived experience of helpers with mental health concerns, addiction, or family violence. In addition, participants speak to what it means to be a professional with lived experience specifically in the area of suicide.

Throughout the interviews, all participants either explicitly or implicitly convey how their history with suicidality is helpful when they engage with people who are suicidal. Nina, Salal, and Lila tell stories in which they show how they use their lived experience with suicidality as a roadmap for their engagement with clients who deal with the same issue. Nina makes clear that her recently acquired lived experience with suicide has reshaped her practice with suicidal clients, and Lila explicitly notes that her experience is helpful to her work. Meanwhile, Michael, Nina, and Hollie tell stories in which they show how they have disclosed their lived experience with suicidality to help clients. Thus, participants align themselves with what is the core feature of the wounded healer discourse, namely that the healer’s wounds have the potential to be useful to the healing relationship. In the context of existing research, this is most often understood as
allowing the professional a greater empathic understanding that assists them in their work (e.g., Conchar & Repper, 2014; Cvetovac & Adame, 2017; Davison, 2013; Kern, 2014; Martin-Calero Medrano, 2016; Oates et al., 2017; Richards, Holttum, & Springham, 2016; Streeter, 2018; Zerubavel & Wright, 2012).

Expressly, several participants note that their lived experience adds another dimension to the clinical or theory-based knowledge that they have, which can be understood as an “expertise by experience” (Adame et al., 2017; Oates et al. 2017). Whether or not they are disclosing their lived experience to others, participants said they actively use themselves, that is, their identities of both a person with lived experience and a service provider, as a tool in their work with clients (Adame et al., 2017; Davison, 2013; Martin-Calero Medrano, 2016; Oates et al., 2017; Richards et al., 2016).

Congruent with Gilbert and Stickley’s (2012) findings, the participants of this study see this occurring on two levels. The first is an increased capacity for empathy for the suicidal person. The second level refers to the intellectual understanding of what the other person is going through – a deeper knowing – which enables participants to interact with their clients in ways they find appropriate and useful. This is particularly visible when Lila, Nina, and Salal discuss their desire to engage with clients who are in acute crisis situations in supportive, co-operative and non-coercive ways, based on their own experience, and based on what they have preferred or would have wanted when they found themselves in situations similar to those of their clients.

The desire to provide to one's clients the help one would want for oneself is also present in the wider literature, for example, in the authors’ accounts in Adame et al. (2017), who are psychiatric survivors who became therapists. Similarly, it can be seen in Davison’s (2013) participant group, who are clinical psychologists. Some of the participants note that their own
experience has led them to identify more strongly with clients, and to want to advocate for them and “uphold patients’ rights” (p. 66). Both mental health treatment, especially if it involves psychiatric hospitalization, and suicide intervention contexts are ripe with coercive treatment of those seeking help (LeFrancois, Menzies & Reaume, 2013; Marsh, 2010). Helpers who have encountered this may have a better understanding of the trauma these situations can cause for both suicidal people and people who come in contact with the psychiatric system. As a result, these helpers may work differently with clients that are in these situations in order to prevent this harm from occurring.

On the other hand, as Salal’s stories have shown, while she has strong beliefs about what constitutes helpful approaches to supporting people when they feel suicidal, she still exists within systems of suicide intervention that react in less supportive and more coercive ways than what she envisions. Additionally, not every wounded healer will draw the same conclusions from their experiences. This is apparent in Adame’s (2012) case study of her interaction with a research participant who did not identify as the political and anti-psychiatry connoted position of psychiatric survivor, even though her experiences with the psychiatric system were similar to those of Adame’s other research participants.

Throughout the interviews, several participants talked about how they make meaning of suicidality and suicide, both that of their clients’ and their own. Michael and Hollie, who both work for organizations that serve LGBTQ clients, speak to the oppression that their clients face and link it directly to why these clients experience suicidality and, in Michael’s client’s case, die by suicide. Similarly, Salal and Lila connect their client’s suicidality to difficult life circumstances and injury. Participants’ own experiences with suicidality are varied and, based on
what they have shared, connected to crises, mental and existential pain, and medication side effects.

Participants’ understanding of suicide in this way runs counter to the dominant medicalized suicide prevention discourse that reduces suicide in its essence to an individual act of mentally unwell people. Within this discourse, the complex reasons for why people experience suicidality are not considered (Fitzpatrick, Hooker, & Kerridge, 2015; Marsh, 2016; White, 2016). Resulting from this discourse are approaches to suicide prevention and intervention that are mainly located within the mental health system and focus on what Marsh (2016) calls the “confinement/constant observation/restraint model” (p.228), which Salal also describes in her stories as troubling and unhelpful.

In contrast, the wounded healer participants of this study respond to their clients’ suicidality within a social justice discourse that strives not to seek the cause for an individual’s suffering only within that person, but to consider the impact of the social and political context that the person lives in (Button, 2016; Fitzpatrick et al., 2015; Marsh, 2010; Reynolds, 2016; White, 2016). Michael does this specifically when he refers to his client’s death as “murder by transgender oppression”. Hollie explains to her client that many people in the queer and trans community experience suicidality, aiming to place her client’s experience in a broader context, during their interaction when she discloses her own lived experience with suicidality to them. She is thus working from a social justice perspective (White, 2016).

Based on their own lives, several participants voice the belief that suicide is only truly preventable when the suicidal person is willing to let it be prevented. In their stories relating to this, several participants express ambiguity towards the prevention of suicide. Ambiguity inconveniences a tenet of the current dominant suicide prevention discourse which states that
suicide can be prevented if psychology or psychiatry professionals use the appropriate methods developed based on the best evidence, gathered using primarily quantitative methods (Marsh, 2010, 2016; J. White, 2016). It is, however, supported by the voices of people who have experience with the system of suicide prevention and intervention, and have found it unresponsive to their needs. Laura Delano, who is a writer, speaker, and ex-psychiatric patient, for example, writes about the lack of agency that people who are suicidal feel within current suicide prevention and intervention encounters. She writes (2013):

   Missing from this “Suicide Prevention” framework is acknowledgement of the agency of the person considering suicide; of the dignity of risk and choice; of the human legitimacy of thoughts about life and death, especially when life has lost its meaning; of the right to feel and believe what one desires, however dark and scary that may be to those around her. […] When the hand of fear grabs hold of the topic of suicide, it pushes everything else aside and leaves no space to explore. Fear drowns out curiosity, faith, honesty, empathy, and the opportunity to listen with open ears and hearts. It forces an immediacy that simply can’t allow for the lapse of time, for uncertainty, or for the unknown. […] At the heart of it, fear of suicide strips away the humanity of life and death, leaving in its place a sterile, objectified “problem” or “symptom” that allows for only one course of action: prompt and effective intervention and prevention […].

Participants in this study voice agreement with Delano when they talk about how they envision and enact suicide prevention and intervention practices in their work. When they engage with clients who are experiencing suicidality they strive for practices that are characterized by communication, openness, patience, collaboration, trust, and the respectful belief that the suicidal person has a choice in the decision whether they want to live.
Even though participants consider their lived experience with suicidality mostly useful for their work as helping professionals, there are also difficult moments, the dark side of empathy, if you will. Hollie and Lila share stories about encounters with clients whose experiences with suicidality felt very familiar to them and thus affected them deeply. Their stories highlight that there is the potential for a healer’s wounds to be opened during their work with clients (Zerubavel & Wright, 2012). This aspect of the wounded healer discourse is also present in the wider literature. Some of Streeter’s (2017) counsellor participants, for example, noted that encountering clients with similar lived experience to their own at times left them upset, distressed, and drained. Shadley and Harvey (2013), in their discussion of the use of self in the addictions recovery context, suggest that addictions counsellors who have not left their past wounds behind completely may be vulnerable when they encounter clients with whom they have ‘too much’ in common. For these helping professionals, they suggest, it may be best to strive for feeling less, rather than match their clients’ feelings. Cvetovic and Adame (2017) similarly take up the issue of overidentification with clients’ difficulties, and state that it may lead to the failure of empathy in the helping relationship. It is particularly the issue of countertransference in the context of unhealed wounds that concerns many authors. Countertransference can be understood as “the therapist’s internal or external reactions that are shaped by the therapist’s past or present emotional conflicts and vulnerabilities” (Gelso & Hayes, 2007, p. 25, in Cvetovic & Adame, 2017, p. 350). With this, these less positive elements of the wounded healer discourse, while they are often presented as areas of concern about the helpers’ wellbeing, also take on a warning character with respect to the helping relationship: If helping professionals are not careful, they may become ‘impaired professionals’, whose unresolved or otherwise present and activated wounds adversely affect the clinical process, thus potentially hurting the client (Jackson & Ta,
2001; Zerubavel & Wright, 2012). Hollie and Lila speak to this. While they share stories about how their experience of sameness with their clients’ circumstances brought up difficult emotions for them, they also speak about their responsibility to be a certain way as professionals. Hollie calls this “doing her own work”, work that is needed so she can be a capable therapist. Lila, meanwhile, is adamant throughout the interview that as a professional helper she has the responsibility “to be okay”.

The wounded healer discourse thus contains a dichotomy between the wounded healer, which is the valorised professional who uses their wounds to positively affect the healing relationship, and the impaired professional, whose wounds have the potential to endanger the healing relationship. Presenting the two subject positions of wounded healer and impaired professional as a dichotomy would suggest that they are clearly defined. However, the literature contains a wide range of viewpoints with respect to what constitutes either. Some authors maintain that wounds must have fully healed (Costin & Johnson, 2002, in Cvetovac & Adame, 2017), while others suggest that partial healing is acceptable (Hayes, 2002, in Cvetovic & Adame, 2017). Zerubavel and Wright (2012) state that it is not the wound that is the main point, but that some healing must have occurred so that the healer can draw on the experience of healing itself in their work with clients (Zerubavel & Wright, 2012).

Similarly, the participants in this study have a range of viewpoints on this. Lila speaks to the need to be okay in order to be helpful, and offers up her current therapist who speaks openly about having overcome previous mental health difficulties as an ideal. In contrast, Nina continued to work in the depth of depression and suicidality, and found that this benefitted her as well as her clients. While he discloses his past experience with suicidality to clients when he considers it helpful, Michael also cautions that presenting as a therapist who has overcome past
difficulties may not always create hope. On the contrary, it may make clients feel as though they, who are still in the midst of their pain, are not succeeding at getting better. Healing thus becomes an unattainable goal, something that only someone like a therapist is able to do. In this way, he suggests, being a wounded healer can create an even bigger separation between the professional and the client, instead of bridging the divide between the two (Adame et al., 2017).

Another area of congruence with the wider wounded healer literature outside of the suicide context can be found in the ways in which participants approach the disclosure of their lived experience to clients and others in the professional context. Participants hold a range of opinions on this matter. Lila does not share her lived experience at all. In conversation with clients, Salal often implies that she has lived experience, but she does not explicitly confirm this or provide specific examples. Both have made the decision to approach disclosure in this way, at least partially, based on their own experience as clients. Additionally, Lila also cites her training as a counsellor, and how she sees her role as a helping professional as reasons why she does not share her lived experience. Salal does not want to know too much personal information about her own treatment providers as she feels this would direct the focus of her treatment away from herself. Lila values boundaries, both as a client and in her practice. Both participants’ reasons for why they do not share their stories, or do so only implicitly, match closely what studies on wounded healers in the mental health context have found (e.g., Oates et al., 2017; Zerubavel & Wright, 2012).

Of note, neither Salal nor Lila distinguish between disclosing their lived experience with mental health concerns and suicidality. Nina, Michael, and Hollie, on the other hand, speak about disclosing their experience with suicidality specifically. All three tell stories that show that they share information about their lived experience with clients only occasionally and thoughtfully,
and when they feel it will serve the client. As discussed elsewhere, Hollie’s reasons for disclosing her lived experience to only one client are also related to her workplace and status as a new therapist under supervision. Nina, Michael and Hollie’s goals for disclosing their lived experience with suicidality range from wanting to combat their clients’ isolation caused by the stigma of feeling suicidal, to instilling hope in the client about the efficacy of seeking help. Their approaches again match the findings in the wounded healer literature in mental health (Adame et al., 2017; Kern, 2014; Oates et al., 2017).

It is in the discussion of participants’ opinions about professional self-disclosure that a more nuanced picture with respect to the difference between disclosing various kinds of lived experience emerges. This speaks to the varying levels of stigma that certain lived experiences carry. Stigma can be defined as “an attribute that is deeply discrediting” and must be seen as “relational” and changing over time, in that the attribute in question is “discrediting in certain eyes at certain times” (Hacking, 2004, p. 296). Thus, stigma exists in context.

Both Hollie and Lila state that the stigma of suicide has at some point in their professional lives played a role in their considerations about whether to speak about their histories of lived experience with suicidality. Lila has felt ashamed and has feared that she would not be taken seriously as a suicide intervention professional if people knew that she has felt suicidal. Hollie talks about her concerns that she might face professional repercussions, specifically for disclosing her emotional difficulties related to suicidality. She thus holds this back from her supervisor, even though she has been able to discuss other sensitive matters, related to mental health concerns with her. Within the culture of her workplace, she understands that disclosing her mental health problems is allowable, but she is left guessing whether disclosing her history of suicidality is acceptable. In this context, she also speaks about a lack of
professional role-models to guide her as a professional with the particular lived experience of suicidality. This lack is echoed in a wider context: While there is a growing body of literature that openly discusses different facets about what it means to be a wounded healer in the mental health context, this is not the case for literature about suicide. With this study, I now have role models in participants, and I hope that sharing this paper with them, this will also be the case for them.

Within the wider wounded healer literature, Cvetovic and Adame (2017) note that different wounds carry different stigma; there is a hierarchy of stigma (Rüsch et al., 2005). An example for this is that psychosis, or hearing voices, or being a patient in a psychiatric hospital, especially on an involuntary basis, is more stigmatized and often taboo. Thus, these experiences are more difficult and risky to speak about than, for example, sharing that one has anxiety or depression, or that one receives out-patient counselling (Adame et al., 2017). All of this again depends on the context, such as the workplace one is employed at, as in Hollie’s story. Because Hollie is a new counsellor, she is concerned about negative consequences resulting from disclosing her history of suicidality. Nina and Michael, on the other hand, may as professionals with established careers and working in private practice have less fallout to fear. Lastly, Salal and Lila who work directly in suicide prevention, and in different workplaces in the public sector, may fear and face stigma precisely because their professional contexts value scientific approaches to suicide prevention over “expertise by experience” (Oates et al., 2017, p. 478; White, 2016). While participants did not explicitly explore this in their stories, the intersecting oppressions people face based on race, gender, sexual orientation, and others, also play a role in the assessment of whether or not it is safe for a professional to speak openly about highly stigmatized experiences.
By creating a dichotomy between wounded healer and impaired professional, and issuing cautions about the latter, the wounded healer discourse seems to suggest that the ideal helping professional is one who remains (relatively) free from woundedness. This is a state mostly only attainable by professionals from privileged backgrounds, for example, those who are white, male, and/or have economic safety. For people whose social locations expose them to poverty, racism, sexism, heterosexism, or other forms of injustice, this may be out of reach. Similarly, healing one’s wounds is much more difficult for people who continue to face injustice, for example, Indigenous professionals who witness the ongoing oppression of Indigenous people in Canada and elsewhere. Thus, correlating unwoundedness, be it initial unwoundedness or the successful healing of wounds, with being a ‘good’ professional places a much larger burden on marginalized people and in effect suggests that true professionalism is the domain of dominantly located people.

Based on my experiences with disclosures of my own history of suicidality, I agree with Hollie that suicidality is a highly stigmatized experience. This is connected to the ways in which suicide is constructed within a medicalized discourse, as noted above. Within this discourse, suicide is irrational and akin to ‘madness’, and people who want to kill themselves are not only not mentally well, they can also not be trusted and must be confined, observed and restrained (Marsh, 2010). Thus, it becomes complicated for a helping professional to speak openly about current suicidal feelings, or about how a client’s suicidality has made an emotional impact, lest they be also seen as not trustworthy or in need of intervention. While I do not have personal experience with psychosis, psychiatric hospitalization or similar, I believe that professionals with these experiences face similar stigma (Adame et al. 2017).
As I prepared for this study, I experienced an expression of the stigma of being a professional in my field who also has personal experience with suicidality. During the recruitment process, I asked professional contacts in mental health and suicide prevention and intervention contexts to send out my project information and invitation to participate through their professional networks. I requested that they only did so if they felt comfortable with the project and offered to address any questions or concerns that they might have. In response to this, a mental health professional I had approached, and who at the time supervised other mental health professionals, commented that they doubted that my target population existed. Further, if it did, they questioned whether the helping professionals who had personal experience with suicidality should be working with suicidal people at all. I was taken aback by this interaction with a fellow professional, who was so secure in their conviction that they did not even consider that I had chosen this topic as a matter of personal interest – either that or they were telling me implicitly that I, too, do not have a place within suicide prevention work. Even though this person did not have any professional power over me, and I do not think they will in the future, I did not tell them about my lived experience. As I considered this interaction, I realized it did not feel safe to speak, despite my relative security of position in the situation. While I am not proud of my silence – in fact, when I first began to think about this interaction, I felt ashamed that I did not say anything about why I wanted to do this study – I doubt that my speaking up would have prompted the person to rethink their position.

In summary. The wounded healer discourse can offer additional and different ways of engaging with clients for professionals who have lived experience with the very things they hope to assist others with. Being a wounded healer can help decrease the artificial dividing lines between the ‘well’ professional and the ‘ill/unwell’ client that are common in current discourses
of helping. It can thus offer a helping relationship that reaches “beyond us and them”, as Adame et al. (2017) put it. Being a wounded healer and showing it can also be a way to combat the stigma that clients face. In the area of suicide in particular, bringing in experiential knowledge, in addition to professional knowledge, can create spaces where clients are better able to address and work through feelings of despair, precisely because the helping professional has been there and has an idea of what would be helpful.

Participants at times struggled with their dual identities as people with lived experience with suicidality and helping professionals, but they ultimately found them helpful. Much of the struggle they described was related to the professional expectations they felt themselves under, which are closely connected to the undesirable elements within the wounded healer discourse, the impaired professional, whose wounds are seen as posing a risk in the helping relationship. The focus on preventing impaired professionals from being a danger to their clients seems unnecessary: The research, both gleaned from this study and from the wider literature, overwhelmingly describes thoughtful helping professionals who deeply care about their clients and do not want to negatively affect their clients’ healing process. This can be seen when participants of this study thoughtfully consider how to use their own experience in ways that are helpful to their clients, and whether it would benefit their clients to know about their histories with suicidality. It can also be seen when Hollie shares her history of lived experience with a client, even though it means that there is a chance of professional repercussions.

The fear of being found to be an impaired professional adds to the stigma that people with certain lived experiences, such as suicide, already disproportionately feel. This creates a climate of shame and fear in which professionals do not feel safe to disclose their lived
experience, even in contexts that are deliberately set up for this purpose, for example, in supervision.

By focussing so much attention on warning of the impaired professional, the wounded healer discourse is permeated by ableism, sanism and a deep mistrust for people who consider suicide. Within this discourse, it is acceptable for a professional to be wounded but at the same time, (certain) wounds are stigmatized. Such clear distinctions between wounded healers and impaired professionals, who are then no longer called healers, seem to also negatively comment on the lived experiences of clients who have the same wounds.

As an alternative, the wounded healer archetype can be read in a way that makes the dichotomy of wounded healer and impaired professional obsolete (Benziman et al., 2012): Chiron did not experience healing or lessening of his own pain, yet he healed people and taught other healers, even as he suffered from incurable and excruciating pain that was only resolved when he gave up his immortality and died. The wounded physician Al-Razi declined to have his blindness cured, and instead used his continued impairment to help heal others. In both instances, the pain and the continued impairment are the point, they are what gives the wounded healers their ‘edge’.

In contrast to mental health and suicide prevention, addiction and eating disorder contexts seem to favour a discourse of ongoing recovery, as modelled by Nina’s eating disorder group leader who herself is recovering from an eating disorder. This may be the result of addictions treatment’s history: People in recovery found that they needed to enter the field as helpers when other professional would not, due to the stigma of addiction (Shadley & Harvey, 2013). Perhaps similarly, Hearing Voices Networks create safe spaces for people who have another deeply stigmatized type of experience (Clarke, 2016).
Recovery models in mental health, while they also view recovery as an ongoing process, are still suffused with the idea that there is an illness one must recover from. This is criticized by people within the Mad movement, who see this approach in line with a medicalized view of mental distress that psychiatrizes said distress (Morrow, 2013; Morrow & Weisser, 2012; Woods, Hart, & Spandler, 2019). It is also not a useful approach for people living with suicidal ideation, given that suicidality is not a medical condition but a complex human experience. The goal must be to help people live in circumstances that allow for a good life, rather than narrowly focus on the prevention of “self-accomplished death” (March, 2010, p.12). Indeed, as Michael’s story suggests, wounded healers who have not ‘overcome’ may be better suited to give people in distress hope by modeling that it is possible to live with suicidal ideation while it is happening.

**Implications and Recommendations**

This research has implications for the field of suicide prevention and intervention. The stories the wounded healer participants of this study have shared about how their lived experience with suicidality shows up in their work with suicidal clients have revealed how much the dominant discourses in suicide intervention and prevention are permeated by the stigma that surrounds the topic of suicide.

Different from the evolving wounded healer discourse in mental health that has seen such concerns as anxiety and depression – though not other, more stigmatized experiences – become more acceptable, lived experience with suicidality remains a taboo among professionals in suicide prevention and intervention. Certain features of the wounded healer discourse, namely that some wounded healers can become impaired professionals and put the healing process and thus the client at risk, have contributed to this taboo.
Yet, wounded healers carrying the wound of suicidality at various stages of healing work with suicidal people, actively using what they have learned from their own lives as roadmaps to help their clients. In this study, they detail how their experience has provided them with deeper knowing, greater empathy, and helped them to feel more equipped to work with suicidal people in nuanced, authentically empathic, and caring ways. Participants also speak about a need for and commitment to stigma reduction and combatting the shame and isolation their clients feel. It is apparent that the wounded healer professionals in suicide prevention and intervention also experience stigma, shame, and isolation.

The field of suicide prevention and intervention has much to learn from the wounded healers here, and an open conversation that embraces professionals who know what it feels like to be suicidal must occur. This additional source of knowledge can only benefit the knowledge base of the field in theory and practice.

Greater openness towards the experience of suicidality will allow wounded healer professionals to seek support when they need it, for example, in supervision. It will further create professional role-models, which is specifically helpful for newer practitioners who are currently often left alone to navigate a stigmatized experience in their work environments.

Greater openness thus decreases the isolation that is often the result of having a stigmatized experience, and will allow practitioners to make decisions about if and how to share their experience based on what is right for them and their clients, not based on fear of repercussions. This will also have a positive effect on suicidal people at large.

This responsibility for openness cannot rest on professionals with lived experience with suicidality alone, though perhaps more people who hold positions of greater professional safety will feel compelled to act as role-models for their peers over time. This study has begun a
dialogue between the group of professionals who agreed to be interviewed and me. Throughout the interview process I shared with participants not only my story but also what I had heard from other participants in the interviews, and I will share this thesis with all of them. My hope is that our dialogue will continue with others who become part of the conversation about this project in various ways.

Additionally, voices within academia, and specifically critical suicidology, have a role to play in opening up the conversation. I hope to have added my voice to this with this research.

**Limitations**

**Small sample size.** This study used a small sample of five interviews. This was due to several factors. Firstly, the scope of the project was a Master’s level project, conducted by a new researcher, which resulted in both time and resource constraints that would have made a larger research project difficult to complete. Secondly, I deliberately chose narrative methodology as a suitable approach to investigate this topic. Narrative methods often result in large quantities of data, and, as May (2014) notes, a small number of participants is preferable to allow for a close reading of the texts. Thirdly, as I have outlined in the methodology chapter of this paper, the extensive recruitment process I conducted only yielded two responses, while the remaining participants came forward when they found out about the study in conversation with me.

**Relatively homogenous group of participants.** The participants that I interviewed for this study came from different helping professions, worked in private and public contexts, and differed in terms of race, religion, gender, and sexual orientation. Nevertheless, the group represented a relatively homogenous sample in terms of class background, age, and ability. Participants further had similar economic, education, and employment backgrounds. Largely,
this homogeneity was due to the recruitment process which was specifically geared towards people currently working in suicide prevention and intervention contexts.

I regret that I was not able to recruit Indigenous participants, or participants who were recent immigrants.

**Researcher background.** I conducted this research project as a new researcher. This meant that I engaged in a learning process every step of the way through the research process, from choosing a topic and a suitable methodology, and recruiting participants, to preparing and conducting interviews, and analysing the data that the interviews yielded. It is entirely possible that my lack of research experience may have been a hindrance at times during the project but I nonetheless sincerely hope that I have done the participants and this important topic justice.

Another important point is that I identify as an insider to the topic of this research, as I, too, am a helping professional with lived experience with suicidality. I have defined my experience in more detail elsewhere in this thesis. I consider my insider location to be an advantage, as it has allowed me to engage more deeply with the topic. At the same time, it also impacted my ability to separate my experience from that of participants at all times, and I had to mindfully attend to this issue as it came up, for example in my interview with Salal. While difficult at times, my examination of my own location in relation to the topic of this project has yielded important information, as I have documented throughout this paper.

**Recommendations for Future Research**

This study examined the experiences of helping professionals who work in suicide prevention and intervention, and who have lived experience with suicidality. Despite a growing body of literature on the issue of practitioner lived experience in other areas, for example in mental health, this is not a well investigated subject within the suicide prevention and
intervention context. There are several possible reasons for this. As mentioned above, the field of suicidology favours quantitative methodologies, which are not well suited for examining the personal experience of suicidality. Secondly, as the research conducted in this study has shown, the experience of being a suicide prevention and intervention provider who has lived experience with suicidality is highly stigmatized. Not many professionals openly share their experiences. Lastly, and as touched upon in the literature review, scholars may fear that examining the lived experience of professionals who live with suicidality may lead to a “normalization” of suicidality and more suicides, even if, as the literature demonstrates, this belief is unfounded.

However, the lived experience of wounded healers in suicide prevention and intervention has much to teach the field and thus should be examined. Additionally, academic contributions are important when it comes to creating the greater openness I speak about in the implications and recommendations section of this chapter.

Given the sparseness of existing research, future research in this area could take many forms. As this study included only a small number of relatively similarly located participants, another study could take up the same question with a larger, differently configured group of participants. Alternatively, research could more specifically call attention to a particular aspect of the wounded healer discourse.

Further research will help broadening the conversation about what it means to be a helping professional with lived experience with suicidality in the area of suicide prevention and intervention. This has the potential to lessen the stigma that people face who experience suicidality, whether they are helping professionals or people who access services.

**Reflections on the Research Process**
This project represents the first time that I conducted research by collecting data through direct engagement with participants, rather than using literary or archival sources. In the following I outline some of what I have learned about research through this process.

**Interviewing for stories.** I once heard a storyteller explain what it means to invite someone to tell a story. One day when he sat in a bar to write, a man came in, and they began to talk. The man told him that his son had died. Instead of merely expressing his condolences by saying “I am sorry for your loss.” and thus potentially closing the conversation, the storyteller asked the man: “What was his name?” and the man began to tell him stories about his son. The storyteller believed that it had been the simple inquiry about the son’s name that had given the man permission to share stories about his child.

Given the difference in how many and what kind of stories the interviews I conducted yielded, I am certain that personal communication styles, influenced by cultural, gender, and other factors played a role in how much each participant communicated using storytelling. However, I am also wondering if a more narrative-focused interview style, along with prompts specifically geared towards storied responses could have invoked more storytelling.

**Researching up.** Prior to and during my interview with Michael, I was very nervous. This was different from the nervousness I had felt about my other interviews. I felt self-conscious interviewing someone with research experience far beyond mine, and who is an expert in his field. I wanted to ‘do well’ in this research relationship, partly because Michael was my teacher. I wonder how the power dynamic has played a role for him, as he is normally the one asking for stories, especially in his work as a therapist.

As I listened to, transcribed and re-read Michael’s and my interview, I noticed how my experiencing this relationship as somehow different had shaped the interaction. Throughout the
interview I speak more and in longer stretches than in other interviews. Where I do this, I can tell that I do not do it to put Michael at ease, as I have done in other situations, where I offered a story of mine in return to the participant. Neither do I speak more in an effort to support Michael as he talks about a challenging topic or situation, which I did in my interview with Hollie. There, I provided my opinion in an effort to fend off self-blame when she expressed that it was just her “anxious brain” that made her worry about the professional repercussions of talking about her lived experience with suicidality. While I am not sure whether this effort was justified or helpful in that interview, it was in keeping with how I understand my approach to ethics in this project: I stood in solidarity against the participant’s self-designation as ‘just overly anxious’ in the face of professional uncertainty, just as she had done when disclosing her suicidality to a client who had been ashamed that they were alone in feeling suicidal.

In my interview with Michael, I talk to overcome the insecurity I have about my position as a researcher. I talk to show that I am well prepared and that there is merit to my work. It was uncomfortable, and I got a glimpse into how power differential affects research, and how challenging it would be to truly research ‘up’.

A conversation between equal partners. Prior to embarking on this project, I would have assumed that it would be me in my role as an interviewer to put the interviewee at ease. Throughout the interview process I learned that it was possible to conduct an interview as a conversation between two equal partners, a give and take. This was made particularly clear during my interview with Nina. I had not met Nina prior to our interview, and I was quite nervous, as I did not know what to expect. However, as I realised upon meeting her, making the other person feel safe and comfortable became a joint endeavour. This process became a representation of what I aspire to in my professional life.
Conclusion

The goal of this study was to provide an open space to hear the stories of people who work in suicide prevention contexts and have personal histories of suicidality. I came to this research from an insider perspective and hoped to learn from other professionals how they navigate having personal experience with the very issue they are tasked to assist others with.

Each wounded healer I interviewed spoke about how their lived experience benefits their practice and the people they work with. Yet, concerns and fears about sharing their suicidality in professional contexts were also woven through the stories, making them both wounded and stigmatized healers.

My hope is that this thesis can contribute to the evolving narrative of the wounded healer in the area of suicide and, by extension, help create a more accessible and shared narrative of the nature of suicidality and how to live through and live with it.
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Appendices

Appendix A: Interview Guide

Interview Question, Prompts & Topics to potentially cover

Initial Question:

“Please tell me the story about your experience as a [participant profession] who has lived experience with suicide and who works with people who are also suicidal.”

It is likely that participants will have questions for me following this, and we will collaboratively decide the flow of the interview, based on our discussion.

I will use general prompts, such as “Would you tell me more about this?” and clarifying or prompting questions to keep the interview flowing.

To facilitate the interview process, I have also prepared a list of topics I anticipate we may cover, rather than pre-scripted questions. This is not a closed list, and I am not sure if I will be able to cover it in its entirety, or in this order.

- Thoughts about disclosure, generally and specifically about the topic of suicide (difference?) – stories about disclosure of other personal topics vs. suicidality

- Decision making process about whether to disclose
  - Fears, hopes about disclosure
  - To Clients
  - To Colleagues
  - To Superiors
  - In the past vs. now (has the climate changed?)
  - Early in career vs. later

- Experiences with disclosure in a professional context (positive/negative) – stories about this
  - Clients
  - Colleagues
  - Superiors

- Thoughts about professional identity, how does having first-person relationship with suicidality affect this?
  - Personally (just with self) – Concept of wounded healer – consider it helpful, not helpful – how to know?
- Impression of expectation of other (when they don’t know)
- When others know
- Does work context (self-employed, employee...) matter?

- Thoughts/values re: suicide
  - How is this connected to own history? How does it affect work with clients? Does it?
  - Is there friction with employer’s expectation? How about society’s expectations about suicide prevention/intervention? Professional obligations/standards (college/association)??

- Thoughts about suicide prevention/intervention and what is helpful – how does own history affect this?
  - Knowledge about what occurs when crisis services are engaged

- Is own experience:
  - Helpful?
  - Hindrance? Fears of consequences?
  - How to know?
  - Does own experience create more fear of consequences?

- Stigma
Appendix B: Recruitment Email to Colleague

Dear [name of colleague],

I am currently seeking participants for a qualitative research project I am completing as part of my Master of Social Work program. The project focuses on helping professionals who have a first-person relationship with suicidality and work with suicidal clients. I hope to conduct interviews with participants to hear their stories.

I have attached an invitation to participate and hope that you feel comfortable passing this on to colleagues and your networks, as you feel is appropriate. Please circulate this invitation only to helping professionals and not to clients, even if there are helping professionals among your clients. Potential participants are invited to contact me directly at the included details to ask further questions or to indicate their wish to participate.

Please note that participants must be 19 years or older and work in a professional helping capacity where they at times encounter and engage with clients who are suicidal. They must have lived experience with suicidality in the sense that they at some point during their lives have had suicidal ideation.

All information shared with me will be confidential and no personal identifying details will be included in any material arising out of the study.

The study will accommodate participants’ availability. Interviews may be conducted online, by phone, or in person at times and locations that suit each participant and in which confidentiality and privacy can be maintained.

My goal is to open up the conversation on this important subject with fellow professionals. I hope that with this study I can contribute to lessening the stigma that many helping professionals encounter when they, often silently, deal with similar issues as those that face their clients.

Please let me know if you have any concerns, or if I can answer any questions about this request.

Thank you for considering to help with this project. I truly appreciate it.

Sincerely,

Sabine Huss, RSW

[Contact information]
Appendix C: Recruitment Email to Organization

Dear [name of organization],

I am currently seeking participants for a qualitative research project I am completing as part of my Master of Social Work program. The project focuses on helping professionals who have a first-person relationship with suicidality and work with suicidal clients. I hope to conduct interviews with participants to hear their stories.

I have attached an invitation to participate and hope that you feel comfortable passing this on to your staff via a message board or listserv, as you feel is appropriate. Please circulate this invitation only to helping professionals and not to clients, even if there are helping professionals among your clients. Potential participants are invited to contact me directly at the included details to ask further questions or to indicate their wish to participate.

Please note that participants must be 19 years or older and work in a professional helping capacity where they at times encounter and engage with clients who are suicidal. They must have lived experience with suicidality in the sense that they at some point during their lives have had suicidal ideation.

All information shared with me will be confidential and no personal identifying details will be included in any material arising out of the study.

The study will accommodate participants’ availability. Interviews may be conducted online, by phone, or in person at times and locations that suit each participant and in which confidentiality and privacy can be maintained.

My goal is to open up the conversation on this important subject with fellow professionals. I hope that with this study I can contribute to lessening the stigma that many helping professionals encounter when they, often silently, deal with similar issues as those that face their clients.

Please let me know if you have any concerns, or if I can answer any questions about this request.

Thank you for considering to help with this project. I truly appreciate it.

Sincerely,

Sabine Huss, RSW

[Contact information redacted]
Appendix D: Invitation to Participate

INVITATION TO PARTICIPATE IN RESEARCH

Dear Helping Professional,

I am conducting interviews as part of a Master of Social Work (University Of Victoria) research study entitled “Wounded healer or stigmatized healer? First-person experience with suicidality among helping professionals in suicide prevention and intervention”.

I am interested in hearing your story about your experiences as someone who works with suicidal people and who has lived experience with suicidality, by which I mean that you at some point during your life have had suicidal ideation. Please note that you have to be 19 years or older to participate.

My goal for this research is to open up the conversation about suicidality among professionals working in suicide prevention and intervention. I hope that with this study I can contribute to lessening the stigma that many helping professionals encounter when we, often silently, deal with similar issues as those that face our clients.

The interview will be informal, and its length will be up to you. It can be conducted in person at a neutral location where privacy and confidentiality can be preserved, by phone, or online via a service such as Skype or Facetime, at a time that suits you. Aside from the opportunity to share your story and thereby contribute to changing the dialogue around helping professionals’ experience with suicidality, there is no compensation for participation.

All information you share with me will be confidential and no personal identifying details will be included in any material arising out of the study.

If you are interested in participating, or if you have any questions, please contact me directly by phone at [redacted] or by email at [redacted].

Thank you!
Sabine Huss, RSW
Appendix E: Consent Form

Wounded Healer or Stigmatized Healer?
First-Person Experience with Suicidality among Helping Professionals in Suicide Prevention and Intervention

Participant Information and Consent Form

Thank you for your interest in the research study entitled “Wounded healer or stigmatized healer? First-person experience with suicidality among helping professionals in suicide prevention and intervention” that is being conducted by Sabine Huss, RSW. As a Graduate Student in the School of Social Work at the University of Victoria, I am required to conduct research as part of the requirements for a Master’s degree in Social Work. While I am a registered social worker, I am not acting in this role in relation to research participants, as the participants are not clients.

You may contact me at [redacted] or [redacted] if you would like further information or have questions about the study. The research is being conducted under the supervision of Dr. Susan Strega. You may contact my supervisor at [redacted] or [redacted].

Purpose of this Research
The purpose of this research project is to explore the experiences of helping professionals who work with suicidal clients and who themselves have a first-person relationship with suicidality. The project will use narrative methodologies, a research approach that invites participants to tell their stories and speak about what is important to them about the topic. Research of this type is important because it opens up the conversation about first-person experiences with suicide among helping professionals. By doing so, the study can contribute to lessening the stigma that many helping professionals encounter when they, often silently, deal with similar issues as those that face their clients.

Participant Selection
You are being asked to participate in this study because you identify as a helping professional who works with suicidal clients and who also has a first-person relationship with suicidality. To participate you must be 19 years or older.

What is involved
If you consent to voluntarily participate in this research, your participation will include taking part in an in-depth interview about your experience. The interview can be conducted either in person or using a service such as Skype or Facetime, or by telephone. We will meet when and where it is most convenient for you, so long as privacy, anonymity and confidentiality can be preserved. The length of the interview is up to you.
The interview will be recorded and I will make a transcription. I will also take written notes.

Once the interview is completed and transcribed, you will have the option to read the transcript of your interview and to provide input.

Later on, you also have the option of participating in what is called member checking. This means that I will share a preliminary data analysis with participants and ask them to comment on it.

**Voluntary Participation**
Your participation is entirely voluntary. You should not participate in the project if you anticipate that taking part in this research will cause you any distress. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study, your data collected up until that point will only be used in the study if you give me permission to do so, and I will ask for your permission at that time.

**Inconvenience**
Participation in this study may cause some minor inconvenience to you, such as the time spent for the interview, for the optional review of transcripts, and the optional participation in member checks.

**Risks**
There are no known or anticipated risks to you by participating in this research.

**Benefits**
As there is little research available exploring the lived experience of service providers in the field of suicide prevention and intervention, I hope that this study will contribute knowledge in this area, and help decrease the stigma that surrounds this topic. I further hope that participating in this research will be of benefit to you personally, for example by offering you an opportunity to speak about your experience with another helping professional who also has first-person knowledge about suicidality, and by knowing that you have contributed to research in this important area.

**On-going Consent**
In case you wish to review your transcript following the interview, and/or participate in member checking, I want to make sure that you continue to consent to participating in this research. I will review this consent form with you again at that time.

**Anonymity**
In terms of protecting your anonymity, I will make every effort to prevent other people from being able to identify who you are based on your responses:

- Prior to transcription of the interviews, your identity and any contact information will be separated from the audio recording of your interview.
- The signed informed consent forms will be stored separately from all other study materials in a locked filing cabinet.
- During transcription of the interview, any identifying information will be removed and a pseudonym or code will be assigned. Any data selections that appear in the thesis or otherwise disseminated information about the project will use these pseudonyms and be checked carefully to ensure no identifying information appears.
Confidentiality
In order to protect your confidentiality and the confidentiality of the data I will store paper files (consent forms and paper notes) in a locked filing cabinet in my home. Electronic data will be stored as password protected computer files on a password protected computer, and on the University of Victoria’s server. Only I will have access to the data.

Dissemination of Results
The results of this study will be shared with others in the form of a thesis, which will also be available to the public on the University of Victoria’s website. There may also be a possibility of this research data being used to write a journal article.

Disposal of Data
I will dispose of data from this study once the thesis is successfully defended and all changes requested by the examining committee have been made to the thesis. Should I write a journal article, I will destroy the data once the article has been published. The data will be disposed of by erasing electronic data and shredding paper files.

Contacts
If you have any questions or concerns regarding this study, you may contact Sabine Huss (Researcher) by email at [email] or by phone at [number]. You may also contact Dr. Susan Strega (Supervisor) by email at [email] or by phone at [number].

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria ([email] or [number]).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researcher, and that you consent to participate in this research project.

<table>
<thead>
<tr>
<th>Name of Participant</th>
<th>Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

A copy of this consent will be left with you, and a copy will be kept by the researcher.
Appendix F: Ethics Approval

Certificate of Approval

<table>
<thead>
<tr>
<th>PRINCIPAL INVESTIGATOR:</th>
<th>Sabine Huss</th>
</tr>
</thead>
<tbody>
<tr>
<td>UVic STATUS:</td>
<td>Master's Student</td>
</tr>
<tr>
<td>UVic DEPARTMENT:</td>
<td>SOCW</td>
</tr>
<tr>
<td>SUPERVISOR:</td>
<td>Dr. Susan Strega</td>
</tr>
<tr>
<td>ETHICS PROTOCOL NUMBER:</td>
<td>18-219</td>
</tr>
<tr>
<td></td>
<td>Minimal Risk Review - Delegated</td>
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<tr>
<td>ORIGINAL APPROVAL DATE:</td>
<td>26-Jul-18</td>
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<td>APPROVED ON:</td>
<td>26-Jul-18</td>
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<tr>
<td>APPROVAL EXPIRY DATE:</td>
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PROJECT TITLE: Wounded healer or stigmatized healer? First-person experience with suicidality among helping professionals in suicide prevention and intervention

RESEARCH TEAM MEMBERS: None

DECLARED PROJECT FUNDING: None

CONDITIONS OF APPROVAL

This Certificate of Approval is valid for the above term provided there is no change in the protocol.

Modifications
To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.

Renewals
Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.

Project Closures
When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.

Certification

This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations involving Human Participants.

Dr. Rachael Scarth
Associate Vice-President Research Operations

Certificate Issued On: 26-Jul-18
# Certificate of Renewed Approval

<table>
<thead>
<tr>
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<td>ORIGINAL APPROVAL DATE:</td>
<td>26-Jul-18</td>
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<tr>
<td>RENEWED ON:</td>
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<tr>
<td>APPROVAL EXPIRY DATE:</td>
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**PROJECT TITLE:** Wounded healer or stigmatized healer? First-person experience with suicidality among helping professionals in suicide prevention and intervention

**RESEARCH TEAM MEMBER:** None

**DECLARED PROJECT FUNDING:** None

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Dr. Rachael Scarth  
Associate Vice-President Research Operations

Certificate Issued On: 15-Jul-19