

The Front-line Practitioner's Experience of Working with Children or Youth
Engaged in Suicidal Behaviour

by

Patricia Ranahan
B.A., Malaspina University-College, 2001
B.A., Carleton University, 1995

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ABSTRACT

The purpose of this phenomenological study was to explore the experience of front-line practitioners working with suicidal children and youth. Five front-line practitioners who had experienced working with children or youth who were suicidal participated in the semi-structured interviews. Transcripts of the interviews were analyzed and summarized under the following three areas of experience: Participants' Descriptions of Working with Suicidal Children and Youth, Knowledge Valued by Participants' to Inform their Practice with Suicidal Children and Youth, and Participants' Physical and Emotional Responses to Suicidal Children and Youth. There were a total of sixteen emergent theme clusters. The themes related to the experience of practice with suicidal children and youth provided a rich context for understanding the nature of meaning of the suicidal behaviors for participants. The emergent themes relating to the knowledge valued by participants to guide their approach provided a specific understanding of the multiple sources of knowledge participants were drawing from in the encounters. The emergent themes relating to the physical and emotional responses participants experienced in relation to their encounters with a suicidal child or youth provided an awareness of the impact the encounters had on participants. The major findings included the participants' broad scope of knowledge they used to guide their approach, as well as that encounters with suicidal children and youth did evoke strong physical and emotional responses amongst participants. The study concludes by describing the implications of these findings for Child and Youth Care practice and for future directions in research.

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Thank you to those in my life who have offered support and stood beside me throughout this endeavor. I am grateful you have been there.

DEDICATION

For my spotted friend, who kept his promise.

For Ellaine, the “child-whisperer.”

For Mike.

For anyone who has been touched by suicide.

CHAPTER ONE

Introduction

No one knows who the first was to slash his throat with a piece of flint, take a handful of poison berries, or intentionally drop his spear to the ground in battle. Nor do we know who first jumped off a cliff; walked without food into an ice storm; or stepped into the sea with no intention of coming back.

Kay Redfield Jamison, 1999

Impetus for the Study

The experience of death can be considered an essential part of life. Experiencing the death of a loved one, a family member, a neighbor, or colleague is an inevitable consequence of living. Death enters people's lives through sickness, accidents, war, and acts of terror. Death also appears in life as the willful act of ending one's life as the act of suicide¹. Taking one's own life is a unique and challenging event to understand, especially by the survivors who are left to grieve the life lost to suicide. The number of suicide survivors is estimated to grow by 180, 000 each year in the United States alone (Jobes, Luoma, Hustead & Mann, 2000). With the World Health Organization reporting approximately 873, 000 people dying each year by suicide², the experience of a death by suicide of a loved one, including a child or acquaintance can also be a common experience of living.

¹ <http://en.wikipedia.org/wiki/Suicide>

² http://www.who.int/mental_health/prevention/suicide/suiciderates/en/

Death by suicide is a Canadian experience as well. In Canada, males and females are killing themselves at a rate of 19.5 and 5.1 per 100 000 respectively³. Statistics Canada reported a total of 3681 suicide deaths in the year 1997, including 605 children and youth under the age of 25 who died by suicide⁴. Suicide, the willful act of ending one's own life, is reported in Canada as the second leading cause of death for children and youth, only second to accidents⁵. The British Columbia coroner reported a total of 516 suicide deaths in 2004, including 27 youth between the ages of 13 and 19 and one child under 12-years-old⁶. Undoubtedly the evidence is clear that suicide and survivors of suicide are amongst the young in Canada's population. This evidence does not include the prevalence of thoughts of suicide amongst young people, which may eventually lead to death. According to the most recent adolescent health survey, 16% of students in the province of British Columbia reported they had considered suicide (McCreary Centre Society, 2005). Mishara (1999) found in his study on children's conceptions of death and suicide, that 14% percent of their sample had considered killing themselves. In a sample of 8-year-old children who had experienced, or were at risk for maltreatment, children's self-reports on the prevalence of suicidality was 9.8% (Thompson, Dubowitz, English, Noonan, Wike, Bangdiwala, Runyan & Briggs, 2006). Children and youth are not only dying by suicide, but thinking about ending their lives as well.

³ <http://www40.statcan.ca/l01/cst01/health01.htm>

⁴ <http://www40.statcan.ca/l01/cst01/health01.htm?sdi=suicide>

⁵ http://142.206.72.67/02/02b/02b_004_e.htm

⁶ http://www.pssg.gov.bc.ca/coroners/statistics/pdfs/SUICIDE_IN_BC.pdf

As a preventable death, the prevalence of children and youth dying by suicide and considering killing themselves signifies the importance of exploring how professionals employed in direct service with this population respond to suicidal behaviour.

An Exploration of Front-line Practitioners' Experience of Working with Suicidal Children and Youth

Direct practice, the front line, is often considered the trenches of care work with children and youth experiencing a range of difficulties. The day to day grind, if you will, occurs in close proximity in the daily lives of children and youth. Caring for children and youth often offers difficulties beyond normative relational challenges for both the child or youth and front-line practitioner. The child or youth may have experienced attachment difficulties as a consequence of neglect in their early years of development. The front-line practitioner may encounter youth in their practice who are struggling to find their own sense of belonging or using alcohol or drugs as a means of coping with emotional pain. Additionally, front-line practitioners may work with children who have experienced sexual abuse and have difficulty developing or understanding personal boundaries. Children and youth served by front-line practitioners may also be experiencing deep psychological pain and contemplating suicide. When children or youth question whether to live or to die, how is this experienced by the practitioner whose practice of care exists in this proximity? Consider the following vignette of Child and Youth Care practice.

Imagine you have been working with Nina, a 15 year old girl, in her foster placement for approximately 8 months. It has taken a long time to build a connection with Nina as she is very quiet and reserved. You are aware that Nina has a family history of severe emotional, physical, and sexual abuse, which has led to her placement in the child welfare system. As well, even at her young age, Nina has already endured a number

of years using drugs and working in the sex trade. You connect with both Nina and her foster parent almost daily either in the home, or at the outreach office. Although Nina has been considered by other community service providers as “service resistant,” you believe your relationship with her is strong. Today Nina presents as anxious, fidgeting as she sits on the couch in your office. Your usual “check in” with her leaves you with questions as to how Nina is really doing as her answers are vague. Nina comments that she “just wants to get out of this life” and that she “can’t take it anymore.” You start to wonder what Nina is thinking about as she makes these various statements. You wonder, is she thinking of hurting herself? You second guess that thought, rationalizing that Nina hasn’t really said anything about suicide. Nina comments that she wants to be in a better place. You experience a queasy feeling in your stomach. Once again a thought crosses your mind as to what Nina is referring to, and if she is thinking of suicide. You quickly dismiss the thought and the queasy feeling, and think that Nina may be saying she’s ready to exit the sex trade and get clean off of drugs. Glad that you now have this focus, you inform Nina of a new program for young women trying to leave the sex trade. As you talk about the new program and show Nina some pamphlets, you can feel the disconnect. Your eyes are not meeting, her head is down, and the fidgeting appears to be getting worse. Suicide jumps into your mind again. “Could she really be thinking of that?” you ask yourself, hesitating to even use the word, suicide. The knowledge from workshops, books you’ve read, and discussions with colleagues directs you to ask. Your relationship with Nina also informs you that you are missing something. You take a breath and ask Nina if she is thinking of suicide. Nina looks up, and nods “yes” and you feel your connection is regained. You begin to explore with Nina the emotional pain that she is experiencing that

is leading her to think of suicide and the reasons she wants to die. Various thoughts, emotions, and physical responses emerge as you work through this process with Nina. You notice a bit of adrenaline pumping through your body as you sit with Nina hearing her talk of death while you internally think about how many risk factors she possesses, and wondered how committed she is to her plan of dying. You try to follow your knowledge and bring the training garnered from various workshops into this moment with Nina, and yet you still experienced anxiety. You ask yourself if you should just take her to the hospital and let them handle it, yet she seems relieved as she talks. She begins to talk about how much she loves her foster parent, the other kids in the home, and how they have pot roast every Sunday for dinner. You begin to explore with Nina her reasons for living, and develop a plan to keep her safe. With your help, Nina contacts her foster parent and her social worker, informing them of her feelings of suicide and the safety plan she has created with you. The foster parent meets Nina at your office and takes her home. You sit back in your chair, realizing that you have just had a life or death experience. You wonder what would have happened had you not asked Nina about suicide. Even now, you ask yourself if you should have done more. You stay awake that night wondering if she will be alive tomorrow. What will your relationship be like next time you see her? Have you contacted everyone that would need to know? You wonder if Nina even has the capacity, at 15, to be serious about dying. You wonder how much responsibility is 'yours' for Nina continuing to live, or how much to respect her decision. You recall a time when you had thoughts of suicide many years ago and how painful those moments were. Questions about life and death, ethics and morals, agency policy and practice, flood your mind and body.

This example provides a context of what the experience of suicidal behaviour in children and youth potentially may have for the front-line practitioner. Exploring further the experiences of the front line practitioner may provide deeper understanding of their perspective and enhance the effectiveness of response and intervention with suicidal children and youth.

Overview of the Study

This study evolved from my curiosity about my own experiences with suicidal children and youth, both in direct front line practice, and from a supervisory position. It is an exploration of the front-line practitioner's experience and perspective including an examination of the nature and range of practitioner responses to suicidal children and youth in their care, how practitioners make sense of their encounters, and an examination of the way in which practitioners describe their encounters. A qualitative approach was deemed appropriate to provide "...well-grounded, rich descriptions and explanations of processes..." (Miles & Huberman, 1994, p. 1). Qualitative interviews were chosen to as the most suitable method to learn about front-line practitioners' interior experiences, what they perceived, how they interpreted their perceptions, and how events affected their thoughts and feelings (Weiss, 1994).

This study is designed to examine how front-line practitioners describe and conceptualize their encounters with suicidal children and youth. As a researcher, a registered trainer in suicide prevention and intervention, and a Child and Youth Care practitioner who has worked with suicidal children and youth, I have a significant professional investment in the topic of suicide. I believe that the moments I have spent in my practice being present with a youth that is having thoughts of killing him/herself, or

addressing the myths and stigma around suicide during training opportunities, have been life-saving moments. My decision to explore this topic is additionally strongly motivated by my professional aspirations. I have a professional interest in highlighting the competencies of Child and Youth Care practitioners to meet the needs of suicidal children and youth. I believe that Child and Youth Care practitioners have the capacity to create equitable partnerships with other professionals from various disciplines in caring for children and youth who desire to kill themselves.

The purpose of this chapter is to provide an introduction to the present research study, which will focus on front-line practitioners' experience of working with suicidal children and youth. It will begin by presenting the statement of the problem to be explored in this study. It will then describe the broad purpose of the study and the reasons for carrying out the research. This chapter will also define and clarify the terms utilized in the study within the context of this research. The intentions of the research will also be addressed in this chapter through identifying the delimitations of the study.

Statement of the Problem

The problem of the study is broadly expressed by the following question: How do front-line practitioners describe and conceptualize suicidal behaviour among children and youth in their care? The front-line practitioners' experience will be explored in relation to the following sub-questions:

- What are the front-line practitioners' physical and emotional responses to suicidal children and youth?
- What knowledge do front-line practitioners value to inform their practice with suicidal children and youth, i.e., how do they make sense of their encounters?

- How do front-line practitioners describe their experience of working with suicidal children and youth?

Broad Purpose of the Study

The purpose of this study is to develop a deeper understanding of the front-line practitioner's experience and perspective of working with suicidal children and youth to better inform practice and enhance the effectiveness of response and intervention. Exploration of the front-line practitioner's experience and perspective includes an examination of the nature and range of practitioner responses to suicidal children and youth in their care, how practitioners make sense of their encounters, and an examination of the way in which practitioners describe their encounters.

This study identifies front-line practitioners as a population that warrants attention and it provides the participants with an opportunity to share their stories and experiences in working with suicidal children and youth. For the purposes of this study, the "front-line practitioner" is defined as a professional in direct care practice with children and youth within their daily living environments. Further definition of the principles that generally guide the front-line practitioners' practice will be offered in conjunction with other terms to be clarified. This study has the potential to enhance the ability and capacity of front-line practitioners to respond to suicidal children and youth through advancing the knowledge base that informs direct practice.

The existing body of clinical literature that currently informs professionals across multiple disciplines is predominantly garnered from the fields of Psychology, Psychiatry, Nursing, and Mental Health⁷. In a careful exploration of the literature specific to the Child and Youth Care field, limited research was found that was focused on practitioners'

⁷ http://www.psych.org/psych_pract/treatg/quick_ref_guide/Suibehavs_ORG.pdf

experience and perspective when working with suicidal children and youth. Estefan, McAllister, and Rowe (2004) discuss nurses' first-hand experience of working with patients who self-harm and the tensions that affect their ability to provide skillful caring practice in mental health nursing. Although Estefan et al. (2004) focus on nursing practitioners' experience of self-harm behaviour in an adult population; it highlights the importance of research into the professionals' experience of direct-care practice with specific populations. Therefore, the proposed study has the potential to build on the existing knowledge within the clinical fields of Psychology, Psychiatry, Nursing, Social Work, and Mental Health, and inform front-line practitioners' practice in an additional way.

Professionals (e.g., supervisors, administrators, government decision makers) who create and form policy that sets out guidelines on how to respond to suicidal children and youth will benefit from further understanding of their current experiences and perspectives. Educators in the field of Human Service may also benefit from additional knowledge in preparing Child and Youth Care, Human/Social Service Worker, and Social Work students for front-line positions in the lives of children and youth, beyond the use of standardized suicide risk assessments.

Ultimately, the study of front-line practitioners' understanding and perspective of suicidal behaviour has the potential to impact the lives of children and youth they serve. Findings from this study will be used to inform where there are gaps in practitioner knowledge. Additional knowledge will support practitioners to increase their effectiveness in relationship with suicidal children and youth and potentially save lives.

Definitions and Clarifications of Terms

Definitions and clarification of terms are offered to ensure proper interpretation of the terminology used in this study and to outline the purpose and objectives of the research. The definitions and terms that are clarified are used for the purposes of this study only and are drawn from a variety of sources.

Suicidal Behaviour

The language utilized to describe suicidal behaviour has been chosen purposefully and the concept of suicidal behaviour requires explicit specification. The suicidal behaviour that is being considered in this study has the intent or goal of death as the outcome of engaging in this behaviour. The intent or goal is to stop "...the painful flow of consciousness" (Shneidman, 1992, p.53), even though the child or youth may be ambivalent, both wanting to live and wanting to die, the presence of intent to stop life is a key assumption in the concept of suicidal behaviour. It is important to emphasize that the motivation behind engagement in suicidal behaviour cannot be in the absence of intent to die. This assumption distinguishes suicidal behaviour from self-mutilation where the child or youth may engage in self-mutilation to release emotional pain without intent to die (see Levenkron, 1998). The purpose of this study is focused on front-line practitioners who work with children and youth who have engaged in suicidal behaviours. Thus, information related to children and youth who have died by suicide will not be included in the study.

Further clarification of the terms for suicidality are provided by O'Carroll, Berman, Maris, Moscicki, Tanney and Silverman (1996) who attempt to provide definitions for the purpose of consistency amongst professionals (see Table 1.). For the

purposes of this study, suicidal behaviour in keeping with the behaviour outlined by O'Carroll et al. (1996) as *suicide attempt with injuries*, *suicide attempt without injuries*, *suicidal threat*, and *suicide ideation*. *Instrumental suicide-related behaviour* or self-mutilating behaviour, as well as *suicide* will not be included in the study.

Table 1. Clarification of Terms for Suicidality

Term	Intent	Definition
Suicide	Death	Death from injury, poisoning, or suffocation where there is evidence (either implicit or explicit) that the injury was self-inflicted and the decedent intended to kill him/herself.
Suicide Attempt With Injuries	Death	An action resulting in non-fatal injury, poisoning, or suffocation where there is evidence (either implicit or explicit) that the injury was self-inflicted and that he/she intended at some level to kill him/herself.
Suicide Attempt Without Injuries	Death	A potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either implicit or explicit) that the person intended to kill him/herself.
Instrumental Suicide-Related Behaviour	Not intending death	Potentially self-injurious behaviour with a nonfatal outcome, for which there is evidence (either implicit or explicit) that the person did not intend to kill him/herself (i.e. zero intent to die) and the person wished to use the appearance of intending to kill him/herself in order to attain some other end (e.g., to seek help, to punish others, to communicate pain). Instrumental suicide-related behaviour can occur with injuries, without injuries, or with fatal outcome (i.e., accidental death).
Suicidal Threat	Future Engagement in Suicide-Related Behaviour	Any interpersonal action (verbal or non-verbal) stopping short of directly self-harming that can reasonably be interpreted as communicating that a suicidal act or other suicide-related behaviour might occur in the near future.
Suicide Ideation	Future Engagement in Suicide-Related Behaviour	Any self-reported thoughts of engaging in suicide-related behaviour.

Adapted from O'Carroll et al. (1996).

It is assumed that the experience of a child or adolescent's death for the front-line practitioner is separate from the experience of working with a child or youth engaged in suicidal behaviour. Self-mutilation or *instrumental suicide-related behaviour* does not hold the intent of death according to the defining terms offered by O'Carroll et al. (1996).

The Front-line Practitioner

The "front-line practitioner" also requires further definition. For the purposes of this study, the front-line practitioner is an individual providing direct service to children, youth and families, employed in the Human Service field, specifically within an identified community services agency in a small city in British Columbia, Canada. The front-line practitioner may be formally trained in a variety of academic disciplines including Psychology, Child and Youth Care, Social Work, Sociology, Criminology, Education, or other related fields of study. The length of academic study ranges from certificate programs completed within one year, 2-year diploma programs, or 4-year degree programs. The front-line practitioner may be in process of obtaining any of these academic credentials; however practicum students will not be included in the definition of front-line practitioner. The front-line practitioner holds various titles including, but not limited to, family support worker, youth worker, child care worker, support worker, or youth mentor. While the term "front-line practitioner" clearly encompasses a broad range of direct service providers, one way of highlighting its distinctive character is to explore specific descriptive dimensions that typify the nature of their practice. An overview of the dimensions of practice will be offered to define the front-line practitioner population that is the focus of this study. For the purposes of this study, practitioners will be invited to reflect on the full range of their practice experience with suicidal children and youth.

Therefore, the front-line practitioner may be drawing from a number of experiences with different suicidal children or youth, or one practice experience.

Descriptive Overview of the Front-line Practitioner Role

The population of front-line practitioners was chosen initially as the focus for the study due to the unique position they have in the daily lives of children and youth. The population of front-line practitioners from which the participants were drawn may align themselves with various disciplines within the Human Services profession. An exploration of the front-line practitioner role from a Child and Youth Care approach may illuminate further understanding of the role and position of the front-line practitioner and further delineate this position.

Literature within the field of Child and Youth Care describes the craftsmanship of front-line practice (Beker & Baizerman, 1982). "Craftsmanship...is viewed as an individualistic, expressive process that can...be taught, generally more through modeling than academically, but with distinct conceptual principles at the foundation," (p. 17). The conceptual principles that provide understanding of the unique position of the front-line practitioner include the close proximity to children and youth, the focus on practitioner self-awareness, the emphasis on the therapeutic relationship as the main mode of treatment, the developmental orientation to practice, a multi-faceted generalist approach, and the practice principle of family involvement. To further enhance the relevance of the front-line practitioners' role in responding to suicidal children and youth, relevant literature from the field of Suicidology will compliment the exploration of the front-line practitioners' craft.

Proximity

Key to defining the front-line practitioners is the proximity they have in their work with children and youth. They practice within homes, residential group care, shelters, schools, and community. These locations depict the daily living environments in which children and youth exist, and where face-to-face regular contact with a front-line practitioner occurs. The proximity of the front-line practitioner to children and youth is well documented in the Child and Youth Care literature. Anglin (1999) indicates that the foundation of practice is "...direct, day to day work with children and youth in their environment," (p. 145). The three functions of daily care, activities and counseling give the role of the front-line practitioner "...its potency in facilitating development," (Beker & Barnes, 1990, p. 166). Within the daily care of children and youth, "the professional closest to the maladjusted child is an extremely important individual in his total re-education," (Linton, 1968, p. 324). Furthermore, Linton suggests that the close proximity of the practitioner is a "...central force in re-directing his moral, social, and cognitive development," (p. 324). Beker (2001) emphasizes that practice takes place in the life space of children and youth. The focus is not on the daily life of the child, but rather entering into and becoming a part of the child's life (Linton, 1968, p. 325). The tasks of daily living, such as meal preparation and recreation, are in addition to the central focus of being supportive and nurturing "against a backdrop of dependable presence" (Maier, 1991, p. 393).

The principle of proximity in Child and Youth Care practice can provide opportunities for the front-line practitioner to work with suicidal children and youth. "Child and youth care professionals, by virtue of their proximity to potentially vulnerable

youth across a wide array of settings... provide many key suicide-prevention services” (White, 1997, p.48). The proximity that front-line practitioners have in the lives of children and youth allows for immediacy in intervention as they are accessible to respond to suicidal children and youth. Suicidologists also indicate the need for accessibility (i.e., phone contact) in working with suicidal persons as it allows for meeting the need of the suicidal person in the moment. Dialectical Behaviour Therapy (DBT), developed by Linehan to treat suicidality (Linehan, 1993a, as cited in Swales, Heard & Williams, 2000), strongly advocates for client accessibility to the therapist through the use of after hours phone calls when working with suicidal persons. The phone calls function as a means for the therapist to provide crisis support and skill generalization, and the ability to be in close proximity to a suicidal person.

Therapeutic Relationship

The therapeutic relationship is integral to practice and is well documented in Child and Youth Care literature. The front-line practitioner is “uniquely qualified and situated to cultivate meaningful and reciprocally rewarding relationships with children and adolescents” (White, 1997, p.47). The relationship is therapeutic, combining “...the richness and intimacy of the *personal* with the rigor and goal-directedness of the *professional*” (Anglin, 1999, p.145). The relationship that the front-line practitioner has with children and youth is unique in that it is not limited to weekly therapy sessions and often occurs in their daily living environment. Human relationships are considered the main instrument of the front-line practitioners’ work (Tuggener, 1985, p. 24). The therapeutic relationship for the front-line practitioner stretches beyond a one-directional attitude, to “...care interactions...” of a reciprocal nature and process (Maier, 1991, p.

394). The relationship principle is orientated in attachment, recognizing that "...basic to human development is the existence of assured closeness..." (Maier, p. 395).

Within the therapeutic attachment relationship, the front-line practitioner remains child-centered, allowing for individual differences (Feuerstein & Hoffman, 1982). As such, the front-line Child and Youth Care practitioner utilizes a developmental orientation to practice with a focus on normalcy rather than pathology (Halverson, 1995). Labels or diagnosis are secondary to the recognition of the child or youth as "...a real, living, breathing and unique human being waiting to be discovered" (Fewster, 2002, p. 376). Therefore the front-line practitioner has the potential to view suicidal behaviours in a unique light through being strength-focused and identifying the skills needed, rather than emphasizing the behaviours to be eliminated (Beker, 2001). The therapeutic relationship principle and the developmental orientation in the Child and Youth Care approach provides a context for understanding the role of the front-line practitioner in working with suicidal children and youth.

Relationships, as described in the literature in Suicidology, are also a central focus of treatment and intervention with suicidal persons. Pfeffer (1987) discusses "...fostering an intense empathic relationship..." in working with suicidal children, (p.177). Hazler and Denholm (2002) indicate that the starting point of working with socially-isolated suicidal youth is the development of the relationship between client and counselor. A prominent treatment for suicidal behaviour, Dialectical Behaviour Therapy, suggests a strong therapeutic relationship is needed to promote change (Swales, Heard & Williams, 2000). Michel and his colleagues (Michel, Maltzberger, Jobes, Leenaars, Orbach, Stadler, Dey, Young & Valach, 2002) discuss the need for a therapeutic alliance in the treatment

of suicidal patients within an emergency room context. In a related study of nurses' experience of working with patients who self-harm, engagement and caring were seen to open up spaces for therapeutic encounters to occur (Estefan, McAllister & Rowe, 2004). The therapeutic relationship principle is central not only to direct practice with children and youth, but increasingly important in work with suicidal individuals.

Self-Awareness

The focus on practitioner self-awareness is also emphasized in the Child and Youth Care literature. Eisikovits and Beker (2001) describe the principle of practitioner self-awareness as "...self-consciousness... to keep them in touch with what they are doing and its meaning in relation to changes in themselves and those around them" (p.423). As the therapeutic relationship is a reciprocal process for the front-line practitioner, the principle of self-awareness is needed to integrate their knowledge, skills, and elements of self (Anglin, 1999) into their interactions. The "...attachment-based approach opens us to our own thoughts and actions," (Halverson, 1995, p.172). Halverson also indicates that practitioners are required to examine and question their own behaviour and thinking. The practitioner's self-awareness "...is essential, so that the worker does not permit his or her own weaknesses to interfere..." (Beker & Feuerstein, 1990, p. 29). Practitioner self-awareness is central in addressing the purpose of the study of exploring the experience and perspective of front-line practitioners. Through self-awareness front-line practitioners are able to describe and illuminate their experiences and responses to suicidal children and youth in their practice.

Exploration of self-awareness from the Suicidological perspective will be provided further on in a review of the current literature regarding experiences of working with suicidality in Chapter Two.

Multi-faceted Generalist Approach

The multi-faceted generalist approach of the front-line practitioner involves the broad scope of academic training and the ability to work within a system of care that includes professionals from various disciplines. The front-line practitioner also has the potential to be involved with the family of the child or youth through advocacy, mediation, or reunification, and understands the impact, nature, and importance of the child or youth's family relationships on his/her development and demonstration of various behavioural symptoms. The front-line practitioner is concerned with the "totality of the child's functioning" (Anglin, 1999, p. 145). The work is holistic, treating the whole child's functioning, working with a team of professionals within the child's ecology.

The generalist and multi-faceted approach has been noted in the literature as necessary for treatment and prevention efforts with suicidal adolescents. Shaughnessy, Doshi and Jones (2004) found that the majority of Native American youth in their research, who had engaged in suicidal behaviour, were also involved in other high-risk activities. The youth may be involved in the criminal justice system, seeing an addictions counsellor, or connecting with their school child care worker, due to various behavioural symptoms. Each professional that the youth is referred to based on an identified high-risk behaviour, may allow for an opportunity to explore the young person's possible suicidal behaviours as well. Child and Youth Care practitioners are optimally situated to assess the priority needs of the child or youth as they are not restricted to a specific role and

have the professional capacity, for example, to work with children and youth engaging in high risk behaviours as well as children and youth who may be suicidal. Therefore, the front-line practitioner is in a unique position to experience, respond, and reflect on children and youth engaged in suicidal behaviours.

Delimitations of Study

The following delimitations will be imposed by the researcher. Firstly, the study will be limited to front-line practitioners who have experienced working with suicidal children and youth. Secondly, the study will be limited to those participants who participated in a semi-structured interview, developed by the researcher in regards to the experience of working with suicidal children and youth. Thirdly, the study will be limited to how the participants describe and conceptualize their experience, what knowledge informed their practice, and what physical and emotional responses they experienced in their work with suicidal children and youth. Fourthly, this study will be limited to data collected from the participants between March 2006 and April 2006. Lastly, this study is limited to the elements, conditions, and populations specified in this study. Other populations, elements, or conditions will be considered beyond the range of this inquiry.

Summary

Children and youth are dying by suicide. Children and youth are especially vulnerable to suicide ideation or suicide attempts if they have experienced stressful life events, low parent monitoring, poor family environment, drug or alcohol use, and low social competence (King, Schwab-Stone, Flisher, Greenwald, Kramer, Goodman, Lahey, Shaffer & Gould, 2001). Front-line practitioners have opportunities to work with vulnerable children and youth within their daily living environments. This study is

important in its purpose to examine how front-line practitioners' experience working with suicidal children and youth. This study may provide practitioners, educators, trainers, and supervisors with insight into this unique experience and thus help to inform what role front-line practitioners can play in interventions with children and youth who want to kill themselves.

In Chapter One, I have introduced the study, established its purpose, and provided an overview. In Chapter Two, I discuss relevant literature related to practitioner experiences of working with suicidal children and youth, and how this literature relates to the specific research questions and identifies gaps requiring further exploration. Next in Chapter Three, I explain the research design, methods, and analysis. Then in Chapter Four I provide the findings of the study, noting stories, descriptions, themes, discoveries, and impressions of front line practitioner's experiences of working with suicidal children and youth. Lastly in Chapter Five, I provide a discussion, highlighting the implications for Child and Youth Care practice and suggestions for future research.

CHAPTER TWO

A Literature Review

The risks are real in fact; they are not imaginary. This aspect makes the treatment relationship far more than a transference investigation; it is a unique encounter on which everything, at least for the patient, may pivot.

Maltsberger & Buie, 1974

Introduction

The purpose of the present chapter is to review the relevant literature addressing the professional experience of working with suicidal persons. The chapter will begin by identifying the literature search process including the data bases explored, and the search terms used. Various constructs and guides have been established in the literature to describe the responses of professionals to individuals engaging in suicidal behaviours that may inform the present study. In this chapter I will provide an outline of the various constructs authors have developed in the literature that may have influenced professionals' view of clients. This discussion will be followed by a review of current research on professionals' experience of, and responses to, working with suicidal individuals within the fields of Psychiatry, Psychology, Social Work, Nursing, and Mental Health. Only one study was found that (specifically) considered the front-line practitioners' experience and response to working with children and youth. Even though this study focused on children and youth exhibiting aggressive behaviour, this study was included in this review of the literature due to its relevance to the front-line practitioner position. Lastly, I will highlight the gap in the literature that is directly relevant to the

current study on front-line practitioners' experience of working with suicidal children and youth. The front-line practitioner, from a Child and Youth Care perspective, has a unique role in the life space of children and youth (Anglin, 1999). Paulson and Worth (2002) note, "suicidal individuals often communicate their thoughts to someone" (p.86). The front-line practitioner may be located in an optimum position to be the recipient of this communication. A review of the current body of clinical literature across various professional disciplines will be presented and explored to provide a context for investigating the research question; how do front-line practitioners describe and conceptualize suicidal behaviour among children and youth in their care?

Searching the Literature

The current body of clinical literature that discusses professionals' responses to suicidal behaviour reveals the influence of specific intellectual traditions, such as psychodynamic theory, and other psychological and psychiatric approaches to understanding individual behaviour across various professional disciplines. Within these traditions, certain assumptions are made about the nature of treatment. Treatment may include a focus on psychopathology, therapist as expert, and individually-based approaches. Databases searched for relevant literature included ERIC, PsycINFO, PsychARTICLES, Academic Search Elite, MEDLINE, CINAHL, and HealthSource Nursing/Academic Edition. The search terms that were used included the following; suicide, suicidal behaviour, suicidality, countertransference, attitudes, response, practitioner, mental health professional, Nursing, and Social Work.

Constructs Developed to Describe Professionals' Responses to Clients' Behaviour

Various constructs have been identified in the literature to describe professionals' responses to individuals receiving their care. The constructs established have often emphasized professionals' aversive reactions, particularly towards suicidal clients. The constructs of *transference* and *countertransference*, *vicarious traumatization*, *compassion fatigue*, and *malignant alienation* will be explored in relation to practice with suicidal individuals.

Transference and Countertransference

Literature in the field of suicidology has long discussed the issue of transference and countertransference in working with suicidal patients (Maltzberger & Buie, 1974; Bemporad & Gabel, 1992; Kernberg, 1994). Transference occurs when the client displaces emotions they have towards others, onto the therapist. "Countertransference has come to include a large variety of feelings, fantasies, or behaviours that are elicited by a patient in a therapist during the therapeutic process" (Bemporad & Gabel, 1992, p. 105). Countertransference is described as being inevitable in any psychotherapeutic work with patients or clients. The therapist has an emotional response to how the patient is relating to him or her, and how the therapist then relates to his or her patient (Maltzberger & Buie, 1974). When faced with a suicidal patient, Kernberg (1994) notes that there is a "pull to gloss over" the experience (p. 52). Kernberg states further in regards to assessing suicide risk, the therapist "is under the strong influence of transference and countertransference feelings about the patient that may obscure this assessment" to the point that the therapist may under or overestimate the risk of suicide (p. 54). For the therapist working with a chronically suicidal patient, their sense of self may be challenged. The "therapists who

conceive of their role as requiring success in helping to relieve suffering or distress in others may particularly have strong negative reactions to patients who do not get better” (Bemporad & Gabel, 1992, p. 107). Suicidal adolescents can be seen as representing a “threat to the therapist’s professional identity and to his sense of self-worth as a member of a helping profession” (Bemporad & Gabel, 1992, p. 125). The therapists’ own feelings of helplessness, despair, and worthlessness may be elicited by depressed and suicidal children and youth who convey similar negative feelings and emotions (Bemporad & Gabel, 1992). Thus, the therapist may feel pessimistic about treatment, pessimistic about the patient, and pessimistic about their therapeutic skills (Kernberg, 1994). Feelings of sadness may overcome the therapist in working with depressed or suicidal children because of the therapists’ own long term wishes or goals for the child (Bemporad & Gabel, 1992). The prospect of a child or youth dying by suicide or contemplating ending their life can be frightening, and fill the therapist with a sense of “dread, sadness, and personal failure” as the child or youth is seen as having “so much life ahead of him” (Bemporad & Gabel, 1992, p. 125).

Countertransference and transference issues in working with suicidal individuals have been well identified in the suicidological literature. The authors, Malstberger and Buie (1974) identified a specific construct to specifically distinguish such issues for therapists working with suicidal persons. The construct of *countertransference hate* was established by Malstberger and Buie (1974) to describe the mixture of malicious and aversive feelings that suicidal patients arouse in their psychotherapist. Aversive feelings may “give rise to a sense of inner fear and foreboding, while the patient seems abominable” (p. 626). According to Malstberger and Buie, these aversive feelings mix

with feelings of malice in the form of disgust and the patient is loathed by the therapist. The aversive feelings may tempt the therapist to abandon the patient, while the malicious feelings may preserve the relationship. The motivation to preserve the relationship is to further torment the patient, for "the exercise of cruelty requires an object; one cannot kill or abandon another and continue to torment him" (Maltzberger & Buie, 1974, p. 626). The authors note that the intense interactions between a suicidal patient and therapist may elicit identification of the patient's helplessness and anger from the therapist. The therapist may unconsciously defend themselves against this reaction by withdrawing from the patient. As a result, the patient's suicidal urges may increase as they perceive this withdrawal as a rejection. Thus the intense feelings that the therapist experiences in working with suicidal patients can have lethal consequences. "The risks are real in fact; they are not imaginary" (Maltzberger & Buie, 1974, p. 627). Maltzberger and Buie believe that any treatment of a suicidal patient involves countertransference hate. The consequences of countertransference hate can only be countered through acknowledging its existence, bearing the negative emotions, and putting the feelings of hate into perspective. Acknowledging the existence of countertransference hate requires a degree of self-awareness for the therapist working with the suicidal patient. Maltzberger and Buie note that in working with suicidal patients, "the most important problem in treatment is the considerable emotional demand the undertaking from time to time places on the therapist" (p. 632).

Vicarious Traumatization

In addition to the construct of *countertransference hate*, various authors have provided additional constructs to provide understanding of professional responses to

patients or clients in practice. For example, McCann and Pearlman (1990) coined the term *vicarious traumatization* to describe the therapists' experience of working with clients who relay graphic and painful material during sessions. Vicarious traumatization was defined by the authors as "the transformation that occurs within the therapist (or other trauma worker) as a result of empathic engagement with clients' trauma experiences and their sequelae" (p. 558). Through vicarious traumatization, therapists are challenged in their assumptions, expectations and beliefs about self and other. The effects of vicarious traumatization include disruptions in self intimacy and other-esteem, especially for those therapists with lengthy trauma work experience (Pearlman & Mac Ian, 1995). Working with chronically suicidal patients can produce vicarious traumatization and burn out for therapists (Fox & Cooper, 1998). Fox and Cooper explore the dilemmas and challenges of the "awesome responsibility" of working with suicidal clients (p. 143). The responsibility of caring for a suicidal client can be overwhelming.

In spite of theoretical knowledge, therapists are prone to protect or try to rescue the chronically suicidal client, often at the cost of interfering with the client's own sense of responsibility. The chronically suicidal client's emotional life seems organized around an intense, ambivalent wish to receive care through advice, decision making, and assumption of responsibility by another person.(p. 145).

Olin (1976) notes that the most critical aspect of therapy with chronically suicidal patients is to ensure the patient maintains responsibility "for himself, his decisions, and his life" (p. 570). When therapists are not able to work through desires to rescue or assume responsibility for suicidal clients, they can become victims themselves of vicarious traumatization (Fox & Cooper, 1998).

Compassion Fatigue

Joinson (1992) described *compassion fatigue* as emotionally devastating and unavoidable in the role of care giving. "Compassion fatigue... refers to a physical, emotional, and spiritual fatigue or exhaustion that takes over a person and causes a decline in his or her ability to experience joy or to feel or care for others" (Worely, 2005). In an article on working with chronically ill patients, Figley (2002) emphasizes "the costs of caring, empathy, and emotional investment in helping the suffering" (p. 1433). Although no literature was found that directly linked the construct of compassion fatigue and practice with suicidal clients, Figley (2002) describes compassion as bearing the suffering of others. As therapists bear the suffering of clients and respond compassionately towards their suicidal wishes, they too may experience compassion fatigue. Figley further distinguishes the construct of compassion fatigue from countertransference in respect to the faster onset of symptoms, such as feelings of helplessness and confusion. Empathic ability and empathic concern consist of the skill of the therapist to recognize those in need, as well as a motivation to respond and help others. Therapists' experience the emotional energy and suffering through direct exposure to clients who are in emotional pain. As the therapist responds through empathic understanding to the suffering client, Figley argues the on-going demand to relieve the suffering of the client may result in compassion stress, and ultimately, compassion fatigue.

Malignant Alienation

Watts and Morgan (1994) described the process of the progressive deterioration in the relationship between a psychiatric patient and the staff as *malignant alienation*. The

process of malignant alienation appeared to be common with in-patients prior to a suicide occurring. Malignant alienation was characterized by a “loss of sympathy and support from members of staff, who tended to construe these patients’ behaviour as provocative, unreasonable, or overdependent” (Watts & Morgan, 1994, p. 11). The staff may view the patient as “difficult to treat” which can influence the patient, the treatment process, and prognosis (p. 12). The authors suggest various clinical strategies for preventing and managing malignant alienation including reframing challenging behaviour to a patient’s inability to seek help in other ways, acknowledging the patients’ inner distress, promoting a work environment where staff members can discuss feelings towards patients openly, identify early patients whom staff are perceiving as failing to improve, and identify early the lack of therapeutic alliance with a suicidal patient.

The constructs depicted in the literature describe various responses to suicidal patients that therapists, hospital staff, or other professionals may experience. The constructs of countertransference hate, vicarious traumatization, compassion fatigue, and malignant alienation may assist in answering the larger research question for the present study; how do front-line practitioners describe and conceptualize suicidal behaviour among children and youth in their care.

Professionals’ Responses to Suicidality

Attention has been given within the literature to the professionals’ experience of death by suicide of a client or patient in their care (Kleespies, Penk, & Forsyth, 1993; Tanney, 1995). Spiegelman and Werth (2005) invite additional consideration for the emotional toll that an attempted suicide can take on the professional. Efforts have been made within the suicidological literature to identify professionals’ responses to client

suicidality from various professions including Nursing, Medicine, Psychology, Psychiatry, Social Work, and Mental Health. While there remains a gap in the literature in identifying the front-line practitioners' response to children and youths' suicidality, it is useful to explore the experiences of other professionals working with suicidal populations.

Therapists, Clinicians, Psychologists, and Counsellors

Empirical evidence suggests adverse responses to suicidality amongst therapists and counselling professionals. Fremont and Anderson (1998) surveyed 101 counsellors and therapists on their reactions to client behaviours and found that "...situations in which the client makes a suicide attempt after assuring the counsellor that he or she will not..." were reacted to with intense levels of annoyance. In an earlier study, Fremont and Anderson (1986) found that counsellors responded with anger, resentment, frustration, annoyance, aggravation, and exasperation in respect to certain client behaviours such as making the counsellor feel responsible for a suicide attempt. "There is a strong belief among clinicians that when treating a suicidal patient, if you do the right thing, the patient will stay alive" (Roose, 2001, p. 155). Should the patient die by suicide, the clinician may experience feelings of failure and shame.

Other authors note therapists' experience of stress (Kleespies & Dettner, 2000; Rodolfa, Kraft & Reilley, 1988; Kleespies, Penk & Forsyth, 1993) in response to suicidal behaviour. Rodolfa et al. (1988) found that amongst clinicians and therapists, the two most stressful client behaviours were a suicide attempt by a client, and a physical attack on the therapist. Psychologists who experience a patient suicide often report intrusive symptoms of stress (Chemtob, Hamada, Bauer, & Torigoe, 1988).

Anxiety is well-documented throughout the literature as a response to suicidal behaviour by professionals. Kleespies et al. (1993) found that therapists, who experienced a patient suicide, were more likely to experience anxiety when subsequently evaluating suicidal patients. In her extensive work with suicidal children, Pfeffer (1987) states "...working with a suicidal child elicits intense responses in a clinician that can strongly influence the process of intervention..." and that "...the most common feeling experienced during therapeutic work with a suicidal child is anxiety..." (p.175). Pfeffer also notes that feelings of anxiety from the therapist can produce defensive responses that may interfere with treatment.

In an effort to guide therapists in managing suicidal patients, Birtchnell (1983) notes various responses, including anxiety, avoidance, and irritation that can be present in working with suicidality. The author states that anxiety stems from fear that should the patient die by suicide, he or she will experience disapproval from colleagues as well as experiencing feelings of failure as a clinician. Irritation may also arise due to a belief that suicidal patients are "attention-seeking" or "sympathy seeking" (p. 26). The therapist may also respond with avoidance through medicalizing the problem, essentially seeing the suicidal behaviour as a symptom separate from the person. Bennett, Coggan, and Adams (2003) found a dominant medicalized discourse amongst young people interviewed by the authors. The young people came to view suicidality as a disease or illness (i.e., depression) based on the discourse of the mental health professionals providing treatment to them. Constructing a young person as diseased may allow the clinician to avoid responding to the suicidal behaviour itself. Maltzberger, Lipschitz,

Haas and Kyle (2001) provided further evidence of potential avoidance by therapists in their study on therapists' recognition and response to suicidal crises.

Problems in communication between the patient and therapist were identified as factors that interfered with recognizing the suicidal crisis, even though patients had presented with various signs that warned of the presence of suicidality. If recognized, the two most common problems experienced by therapists in their attempts to act were suggestion of hospitalization and a failure to address factors underlying the suicidal intent. Both of the identified problems perhaps speak to the avoidance by therapists through medicalizing the problem and not addressing the person behind the suicidal behaviour.

Pope and Tabachnick (1993) provided further empirical evidence in their study on therapists' feelings of anger, hate, fear, and sexual attraction or arousal in response to their clients. A total of 285 therapists responded to a questionnaire that investigated feelings or reactions to adult clients in respect to specific client behaviours, as well as training in respect to feelings of fear, anger, and sexual arousal. Over 97% of the respondents reported that the most widespread feeling was fear that a client would commit suicide. Furthermore, over half of the participants reported that feelings of fear affected their eating, sleeping, or concentration.

Physicians, Psychiatrists, Nurses, and Mental Health Practitioners

Nurses, physicians, psychiatrists, and mental health practitioners often work with psychiatric emergencies, such as suicidal attempts and behaviour, which can "...pose serious threats of physical, emotional, or social harm" (Newhill, 1989, p. 245). In reflecting on the reactions of health care providers to suicidal patients, Michel et al.

(2002) note that the self-respect of professionals may be tied to their ability or capacity to be healers. When faced with a suicidal patient who is choosing death over requesting help, health care providers are challenged by their inability to heal the patient. Tzeng and Lipson (2005) found that “making a diagnosis characterized the psychiatric subculture around the care of suicidal patients” (p. 456). Psychiatrists tended to explain suicidal behaviour as “a psychotic problem,” “a personality disorder,” or “a low IQ”(p. 460). If a patients’ attempt was not taken seriously, the patient was more likely to be diagnosed with a personality disorder and stigmatized with labels such as “a difficult patient,” “crying for attention,” or making “a suicide gesture” (p. 460). The reliance on making a diagnosis may be related to health care providers viewing their role as healers of physical illness. Roose (2001) furthers the idea of health care providers seeing themselves as healers, in noting the strong belief amongst professionals that “...when treating a suicidal patient, if you do the right thing, the patient will stay alive” (p. 155). As a result of holding this belief, health care providers may respond to suicidal patients with a sense of responsibility and shame should the patient die by suicide.

Nursing professionals may hold additional beliefs around suicidal behaviour that may adversely affect their ability to respond in a caring manner, and result in judgmental or controlling responses (Sun, Long, Boore & Tsao, 2006). As well, Hammond and Deluty (1992) investigated the responses of clinical psychologists, psychiatrists, and oncologists towards suicide through assessing attitudes and the personal, professional, and societal values professionals’ held which underlie these attitudes. The authors randomly selected 363 participants from the various professional groups to complete a questionnaire. Suicides in the face of physical illness were judged to be significantly

more acceptable than death by suicide in response to a chronic psychiatric illness. Hammond and Deluty also found that the majority of the participants did not feel a substantial sense of personal responsibility for either the attempted suicide, or death by suicide of their patient. Attitudes regarding the acceptability of suicide and the degree of personal responsibility for a patient's suicidal behaviour could potentially have an impact on the response to a patient. Professionals may see the patient being fully responsible for their behaviour, and thus may blame the patient for not changing the behaviour that is within their control (Berman & Jobes, 1991). In a survey of staff members from a variety of psychiatric wards, Rossberg and Friis (2003) found that suicidal behaviour elicited mostly negative feelings among staff members. Rossberg and Friis warn that if negative emotions are not acknowledged, staff may prematurely discharge patients or see them as manipulative. Alston and Robinson (1992) investigated nurses' attitudes toward suicide and found that the majority (68.5%) believed that suicidal threats were not real, and 40% believed that suicidal behaviours were attempts to elicit empathy. The authors conclude that inadequate knowledge about suicide may have influenced the nurses' responses on the questionnaire. Ramberg and Wasserman (2003) found that less than half of psychiatric nurses and assistant nurses who work with suicidal patients on a regular basis consider themselves sufficiently trained and many (39%) experience 'lack of job clarity' in their work with suicidal patients. Competency in suicide intervention has been positively linked with level of suicide intervention training, (Neimeyer, Fortner, & Melby, 2001). Education or academic preparation in Psychology, in comparison to Nursing, was found to be associated with increased responsiveness to suicidality (Richards & Range, 2001). The authors note that this may be due to the slight increase of

didactic teaching specifically on suicide that students in Psychology receive in comparison to Nursing students, however, both disciplines received less than 6.5 hours of total training. Acknowledgement of attitudes, beliefs, and increasing training and knowledge for medical personal may influence responses to patient suicidality.

Further assessment of the responses of health care providers to suicidal patients has been explored from the perspective of psychiatric in-patients. In a phenomenological inquiry illuminating the experiences of suicidal psychiatric in-patients being cared for by mental health nurses, Talseth, Lindseth, Jacobsson and Norber (1999) found when patients experience isolation, or being left alone on the ward, suicidality and feelings of hopelessness emerge. When patients attempted to talk to nurses about their suicidal thoughts, they often found that the nurses avoided the subject. Alternatively, when nurses listened to what they had to say, had calm voices and maintained good eye contact, the patients felt safe, accepted, and able to express emotions. These positive interactions gave hope to the patients, and the patients "did not give up" (p. 1040). Sun et al., (2006) also investigated the nursing care of suicidal patients from the perspective of both nurses and psychiatric in-patients in their care. The authors' findings indicated that the nurses utilized a variety of assessment strategies including observations, interviewing skills, recognizing warning signs, and the collation of information about cues to suicide. Nursing of suicidal patients required compassion and sensitivity in order for patients to feel that their privacy and autonomy was maintained. Patient participants in the study indicated they wanted nurses to spend more time with them and help them explore their problems. Similarly, nurses reported wanting more time and skills to work with suicidal patients.

Anderson, Standen, Nazir and Noon (2000) investigated nurses' and doctors' attitudes towards suicidal behaviour specifically in young people. Suicidal behaviour in young people appeared to be seen as more of an impulsive act, a cry for help, or attention-seeking behaviour, and not necessarily indicative of mental illness. In a later study (Anderson, Standen, & Noon, 2003), the authors examined further the perceptions of nurses and doctors practicing with suicidal young people. Nurses' and doctors' both reported experiences of frustration in practice with the lack of time and resources, which often resulted in staff engaging in non-therapeutic encounters with youth. Frustration was also expressed by nurses and doctors in not being able to treat suicidal behaviour as if it was a physical illness. Nurses and doctors expressed wonderment about the effectiveness of interventions even if time constraints were lifted. Nurses and doctors also struggled with seeing suicidal behaviour as a "potential waste of life" and that young people "had no respect for the danger of taking an overdose" (p. 592). Fear was also present for participants in the study regarding the preconception that talking about suicide with a young person would make things worse. Nurses and doctors viewed suicidal young people as requiring specialized care and specialist skills to provide help.

Social Workers

Social workers also represent a population of professionals that may work with individuals contemplating suicide. In a recent survey of 598 social workers, Feldman and Freedenthal (2006) found that 92.8% reported having worked with at least one suicidal client in their practice. Social workers practice in a variety of settings that are not exclusive to mental health practice, but which expose them to children, youth, and adults that may be experiencing numerous psychosocial problems (Feldman & Freedenthal,

2006). Only 21% of participants in the study reported having received any formal training related to suicide, even though the prevalence of suicidality in Social Work practice is at a high level, with over 90% having worked with a suicidal client. Although most social workers in the study reported that the amount of suicide-related education they received was inadequate, 80% stated that they felt both competent and confident in working with suicidal individuals. When considering social workers' attitudes toward suicide education, three out of four participants believed education to be "very important" or "somewhat important" (p. 471). Feldman and Freedenthal additionally reported that 22.6% of participants felt that suicide education was "very unimportant;" a concerning statistic considering the likelihood of suicidality occurring within Social Work practice.

In an additional study that targeted a population of specifically mental health social workers, Jacobson, Ting, Sanders and Harrington (2004) found that 52.5% of the participants had experienced either an incident of fatal or nonfatal client suicidal behaviour in their practice. Social workers reported that the experience of fatal client suicidal behaviour was significantly more stressful than nonfatal client suicidal behaviour. Jacobson et. al also found that male social workers reported more avoidance reactions to suicidal clients after experiencing client suicidal behaviour. The authors concluded that social workers experience stress in response to working with suicidal clients. Beyond stress, mental health social workers practicing in psychiatric settings may experience suicidal patients as "irritating manipulators" and respond with a lack of concern or even dislike (Newhill, 1989). Social Work practice is "complex and fraught with competing demands" as professionals attempt to balance ethical guidelines, laws,

social stigma, and oppressive systems while working with a suicidal client (Mishna, Antle, & Regehr, 2002, p. 276).

In a related study focused on professionals who provide home visitation services to at-risk families, 114 professionals participated in focus groups to identify problem situations they faced in their practice (LeCroy & Whitaker, 2005). One of the most difficult situations faced by home visitors as reported in the study was “helping parents who threaten to commit suicide” (p. 1006). Participants also reported they did not have enough experience to address mental health problems in working with families. Working with suicidal individuals may be difficult due to participants’ belief they did not have the skill or experience to competently address the problem.

The empirical evidence demonstrating numerous adverse responses by health care providers, clinicians, social workers, and therapists to suicidal behaviour, indicates how the experience of working with people who are suicidal can have a tremendous impact on professionals. The various responses including stress, fatigue, and anger, highlight the importance of considering the research sub-question, what are the front-line practitioners’ physical and emotional responses to suicidal children and youth in their care.

A Gap in the Literature

The current clinical literature in the field of suicidology regarding professionals’ experience and perspective of children and youth engaged in suicidal behaviours appears to be heavily influenced by a traditional medical model, the constructs created to understand the nature of professionals’ responses to suicidality, and the assumptions about treatment. Psychiatric approaches can provide careful evaluations of the suicidal patient’s mental state and treatment (often with pharmacological interventions as a

central treatment modality) to alleviate the symptoms and improve overall functioning (Tzeng & Lipson, 2005). Michel et al., (2002) note:

However, the initial hospital experience to which patients are subjected often does little to inspire confidence, a sense of being understood, or to show that professional help involves empathy for what drove them into attempting suicide in the first place.

Psychologists, psychiatrists, therapists, clinicians, and nurses are often limited to emergency responses or one-hour therapy sessions located in office settings with the children and youth that they serve. Workplace pressures for efficiency, minimization of risk, and on outcome-measures may undervalue practices of nurturance, comfort, education, motivation, and support (Estefan, McAllister, & Rowe, 2004). The language within particular theoretical orientations to describe professionals' "countertransference responses" to suicidal persons has included hate, annoyance, anxiety, fatigue, trauma, and stress (Maltsberger, 1974; Kleepies & Dettner, 2000; Fremont & Anderson, 1988; Joinson, 1992; McCann & Pearlman, 1990; Watts & Morgan, 1994). Treatment options for children and youth may also be limited by attitudes of medical personnel (Anderson et al., 2000), and the use of standard diagnostic tools to assess a child's suicidality (Pfeffer, 2001), and the use of psychodynamic frameworks to understand and treat suicidal children and youth (Pfeffer, 1981). While literature relevant to practice with suicidal individuals exists amongst the various disciplines of Psychology, Psychiatry, Nursing, Social Work, and Mental Health, no literature was found that directly explored the experience of front-line practitioners' practice with suicidal children and youth. There is a significant gap in the literature directly related to the front-line practitioner populations' experience of suicidal children and youth. Exploration of the literature revealed only one study with relevance to the front-line practitioner population. Okamoto (2001) conducted

research examining practitioners' experience of fear in working with children and youth exhibiting aggressive behaviours. Practitioner fears included a fear of physical harm, a fear of being labeled incompetent, or fear of litigation. Okamoto described the existence of a "manipulation factor" that involved practitioners avoiding, distorting or withholding information from others in order to protect themselves in their experience of fear (p. 181). No additional research focusing on the front-line practitioner was uncovered in a review of the current literature.

Summary

In this review, I have explored the current clinical literature from the fields of Psychology and Psychiatry relevant to how suicidal behaviour is experienced by professionals. The explorations of the constructs used to describe responses to suicidal behaviour, and the empirical explorations of various adverse responses, such as stress, anger, hate, and fatigue, have suggested some interesting implications for understanding the front-line practitioners' response to suicidal children and youth.

The constructs have provided a context for exploring responses to suicidal behaviour by therapists, clinicians, social workers, and medical personnel. The constructs also provide a way of understanding the interaction between therapist and patient. They also suggest that it is important for therapists, and potentially front-line practitioners, to know themselves well, and receive education and training in suicidology so that they may work effectively with suicidal persons.

Similarly, the empirical evidence that explores responses to suicidality also highlights how suicide in clients and patients can evoke negative feelings in those working with them. Feelings of stress, fatigue, anger, aggravation, annoyance, as well as

multiple others were cited as responses to suicidality. Such adverse feelings may impact the clinician or therapists' intervention with the client or patient, ending in a consequence of death. What this literature does not answer is how the front-line practitioner experiences suicidal behaviour. Is it different for the front-line practitioner who interacts and develops a relationship with a child or youth in their daily living environment? Specific examples of what front-line practitioners experience in their work with suicidal children and youth are missing in this literature.

Direct front-line practice is highly demanding work. The front-line practitioner engages with children and youth in a daily living context that often has them responsible for the whole needs of the child. Counselling may occur while dinner is being cooked, or during a drive with other youth in the van. The issue of suicide may appear in comments made while watching TV, or while a child is demonstrating aggressive behaviour. The front-line practitioner is often immersed in the lives of children and youth, forming a relationship that is created in a variety of interactions, locations, and time periods. It is vital for the front-line practitioner to possess an awareness of self so that they are able to discover each opportunity and moment to promote growth and well being in each child in their care. The clinical literature reviewed from the fields of Psychology, Psychiatry, Nursing, Social Work, and Mental Health, have provided a rich exploration of the various responses and impacts on professionals working with suicidal individuals. While this is highly informative, there is no written evidence that informs us what front-line practitioners experience and how they conceptualize suicidal behaviour in children and youth.

The intention of the present study is to provide an understanding of how front line practitioners experience suicidal children and youth. The results of the study will have implications for the applied practice of Child and Youth Care and allied workers as well as for their professional education.

In Chapter Two, I have presented a review of the relevant literature related to practitioner experiences of work with suicidal children and youth, as well as how this literature relates to the specific research questions and identifies gaps requiring further exploration. Next in Chapter Three, I will explain the research design, methods, and analysis for the present study on the front-line practitioners' experience of working with suicidal children and youth.

CHAPTER THREE

Methodology

The qualitative research interview attempts to understand the world from the subjects' point of view, to unfold the meaning of peoples' experiences, to uncover their lived world prior to scientific explanation.

Steinar Kvale (1996, p. 1)

Introduction

This chapter will present a description of the methodology utilized in the present study. It will begin by providing a general description of a qualitative approach, and the rationale for choosing a phenomenological research design for the study. The core processes of phenomenological research will be explained and described in relation to their function in the present study. Furthermore, this chapter will illuminate the researcher stance, location, and assumptions in conducting this study. It will then outline the participant recruitment and selection process and provide a general description of the selected participants' demographic information. Ethical considerations that were undertaken in this research will also be provided. This chapter will then describe the semi-structured interview used in the study, and provide an account of the data collection process and the procedures utilized for data analysis.

A Qualitative Approach

Qualitative research and inquiry is described metaphorically by Creswell (1998) as a "...intricate fabric composed of minute threads, many colours, different textures, and various blends of material," (p. 13). Creswell's metaphor provides a visual depiction of the layers of information and extensive detail that a qualitative approach can provide

when exploring a human problem or experience. Miles and Huberman (1994) further describe the data derived from qualitative research as "...a source of well-grounded, rich descriptions and explanations of processes..." (p. 1). As well, the chronological flow of experience can be preserved with qualitative data (Miles & Huberman, 1994). The emphasis in qualitative research is on "...discovery, description and meaning rather than the traditional natural science criteria of prediction, control and measurement," (Osborne, 1994, p. 168). A qualitative approach provides rich and extensive detailed chronological accounts that can illuminate human experience.

A qualitative approach is suitable for describing the unique experiences of front-line practitioners working with suicidal children and youth. The nature of the research question in the present study, *How do front-line practitioners describe and conceptualize suicidal behaviour among children and youth in their care*, invites a qualitative approach. Creswell (1998) states "in a qualitative study, the research question often starts with a *how* or *what* so that initial forays into the topic describe what is going on," (p. 17). This study seeks to illuminate the front-line practitioners' descriptions of their experience with suicidal children and youth.

A qualitative approach provides rich data that will address the current gap in the Child and Youth Care literature regarding practitioners' experiences of suicidality in practice. The current clinical literature is situated within a particular tradition (e.g., Birtchnell, 1983; Kleespies & Dettner, 2000) that makes assumptions about treatment that may not be relevant for the front-line practitioner. A qualitative study is chosen because there is a need for a topic to be explored and "...theories are not available to explain behaviour of participants or their population of study," (Creswell, 1998, p. 17).

Beyond the identified gap in the literature, this study was designed to better understand the experience of front-line practitioners. A qualitative approach is used "...because of the need to present a detailed view of the topic..." when a "...close-up view does not exist," (Creswell, 1998, p. 17). A qualitative research interview can provide a close-up view. The qualitative research interview brings two persons, the front-line practitioner and researcher, together to talk about a topic that is of interest to both parties. The phenomenon that was being explored in the study was the experience of working with suicidal children and youth from a front-line practitioner's perspective. I sought out each participant's "lived sense" (Giorgi, 1985, p.12) of their experience in an attempt to "...make genuine discoveries concerning what is important..." about working with suicidal children and youth (p. 13). As a qualitative researcher, I joined each participant in the interviews and listened to his/her lived experience of suicidal children and youth through his/her stories, words, and non-verbal communication, recognizing that I had "...an empathic access to the world of the interviewee," (Kvale, 1996, p. 125). During the process, a deeper understanding and meaning of the experiences of front-line practitioners working with suicidal children and youth emerged through their described experiences. "A qualitative research interview seeks to cover both factual and a meaning level... obtaining nuanced descriptions from the different qualitative aspects of the interviewee's life world..." (Kvale, 1996, p. 32). Through a qualitative approach, "...the researcher builds a complex, holistic picture..." and "...reports detailed views of informants,"(Creswell, 1998, p. 15). Through detailed reports from the participants, the possibility exists "...for readers to grasp a situation from the inside," (Weiss, 1994, p. 9).

A qualitative approach is suitable for obtaining the detailed descriptions of front-line practitioners' experience and addresses the nature of the research question. Additionally, a qualitative study can inquire into the presently unexplored population of front-line practitioners' who have experience with suicidal children and youth. Qualitative interviews can provide a close-up view of the front-line practitioners' "life world" (Kvale, 1996, p.32) and provide an opportunity for learning about responses, interpretations, and occurrences in practice with suicidal children and youth. Therefore, a qualitative approach was determined as appropriate for the study.

A Phenomenological Research Design

In phenomenological research, phenomena are studied, "...and descriptive or interpretive techniques... are used to develop clear and accurate descriptions of these phenomena," (Hein & Austin, 2001, p. 5). As the focus of the present study was on the phenomena or the experience of front-line practitioners working with suicidal children and youth, a phenomenological research design was well-suited to the needs of study as the objective was to describe front-line practitioners' experience. Phenomenological inquiry is concerned with "...understanding how the everyday, inter-subjective world is constituted," (Schwandt, 2003, p. 297 as cited in Denzin & Lincoln, 2003). The focus is on the life world of the participants; "...the attempt at a direct description of experience..." (Kvale, 1996, p. 53). Phenomenological researchers search for the essence or underlying meaning of an experience (Creswell, 1998). Moustakas (1994) describes the essence or underlying meaning of an experience that is sought in phenomenology as "the first method of knowledge" because it begins with "things themselves" (p.41). The descriptions of experience that unfold through phenomenological inquiry are necessary

“...so that we know what actually happened concretely before analysis of some type can begin” (Giorgi, 1985, p. 41). Phenomenological inquiries can provide a foundation of knowledge that further research endeavors can build upon. This is not to say that phenomenologists are seeking to develop a comprehensive theory of human experience. Phenomenology holds a deep respect for the uniqueness of human experience (Hycner, 1985). “It is the uniqueness of the human being which constantly instills novelty and unpredictability into any attempt to totally and comprehensively ‘capture’ the phenomenon of human experience” (p. 300). Phenomenology begins with the appearance of things, seeks meaning from appearances, and is committed to descriptions of experiences that are as close as possible to the original quality of the experience (Moustakas, 1994) and thus the uniqueness of that experience. Meaning is derived through illuminating the experience, examining the whole phenomenon from many sides, and derived from the first-person accounts of the experience (Moustakas, 1994).

Approaching Phenomenological Research

Phenomenological research methods involve various core processes that have informed this study. The core processes include *Epoche*, Transcendental-Phenomenological Reduction, and Imaginative Variation (Moustakas, 1994). Each core process functions to derive knowledge in an open, reflective, and comprehensive way.

Epoche is a Greek word meaning to stay away from or abstain (Moustakas, 1994). Moustakas (1994) describes the *Epoche* as setting aside prejudgments, biases, and preconceived ideas about things, to look at phenomenon in a naïve and fresh way “through a purified consciousness” (p. 85). *Epoche* has also been described as *bracketing* (Hein & Austin, 2001). To look at a phenomenon in a fresh way, the researcher attempts

to set aside or bracket his or her presuppositions, biases, or other personal, professional, or academic knowledge of the phenomenon (Hein & Austin, 2001). The *Epoche* sets aside the "...biases of everyday knowledge, as a basis for truth and reality" (Moustakas, 1994, p. 84). Conventional understandings and assumptions of science must also be bracketed (Giorgi, 1985). The deeply rooted and traditional understandings of science must be suspended as the researcher returns to the origins of experience, which may not be yet articulated (Giorgi, 1985). The *Epoche*, or *bracketing* also involves the researcher articulating his or her presuppositions "...so that the reader can be aware of the perspective from which the research was conducted," (Hein & Austin, 2001, p. 6). By engaging in bracketing and articulating presuppositions, "...the researcher aims at being as open and receptive as possible to participants' descriptions of their experience of the phenomenon" (Hein & Austin, 2001, p. 5). Key to this phenomenological method is the separateness between the researcher's perspective including knowledge and lived experiences, and the participant's perspective and what he or she lives, to obtain an accurate description of what actually happened before analysis begins (Giorgi, p. 41). This means that the researcher's meanings and interpretations are suspended to enter into the unique world of the participants and understand what they are saying from their perspective, rather than from the view of the researcher (Hycner, 1985). Transparency and self-awareness are central to the process of bracketing. The challenge of *Epoche* is to be "...transparent to ourselves, to allow whatever is before us in consciousness to disclose itself so that we may see with new eyes..." (Moustakas, 1994, p. 86). However, a complete bracketing of presuppositions may be impossible in a phenomenological inquiry. The very reason why the researcher is asking a particular research question is an

example of anticipations or preconceptions that are not free of presuppositions (Osborne, 1994). In considering reflexivity in research, Cutcliffe (2003) claims that in order to make known the biases, values, and prior knowledge a researcher brings to a study, the researcher must have self-awareness and that self-awareness is constantly in a state of flux as new experiences and interactions occur. Cutcliffe (2003) thus asks, "...how much of what I think, feel, and know about the phenomenon I am researching can I make explicit?" (p. 139). Moustakas (1994) acknowledges that the Epoche is rarely achieved perfectly, rather that the "...energy, attention, and work involved in reflection and self-dialogue..." along with the intention to bracket attitudes, frame of reference, and biases, "...significantly reduce the influence of preconceived thoughts, judgments, and biases," (p.90). To make transparent my own bracketing process as a researcher in the present phenomenological inquiry, I will articulate the presuppositions I identified further on in this chapter.

The second core process of this phenomenological approach is Transcendental-Phenomenological Reduction (Moustakas, 1994). In this process, each experience is described in its totality. "A complete description is given of its essential constituents, variations of perceptions, thoughts, feelings, sounds, colours, and shapes," (Moustakas, 1994, p. 34). Phenomenological reduction is not only a way of seeing the experience, but includes a way of listening to participants (Moustakas, 1994). The researcher deliberately and consciously opens him/herself to the experience or phenomenon as it is being told by participants. Within the core process of phenomenological reduction, the dimension of horizontalization occurs in which the never-ending process of discovery is unlimited. "A new horizon arises each time that one recedes" (Moustakas, 1994, p. 95). In

horizontalizing, the experience or phenomenon is reconsidered, from various vantage points. Initially, every statement from the participant is viewed and treated as having equal value. The statements that are irrelevant to the topic, as well as those that are repetitive or overlapping are deleted. The textural meanings and invariant constituents are then exposed that are directly relevant to the phenomenon or human experience being studied. The horizons that are left, or the “meaning units” that are directly relevant to the topic (Giorgi, 1985, p. 10), are clustered into themes and then organized into a textural description or summary of the phenomenon (Moustakas, 1994). Giorgi (1985) emphasizes that the meaning units do not exist solely in the transcribed text of the participants. The meaning units that emerge exist in relation to the attitude and location of the researcher. “What stands out depends very much upon the researcher’s perspective” (p. 15). To remain transparent and reflexive, my perspective as a researcher in the present study will be explored further on in this chapter.

The final core process in this phenomenological research is Imaginative Variation. “The task of Imaginative Variation is to seek possible meanings through the utilization of imagination” (Moustakas, 1994, p. 97). The textural description of the phenomenon is approached from various perspectives. The researcher uses his/her imagination to view the phenomenon from different frames of reference, different roles or functions. All possibilities are employed in the search for the essence of an experience. The researcher considers the various structures such as time, space, bodily concerns, causality, relation to self and to others, which may precipitate participants’ feelings and thoughts with regards to the phenomenon being studied. The purpose of Imaginative Variation is to “arrive at structural descriptions of an experience, the underlying and

precipitating factors that account for what is being experienced,” (Moustakas, 1994, p. 97). Through employing the core process of Imaginative Variation the researcher looks at what could be, and what could not be, within the human experience being studied and thus arrives at the features or essence of the phenomenon (Osborne, 1994).

Application of the core processes of phenomenological research will be further explored in this Chapter in relation to the steps of data analysis.

Rationale for a Phenomenological Research Design

A phenomenological method is well suited to address the research question of how do front-line practitioners describe and conceptualize suicidal behaviour among children and youth in their care. A phenomenological method is a “...practice of science within the context of discovery rather than the context of verification,” (Giorgi, 1985, p. 14). As the phenomenon is explored, meaning is discovered, and a deeper understanding can be brought to the phenomenon itself. This method allows for the lived experience of working with suicidal children and youth to be brought forward without a pre-determined scientific hypothesis created by the researcher. As the study was not centered on verification of a formulated hypothesis, but rather on the exploration of a phenomenon through understanding the lived experiences of front-line practitioners, a phenomenological method was determined to be well-suited to address the research question.

Researcher Stance

Within qualitative research, the researcher is viewed as an instrument of data collection (Creswell, 1998). As an instrument of data collection, I was aware of my role of an active learner, “who can tell the story from the participants’ view” (Creswell, 1998,

p. 18). Undoubtedly as the instrument that collects the data and tells the story, my own experiences, knowledge, perceptions, and biases influence the research process and final synthesized descriptions of participants' experiences. Cutcliffe (2003) argues that "everything I am is involved with the analysis and interpretation of the data," (p. 140). Within a qualitative research study, reality is constructed by all individuals involved in the research situation, including the realities of the researcher (Creswell, 1998). As well, I have a relationship with the phenomenon of working with suicidal children and youth that is being researched. To practice reflexivity in the present study, the values, prior knowledge and experiences that I hold as a researcher need to be actively reported. "Reflexivity refers to active acknowledgement by the researcher that his/her own actions and decisions will inevitably impact upon the meaning and context of the experience under investigation," (Horsburgh, 2003, p. 308). Phenomenological research design attempts to address the role of the researcher in data collection through the core process of *Epoche*, or *bracketing*. It is widely acknowledged that bracketing the presuppositions of the researcher is rarely achieved with perfection (Moustakas, 1994; Hein & Austin, 2001; Osborne, 1994). It is the aim of the bracketing process to increase my awareness as a researcher of the influences of biases, presuppositions, experiences, and knowledge that can have a role in the research process. In keeping the core process within phenomenological research of bracketing in mind, I will attempt to make transparent my ontological and epistemological location as a researcher, and explicate the presuppositions I identified through a process of self-reflection and self-awareness.

Researcher's Ontological and Epistemological Location

My personal, professional, and academic experience situated the study in a foundation of knowledge that requires definition. My formal education has been centered within Child and Youth Care. Principles of Child and Youth Care thus influence my professional practice, the relationships I have with my colleagues and my direct work with children, youth, and families. A Child and Youth Care philosophy of practice will inevitably guide the lens in which I view the data. This philosophy encompasses a child-centered, developmental, ecological approach to practice in which the needs of children and youth guide intervention, the understanding that each individual is on his/her own developmental pathway, and the child exists in a system of relationships of influence. Anglin (1999) clearly outlines the characteristics of Child and Youth Care practice that have guided my academic and professional experience. The five characteristics that Anglin describes include; a focus on the growth and development of children and youth, a concern with the totality of a child's functioning, a social competence perspective, direct day-to-day practice with children in their environments, and the development of therapeutic relationships.

Various theoretical traditions have also informed my practice within Child and Youth Care. A humanistic, person-centered approach (Rogers, 1980) which focuses on the phenomenal world of the person, and the attributes of the practitioner in developing a growth-promoting climate, continues to be a core theoretical influence in my Child and Youth Care practice. Attachment theory (Bowlby, 1982) also is central to my understanding of the relationships I develop with children and youth. Undoubtedly, these theoretical traditions have informed the present study particularly in the chosen area of

research and the methodology of phenomenological inquiry employed. My philosophical location not only guides my professional practice, it informed my interest in the study to develop a deeper understanding of the front-line practitioner's experience and perspective of working with suicidal children and youth in order to better inform practice and enhance the effectiveness of response and intervention.

My professional experience has included multiple interactions, interventions, and risk assessments with children and youth engaging in suicidal behaviours in a variety of settings. I have experience working with children and youth in residential settings including as a live-in houseparent, in a crisis shelter for street-involved youth, a transition house for women and children who have experienced domestic violence, as a foster parent, and as a youth worker in a resource staffed in rotating shifts. My professional experience also extends beyond the child or youth's daily living environment to include outreach, counseling, parent-teen mediation, and within school settings. In my career I have held a range of positions including front-line practitioner, supervisor, client services coordinator, and consultant. As well, professionally, I have experienced the death by suicide of one youth I worked with approximately 4 years ago. As a supervisor on a team of front-line practitioners, I have experienced aversive reactions to youth who are engaged in suicidal behaviours by individuals I was supervising. In my personal life I have also had a variety of experiences that relate to suicidal behaviours. As an adolescent I experienced the death by suicide of a co-worker, and the suicide attempt of a friend. I believe the comfort level I have with suicidality has been an important factor in doing this research. "In a phenomenological investigation the researcher has a personal interest in whatever she or he seeks to know; the researcher is intimately connected with the

phenomenon” (Moustakas, 1994, p. 59). My intimate connection with the experience of suicidal children and youth has been the impetus for this study. My “excitement and curiosity inspire the research” and my “personal history brings the core of the problem into focus” (Moustakas, 1994, 104). My professional confidence in working with suicidal children and youth, conducting risk assessments, and determining approach, required suspension for the purposes of the study in order to separate my role as a practitioner and my role as a researcher, and to be open to the experiences of the front-line practitioner. Articulating my stance as a researcher in this study, as well as entering my assumptions that require bracketing, are my attempts to engage in “active acknowledgement” that my own actions and decisions “will inevitably impact upon the meaning and context of the experience under investigation” (Horsburgh, 2003, p. 308). Therefore, the study was located within personal, professional, and academic knowledge and experience that had both the potential of enriching the inquiry and the potential to inflict bias into the research process in the level of familiarity with the behaviour being explored.

Entering Assumptions

In accordance with the phenomenological reduction and bracketing, I engaged in a process of identifying my presuppositions about working with suicidal children and youth to see the phenomenon fully (Osborne, 1994). I wanted to approach the interviews with participants having attempted to eliminate my prejudgments, set aside my presuppositions, and be in a state of openness to the participants’ experience. I identified the following assumptions about the experience of front-line practice with suicidal children and youth:

1. Working with suicidal children and youth will have recognizable psychological effects on the practitioner.
2. Suicidality in children can be dismissed by practitioners based on their understanding of children's perceptions of death.
3. Suicidality in adolescents can be dismissed by practitioners based on beliefs about adolescents being impulsive, manipulative, or attention-seeking.
4. Front-line practitioners have a unique role in the lives of suicidal children and youth and play an important part in treating suicidality within a multi-disciplinary team.
5. Each participant will have a unique experience of working with suicidal children or youth to share. Parts of participants' experiences are common to all.
6. Participants' own beliefs, values, and experiences regarding suicide will consciously and unconsciously influence their accounts of working with suicidal children and youth.
7. Participants will be honest with their responses and do their best to tell their stories from practice with suicidal children and youth.

In reviewing my stance, location and explicating my presuppositions involved in the research, I have reflected on the "influence of self" that can "provide a context within which audiences can more fully understand the researcher's interpretation of the text data" (Sword, 1999, p. 270).

Participant Recruitment

Recruitment of participants for the study was undertaken with both the qualitative approach and the phenomenological methodology in mind. "Qualitative researchers

usually work with small samples of people, nested in their context and studied in-depth..." (Miles & Huberman, 1994, p. 27). As in-depth accounts from participants were sought, boundaries were set including time limits, means, and number of participants. The phenomenological research design required enough participants to illuminate the experience of working with suicidal children and youth. Only a limited number of people require interviewing "...given the vast amount of data that emerges from even one interview" (Hycner, 1985, p. 295). As in-depth interviews are the most commonly used means for data gathering in phenomenological research (Osborne, 1994), the researcher's time limits and means as the sole interviewer in the study, also influenced the desired number of participants. Five participants were sought and successfully recruited for the study. Purposeful sampling strategies were employed to find suitable candidates who were front-line practitioners, have encountered children or youth engaged in suicidal behaviour within their practice, were willing to talk about it, and share their stories. No restrictions were placed on the participants as to the frequency of their encounters with suicidal children and youth in their practice, or the timeframe of the encounter (i.e., at any time in their professional practice). Essentially, within phenomenological research, sampling is limited to all participants having experienced the phenomenon being studied (Creswell, 1998). Being cognizant of these criteria, a recruitment poster (Appendix A) was created and a location for research was identified.

Advertisement for the study was provided to all agency personnel through the recruitment poster (Appendix A) which was displayed in common areas (i.e., staff lunch room), and distributed to various agency sites. The study was characterized in the recruitment poster by the title, a brief description of the significance of the study, and the

desired characteristics of potential participants (i.e., front-line practitioners). Participants from the community agency self-identified their interest in participating in the study after viewing the recruitment poster. Potential participants were invited to contact the researcher and express their interest through a confidential email address and to provide the researcher a phone number for contact. The researcher contacted the potential participants and verbally outlined the time commitment and the possible benefits and potential risks in participating in the research by reading a recruitment script (Appendix B). The recruitment script identified the potential benefits (i.e., enhancing awareness of practice) and potential risks of participation (i.e., stress, fatigue), the nature of the relationship of the researcher to participants (i.e., employee of the same agency), and that participation was voluntary. Potential participants were asked if they wanted to proceed by having the consent form (Appendix C) mailed to them for their review. Contact information was obtained and the consent form was sent to potential participants for their review.

Once they had reviewed the consent form and were willing to participate in the study, participants contacted the researcher to schedule the interview. All participants who contacted the researcher met the research criteria. The recruitment process was successful in ensuring a final number of participants was five (N=5), 2 males and 3 females. The participants were informed during the consent process that confidentiality and anonymity would be maintained, thus a number was assigned to each participant. I choose not to identify participants by a pseudonym to protect the identity of participants through employing non-identifying terms.

The Participants

As demonstrated previously, the study addressed a significant gap in the literature, specifically in considering the front-line practitioner's experience of working with children and youth engaged in suicidal behaviour.

The participant pool of front-line practitioners for this study was drawn from the large community social service agency in which I am currently employed. The agency provides services to children, youth and families through a variety of front-line positions. The agency is located in the interior of British Columbia in a small city with a population of 80,000. The identified community agency is the largest community service provider in this region. The main source of funding for the agency comes from the Ministry of Child and Family Development with services being provided to a diverse population. The practitioners are located across a range of access points, in outreach programs, residential programs, supervised access, and family support programs. The children and youth involved in the various services often share a number of risk factors that heighten their vulnerability for engaging in suicidal behaviours including sexual abuse (Oates, 2004), attachment issues (Lessard & Moretti, 1998), social isolation (Bearman & Moody, 2004; Grossman, Milligan, & Deyo, 1991; Rutter & Behrendt, 2004), and substance abuse (Kral & Sakinofsky, 1994). Essentially, there were approximately 70 front-line practitioners within this research site to draw from.

Participants' Demographic Data

To adequately represent the population recruited for the study, demographic data on participants (i.e., age, sex, education, length of experience) were collected in a structured format upon completion of the interview. Demographic information was

gathered from each participant at the close of the interview in questionnaire format (Appendix D) to provide a comprehensive description of the participants.

All participants were between the ages 30 and 39. The participants consisted of 2 males, and 3 females. Each participant held a minimum of a college diploma, with one participant possessing a university degree. Participants identified their background as being in Education, Child and Youth Care, Human Services, Social Work, and Outdoor Recreation. Length of professional experience in the Human Service field ranged from 24 months, with 3 participants having over 10 years experience. A total of 3 participants identified themselves as a child and youth care worker. The remaining 2 participants identified themselves as a supervisor or coordinator, and a family support worker. The primary practice environment for 3 of the participants was located within a residential setting, whereas the remaining 2 participants practiced primarily within community settings. The participants served child, youth and family populations; with one participant solely working with youth aged 13-24. Four of the participants stated they had over 20 hours of didactic training in suicide prevention, and one participant self-reported 15 – 20 hours of training. When asked about the number of times that they have helped a person at risk for suicide within their professional and personal lives, one participant stated 1-3 times, two participants stated 6-9 times, one participant stated 10-15 times, and one participant stated over 15 times. The monthly frequency of presenting issues related to suicide in professional practice was also recorded by participants. Two participants stated issues related to suicide arose in their practice 1-3 times per month, one participant stated 4-5 times per month, one participant stated over 10 times per month, and one participant stated less than one time per month. Participants were also asked to rate their feelings of

preparedness in working with suicidal children or youth on a continuum ranging from “well prepared” to “not feeling prepared.” The majority of participants indicated a mark within the 75% range on the continuum towards feeling “well prepared.” One participant indicated a mark on the continuum at “well prepared.” The demographic data collected from participants post-interview provides a further look at the characteristics, training, background, experience, and comfort level in practice with suicidal children and youth.

Ethical Considerations

Agency approval for the study was obtained, as per agency policy, through the Chief Executive Officer of the agency in which the study was conducted. The Chief Executive Officer reviewed the proposal for the research and accompanying documents including, but not limited to, the advertisement poster for recruitment of participants, and the consent form. The Chief Executive Officer provided a signed letter of approval for request for research within the organization (Appendix E).

Approval from the University of Victoria Human Research Ethics Board was obtained on January 11, 2006 (Appendix F). Ethical issues, such as confidentiality and potential risks to participants, were taken into consideration during the development of the study and every reasonable effort was taken to minimize the effects on the data being collected. Ethical issues pertaining to ongoing informed consent, confidentiality, the interview method, and the potential risks to participants received due deliberation throughout the study.

Careful consideration was undertaken in respect to obtaining ongoing informed consent from the participants. The researcher requested that once the potential participant reviewed the consent form, he/she contact the researcher to arrange a time for the

interview. The consent process was ongoing and explanations about the study were frequently repeated. Confidentiality was maintained by using codes to identify participants. As indicated previously, a total of five participants were recruited.

Ethical issues that were considered included the maintenance of confidentiality of the children and youth that may be discussed in relation to the front-line practitioner's experience of his/her suicidal behaviour. Any specific examples or names of children or youth potentially used by the practitioners were not recorded.

Additionally, practitioners may have been exposed to minimal risks as a result of participating in the study. Due to the sensitive nature of suicidal behaviour, practitioners may have emotional responses as a result of participating in the study. Emotions may arise from their own professional or personal experience with suicidality. As well, the participants may experience emotions related to the societal stigmatization of suicide if he/she reveals previous personal experience with suicidality. Consideration for all of the potential risks associated with participation in the study occurred. Referrals for further counseling supports were explicitly offered to participants should they require emotional or psychological supports.

Further to the minimal psychological effects on participants, an additional ethical issue was considered in relation to any current practice participants are engaged in with suicidal children or youth. As there were no time limits placed on the experiences participants discussed during the interview, participants may relay information regarding a present suicidal child or youth they are working with. Mishara and Weisstub (2005) state "in suicide research, life and death are potentially at stake" (p. 24). In my dual role as behavioural consultant in the research site and as researcher, careful consideration to

ensure the provision of optimum service to the children and youth involved in the agency as well as upholding the confidentiality of the participants was ensured. Upon embarking on the study, consideration was given to a potential situation in which a practitioner may reveal a current example from practice with a suicidal child or youth in which there exist concerns about the effectiveness of his/her approach or intervention. "Even in a study that is not about intervention or prevention, a person may divulge information indicating that... a third party, is at risk of dying by suicide" (Mishara & Weisstub, 2005, p. 30). Mishara and Weisstub (2005) indicate that it is the researcher's responsibility to have an intervention procedure in such situations where information is provided that a third party may be at risk during a study. To address this issue, the interviews were scheduled within a close timeframe of in-service training in suicide prevention. Certification in suicide prevention is a current requirement of all front-line practitioners within the community service agency designated as the potential research site and various workshops were co-occurring for all staff at the time of the study. At the time of the interviews, four of the participants had completed a suicide prevention workshop that was provided through community service agency in partnership with the regional health authority. Therefore, as all front-line practitioners are required to complete the suicide prevention training, confidentiality of research participants will be upheld and best practices in working with suicidal children and youth will be ensured as completion of certification in suicide prevention would have addressed any issues regarding the effectiveness of any current interventions being applied in the practitioners' work setting.

Participants were fully informed that the research data were analyzed and used for the purposes of completing a thesis, and further dissemination of the research data may

occur through publication, or scholarly presentations. The data will be securely stored in the researcher's personal office in a locked cabinet for a five year period including the period duration of analysis, thesis completion, including oral examination, and further potential publishing. Participants were informed that after the five year period, the data will be destroyed by the researcher by paper shredding all documents, and erasure of audio cassettes, computer files, and related material.

Throughout the study I was fully aware of the dual role, or double agency, that I held as a colleague of the participants and as a researcher. Double agency "refers to fulfilling two roles concurrently – for example, acting as researcher and caregiver at the same time" (Edwards & Chalmers, 2002, p. 131). Although dual relationships or double agency can create complexity; the relationship is not inherently exploitive (Tomm, 2002). During the process, I focused on my primary role as researcher, and resisted taking on a therapeutic role or consultative role with my colleagues. I am aware that the nature of my role in the agency may have had a limited impact on the data collected. The behavioural consultant position requires graduate level qualifications and a substantial employment history in providing direct service to children and youth identified as "high-risk." The behavioural consultant works with children in the care of child protection services who are exhibiting exceptional behavioural challenges for their caregivers within the community and home environments. Foster parents are provided an opportunity to enhance their skills as caregivers with the goal of maintaining the placement for the child or youth. In addition to direct practice with children in care and foster parents, within my role as behavioural consultant I co-facilitate suicide prevention and intervention workshops to community members and agency personnel. Although my role as a

behavioural consultant and trainer in suicide prevention does not include any formal staff supervision, there is a level of authority and potential power influence that exists in this position based on the knowledge and expertise required. "While assuming dual roles can result in benefits for both the study participants and science, it can also cause problems" (Edwards & Chalmers, p. 132). Edwards and Chalmers discuss the difficulties that can arise in the dual roles of researcher and caregiver, such as the participant seeking advice during the collection of the data. I strived to listen intently, remain open to the experience of the participants, bracket my presuppositions, and hold a position of curiosity and respect for each individual participant. Participants are treated as "fully human" and "not as a set of variables for us to measure" in phenomenological research (Rowan, 2000, p. 106). Tomm (2002) argues the human connectedness that occurs within dual relationships can be enriching and affirming to the participant, rather than exploitive.

In addition to acknowledging the nature of my relationship with participants as both a colleague and researcher, the impact of my dual role was limited due to the time I had been involved with the research site. My length of employment at the agency consisted of 16 months at the time of the study. As well, my practice was primarily community-based and therefore the amount of interaction personally and professionally with the potential research participants was somewhat limited. During the interviews I observed no indication participants' descriptions were influenced by our dual relationship. Additionally, no noticeable differences were observed between the four participants who had received recent training in suicide prevention and the one participant who had yet to receive the in-service training in the descriptive accounts that were shared.

Semi-Structured Interview

A semi-structured interview was chosen for the present study in order to obtain rich, detailed descriptions of participants' encounters in working with suicidal children and youth. Through the participants' personal accounts of their stories, interpretations, awareness, and communication can occur for both the participant and the researcher (Osborne, 1994). The aim of the investigation, to illuminate front-line practitioners' experience of working with suicidal children and youth, also lent itself to a semi-structured interview. "Interviewing gives us access to the observation of others" (Weiss, 1994, p. 1) and "rescues events that otherwise [would] be lost" (p. 2).

In-depth interviews were conducted with each of the five participants recruited for the study. Each interview was approached as "...an interpersonal situation, a conversation between two partners about a theme of mutual interest," (Kvale, 1996, p. 125). The purpose of my interviews was to hear and understand the experiences of front-line practitioners when they have encountered suicidal children and youth in their practice. "The phenomenological interview involves an informal, interactive process and utilizes open-ended comments and questions" (Moustakas, 1994, p. 114). Various open-ended questions focusing on various aspects of the research issue were planned as part of the interview (Donalek, 2005). The interview questions (Appendix G) encouraged each front-line practitioner to be a participant in making meaning of their experiences (DiCicco-Bloom & Crabtree, 2006). This approach supported the process of human interaction where knowledge evolves through dialogue (Kvale, 1996). Although the interviews may have appeared more like a conversation, as the interviewer and researcher

in the study I was responsible for directing the participants to the relevant topics related to practice with suicidal children and youth (Weiss, 1994).

Each front-line practitioner participated in one 60-minute conversational, in-depth interview. Interviews were conducted within an office at one of the agency's buildings, and were scheduled at times to meet the needs of the participants and to ensure less likelihood of other agency personnel being aware of their participation in the study (i.e., scheduled after office hours). To ensure ongoing informed consent and voluntary participation, the consent form (Appendix C) was reviewed verbally and signed by the participant prior to starting the interview. Participants had received the consent form for their review prior to scheduling the interview to ensure they understood fully the entire process, benefits and risks involved, and that they were able to withdraw from the study at any time. The verbal review of the consent form provided participants with an opportunity to ask any questions. Participants received a copy of this consent to keep for their own records and the signed original copy was kept by the researcher. The interview was audio taped with the participants' full agreement.

The interview was semi-structured and each participant was asked the same questions (Appendix G). In regards to the sequence of questions, each interview opened with the same open-ended question: Tell me about a time you have worked with a child or youth engaged in suicidal behaviour. In order to encourage a rich dialogue, there was "...an openness to changes of sequence and forms of questions in order to follow up the answers given and the stories told by the subjects..." (Kvale, 1996, p. 24). This approach follows the direction of a semi-structured interview. Prompt questions allowed for further exploration of the participants experience and responses to the child or youth's suicidal

behaviour: Who else was there and what did they do? What influenced your action? These questions helped the participants build upon portrayal of the encounters with suicidal children or youth and deeply explore their experiences, responses, and how they navigated through the event. I was aware of the “patience and skill” required of me to ask appropriate questions of participants and rely on them to discuss the meaning of their experiences (Creswell, 1998, p. 130).

Throughout the interview I maintained awareness of the potential for emotional responses from participants due to the sensitive topic of suicide. I was mindful of Kvale’s (1996) wisdom: “Thus, at the same time that personal expressions and emotions are encouraged, the interviewer must avoid allowing the interview to turn into a therapeutic situation...” (p. 125). One of the risks highlighted by Corbin and Morse (2003) is the potential for interviews on certain topics to arouse powerful emotions. The review of the clinical literature in Chapter Two demonstrates the various intense emotional responses that suicidality can evoke amongst professionals. The relational skills that I brought to the interview process based on my location as a researcher (i.e., academic training and professional experience in Child and Youth Care) provided “...an atmosphere in which the subject feels safe enough to talk freely about his or her experiences and feelings,” (Kvale, 1996, p. 125). As a researcher, I was aware of the relationship that was being created with each participant within each interview regardless of how many times they told their story (Corbin & Morse, 2003).

The interview continued to the point where I had asked the participant the key questions related to the study and she or he had provided answers. Participants were then asked if there was anything they wanted to add to their story (Donalek, 2005). The

interview was closed by the researcher once the participants were able to say they had nothing else to add.

Data Analysis

Denzin and Lincoln (2003) note that “[q]ualitative research is endlessly creative and interpretive...” and that the “...researcher does not just leave the field with mountains of empirical materials and then easily write up his or her findings” (p. 37). Each step in the process of data analysis was informed by the core processes (Epoche or bracketing, Transcendental-Phenomenological Reduction, and Imaginative Variation) of phenomenological inquiry explored previously in this chapter. The steps of data analysis for a phenomenological inquiry were informed by Moustakas (1994), Giorgi (1985), and Hycner (1985). The essential steps of data analysis were as follows: (1) Obtaining a sense of the whole. (2) Delineating units of general meaning. (3) Delineating units of meaning relevant to the research question. (4) Clustering units of relevant meaning and determining themes. (5) Writing a summary for each individual interview. (6) Identifying general and unique themes for all the interviews. (7) Synthesis of transformed meaning units into a consistent statement of the experience of front-line practitioners working with suicidal children and youth. In order to dissect the “...mountains of empirical materials...” (Denzin & Lincoln, 2003, p.37) that I had gathered from the participants’ interviews, I attempted to be faithful to the steps of analysis informed by Giorgi (1985), Hycner (1985), and Moustakas (1994) throughout the process. Each step of data analysis was conducted for each of the five participants.

Obtaining a Sense of the Whole

The raw data, or tape recordings, required processing before analysis could begin (Miles & Huberman, 1994). On completion of each 60-minute interview, and in order to get a sense of the whole, I personally transcribed the 60-minute interviews from audio tape for each individual participant. Transcribing the interviews is an important step in analyzing the data within phenomenological research (Hycner, 1985). The transcription included verbal communications as well as communications by "...tone of voice, expressions, and gestures in the natural flow of conversation," (Kvale, 1996, p. 125). The transcriptions included pauses, voice tone, and verbal sounds (i.e. laughter). This lengthy process resulted in multiple pages of data for each participant. The audio recordings were listened to on multiple occasions and correlated to the transcripts to ensure accuracy in the data generated. The core process of phenomenological reduction was employed during the listening to the recordings. I listened to the recordings with a "conscious and deliberate intention" of opening myself to the phenomenon (Moustakas, 1994, p. 91). The transcriptions were also read multiple times to get a general sense of the whole statement from each participant and fully immerse myself in the data. This step also involved reading the transcripts for understanding of the language of each participant, and reading the text "...as often as is necessary to get a good grasp of the whole" (Giorgi, 1985, p. 10). Giorgi (1985) notes that "what stands out depends very much upon the researcher's perspective" (p. 15). In order to enter into the unique world of each participant, I employed the core process within phenomenological research of bracketing my meanings, biases, values, prior knowledge, and interpretations. As advised by Hycner

(1985), a margin was left to the right of the transcriptions to assist the next step of delineating units of general meaning.

Delineating Units of General Meaning

The second step, after grasping a sense of the whole through the transcription and reading, was to re-read the text with the aim of delineating units of general meaning. Each word, phrase, sentence, paragraph, and noted observation of non-verbal communication was carefully considered in order to gain the essence of the meaning expressed in what the participant communicated (Hycner, 1985). Moustakas (1994) describes this step within the core process of Phenomenological Reduction as horizontalizing, where every statement is treated equally. Each transcription was broken down into manageable units of general meaning. The participants' own words and expressions were used, but condensed into manageable units that were written in the margin to the right of the transcript. For example, at the beginning of Participant 2's interview, the exact transcript is documented in Table 1. These words, phrases, and sentences were written into the general meaning unit as illustrated in the following Table.

Table 1. Delineating Units of General Meaning

Participant 2 Transcript	General Meaning Unit
<p>“That was very similar to the first experience in that I got pushed out of the way in a sense. And actually, I felt that I had acted irresponsibly in my practice because I felt that I had knowledge that I gave to others that didn’t respond in the way that I would have thought to be ethical. And while he may not have - and he didn’t commit suicide, umm.. the message that he got isn’t the message that I would have sent. I would have taken him for assessment and yeah, I felt that umm... in phoning my coworker, my supervisor I phoned who was actually a coworker who organizes the program, in phoning her she was unable to support me in what my role should be rather transferring it to the social worker. Which isn’t what... now in the future I wouldn’t phone the ministry I would phone them from the hospital? But it was almost 4:30 on a Friday and there would be no one to phone.”</p>	<p>Participant 2 informed her supervisor of the situation who referred Participant 2 to the child’s social worker. Participant 2 gave knowledge to others in the situation who responded differently then Participant 2 anticipated, as Participant 2 would have taken the child to the hospital for an assessment. Participant 2 believed others’ response to be unethical even though the child did not commit suicide. Participant 2 plans on phoning the social worker in the future directly from the hospital.</p>

Delineating Units of Meaning Relevant to the Research Question

Once the general meaning units were extracted from the text, the research question (How do front-line practitioners describe and conceptualize suicidal behaviour among children and youth in their care?) was directed to each general meaning unit.

Additionally, the following research sub-questions were also explored in relation to each general meaning unit:

- What are the front-line practitioners’ physical and emotional responses to suicidal children and youth?
- What knowledge do front-line practitioners value to inform their practice with suicidal children and youth, i.e., how do they make sense of their encounters?

- How do front-line practitioners describe their experience of working with suicidal children and youth?

“The researcher addresses the research question to the units of general meaning to determine whether what the participant has said responds to and illuminates the research question” (Hycner, 1985, p. 284). Focusing on the phenomena being researched allows the text to be broken down into manageable units. During this step as well, “statements that are irrelevant to the topic and question, as well as those that are repetitive or overlapping are deleted” (Moustakas, 1994, p. 97). This leaves only the meaning units relevant to the research question. In order to test the remaining meaning units as relevant to the research, Moustakas (1994) suggests asking the following questions: Does it contain a moment of the experience that is a necessary and sufficient constituent for understanding it? and, Is it possible to abstract and label it? (p. 120). In this process, “the meaning unit discriminations are noted directly on the description whenever the researcher, upon re-reading the text, becomes aware of a change of meaning of the situation for the subject...” (Giorgi, 1985, p. 11). To illustrate utilizing the previous example, the following relevant meaning units are noted in Table 2.

Table 2. Delineating Units of Meaning Relevant to the Front-Line Practitioners' Experience of Working With Suicidal Children and Youth

Participant 1 Transcript	General Meaning Unit	Relevant Meaning Unit
<p>“That was very similar to the first experience in that I got pushed out of the way in a sense. And actually, I felt that I had acted irresponsibly in my practice because I felt that I had knowledge that I gave to others that didn't respond in the way that I would have thought to be ethical. And while he may not have - and he didn't commit suicide, umm.. the message that he got isn't the message that I would have sent. I would have taken him for assessment and yeah, I felt that umm... in phoning my coworker, my supervisor I phoned who was actually a coworker who organizes the program, in phoning her she was unable to support me in what my role should be rather transferring it to the social worker. Which isn't what... now in the future I wouldn't phone the ministry I would phone them from the hospital? But it was almost 4:30 on a Friday and there would be no one to phone.”</p>	<p>Participant 2 informed his/her supervisor of the situation who referred Participant 2 to the child's social worker. Participant 2 gave knowledge to others in the situation who responded differently then Participant 2 anticipated, as Participant 2 would have taken the child to the hospital for an assessment. Participant 2 believed others' response to be unethical even though the child did not commit suicide. Participant 2 plans on phoning the social worker in the future directly from the hospital.</p>	<p>Participant 2 experienced being 'pushed out of the way' and unsupported when s/he contacted his/her supervisor and found that others' did not respond as s/he anticipated. Participant 2 felt s/he acted irresponsibly when others' did not take the child for a suicide risk assessment and plans on responding differently in the future.</p>

Clustering Units of Relevant Meaning and Determining Themes

The fourth step in the data analysis for each participant transcription that I followed according to Hycner (1985), was “to determine if any of the units of relevant meaning naturally cluster together...” and where there appears to be a common theme or

essence that “unites several discrete units of relevant meaning” (p. 287). In this step there is a constant return to the relevant meaning units, the units of general meaning, and the original transcript. This process of “looking and noticing and looking again” is aimed at grasping the “full nature of the phenomenon” (Moustakas, 1994, p. 92). The relevant meaning units that were delineated in step three were reread to elucidate thematic aspects of the participants’ descriptions to further understand the events that took place in their experiences of working with suicidal children and youth. The phenomenological core process of Imaginative Variation was used to uncover the essences and themes for each participant. In this process I reflected on all the possibilities contained within each cluster of relevant meaning units. I considered the underlying context that accounted for the emergence of the phenomenon for each participant, as well as considering the universal structures that precipitated the participants’ feelings, thoughts, and physical responses to the phenomenon. “The research interrogates all the clusters of meaning to determine if there is one or more central themes which expresses the essence of these clusters” (Hycner, 1985, p. 290). The clustered relevant meaning units were stated in the form of a central issue or theme for each individual participant. The resulting clustered and labeled meaning units were determined as the core themes of the experience of working with suicidal children and youth for each individual participant. Examples of the themes that were determined from the clustered relevant meaning units will be provided in Chapter 4.

Writing a Summary for Each Individual Participant

In this step of data analysis, I returned to each individual transcription and wrote a summary of the interview while incorporating the themes that were illuminated in step four (Hycner, 1985). For each participant a specific description of the experience of

working with suicidal children and youth was written. The intent of the specific description is to remain "...more faithful to the concrete subject and specific situation..." (Giorgi, 1985, p. 20). Participants own language was used as much as possible in order to remain faithful to their story. Essentially, the summary was a textural description of the experience that helped shape the following steps (Moustakas, 1994)

Identifying General and Unique Themes for All Participants

Commonalities across all of the participants' summaries were explored as well as the individual variations. Essences of participants' experiences in working with suicidal children and youth were illuminated and acknowledgement of differences amongst participants' experiences was noted. Examples of the general and unique themes from participants will be provided in Chapter 5.

Synthesis of Transformed Meaning Units into a Consistent Statement of the Experience of Front-line Practitioners' Working with Suicidal Children and Youth

The final step in the data analysis was to synthesize the transformed meaning units established in step three, and make a consistent statement or summary of the front-line practitioners' experience of working with suicidal children and youth. Once a specific description was written, a more general description was established to communicate a comprehensive meaning of the front-line practitioners' experience of working with suicidal children and youth. The composite description included the essences and meanings of the experience of working with suicidal children and youth and attempted to represent the front-line practitioners who participated in this study as a whole. Moustakas (1994) solidifies the nature of the composite descriptions as follows:

Descriptions retain, as close as possible, the original texture of things, their phenomenal qualities and material properties. Descriptions keep a phenomenon alive, illuminate its presence, accentuate its underlying meanings, enable the phenomenon to linger, retain its spirit, as near to its actual nature as possible (p. 58).

The description of the phenomenon is a synthesis and integration of the insights contained in the units of meaning into the structure of the event (Giorgi, 1985). The structure of the event or phenomenon is communicated to others. In both the specific description and the written general description, I was aware of the audience for whom I was writing. Giorgi (1985) notes "...how the findings are presented [depends] very much upon the audience with whom one is communicating," (p. 20). As my intention is to add to the current clinical literature and the literature in the field of Child and Youth Care, I was mindful of my audience being from various clinical fields.

Summary

In Chapter Three I have outlined the rationale for a qualitative approach to the study of front-line practitioners' experience of working with suicidal children and youth. As the study sought to deepen understanding of the experience of front-line practitioners, and to provide a lived sense description of working with suicidal children and youth, a phenomenological inquiry was deemed as the most appropriate research method. The core processes of phenomenological research were explored and later applied in the identified steps of data analysis. This chapter provided a comprehensive description of the processes used to recruit participants and collect the data. The researcher's stance, location, and presuppositions have been identified within this chapter. The first three chapters have provided a detailed overview of the phenomenon under study, a review of the relevant literature, and the procedures that were followed in conducting the study. In

the following chapters, I will present the unique and general themes from the participants' interviews, and synthesize the essences, structure, and meanings of the front-line practitioners' experience of working with suicidal children and youth.

CHAPTER FOUR

Presentation of Research Findings

Introduction

The purpose of this study was to gain an understanding of front-line practitioners' experience of working with suicidal children and youth. As revealed through the interviews, the encounters with suicidal children and youth were challenging for the participants as they sought to understand the suicidal behaviour, respond to the suicidal crisis, and draw from various sources of knowledge to inform their approach while simultaneously experiencing various physical and emotional responses to the encounter. For many of the participants the meaning of the encounters they shared developed more fully as they told their stories. The experience and meaning of practice with suicidal children and youth was unique to each participant as was the emotional and physical responses to the encounter. The sources of knowledge that participants drew upon to guide their approach to the child or youth were also unique to each participant. Despite the individual and personal nature of the stories each participant shared, 16 theme clusters emerged across the participants' interviews. Some of the theme clusters emerged based on the stage within the encounter, for example, occurring at the beginning of the encounter. Other theme clusters emerged based on the descriptions of the encounter with the suicidal child or youth as a whole. Participants varied in how they related to each of the themes; however each theme cluster corresponds to at least three participants.

The purpose of this chapter is to describe the findings obtained from the interviews conducted with each of the five participants who took part in this research study. First, a brief description of each of the participants and his/her example from

practice will be provided. Secondly, this chapter will present the findings from this study. The findings are divided into the following three sections: Participants' Descriptions of Practice with Suicidal Children and Youth, Knowledge Valued by Participants to Inform their Practice with Suicidal Children and Youth, and Participants' Physical and Emotional Responses to Suicidal Children and Youth. The themes related to the experience of practice with suicidal children and youth provide a rich context for understanding the nature of meaning of the encounters for participants. The themes relating to the knowledge valued by participants to guide their approach provide a specific understanding of what sources of knowledge participants were drawing from in the encounters. The themes relating to the physical and emotional responses participants' experienced in relation to their encounters with a suicidal child or youth develop more fully an awareness and understanding of the impact the encounters had on participants. A summary of all the themes in each section are presented. For each of the 16 theme clusters, selected quotations from the participant interviews are included to enable the participants' voices to describe and illuminate the meaning of their lived experiences. In an effort to remain true to the data and the stories of the participants, larger quotes were included when necessary to provide the reader with a full understanding of the narrative context from which those quotes came.

Participant Profiles

Names were not used in order to protect the identity of the participants. Pseudonyms were also not used in the presentation of the findings also with an effort to protect the identity of the participants. As there were two male participants, and 3 female participants, altered names that still depict the sex of the participant may allow a

participant to be identified; therefore each participant was assigned a number. As the demographic data has been reviewed previously in Chapter Three, the participant profiles presented here will define the context of the encounter(s) the participant explored during the interview.

Participant 1 presented an example from practice that involved a male youth who had recently attempted suicide. Participant 1 received a referral to provide service to the youth and his mother for the purposes of following up the suicide attempt and set in place safety measures to address the youth's suicidality.

Participant 2 provided two practice examples. Participant 2's first encounter involved a youth who communicated that he wanted to kill himself after having been informed by his social worker that he would be moving to a new foster placement. The second example Participant 2 provided involved an 8-year-old male child who expressed thoughts of suicide and had a previous suicide attempt.

Participant 3 provided two examples from practice. The first example occurred in a wilderness camp for youth. A male youth disclosed he was thinking of suicide by hanging himself from a tree. The second encounter described by Participant 3 involved a suicidal female youth who ingested large amounts of medication while also using illegal substances.

Participant 4 provided two examples from practice of encounters with suicidal female youth. In the first encounter, the youth engaged in various high risk behaviours and had a history of suicidality. The second encounter involved a youth who made a plan to die by suicide, yet Participant 4 had no knowledge of any suicide history for the youth.

The youth disclosed to Participant 4 her suicide plan while meeting Participant 4 for coffee.

Participant 5 provided an example from practice of a male youth who accessed residential services at a youth shelter on a number of occasions. The youth disclosed at various times thoughts of suicide and historically presented as depressed when accessing the services at the youth shelter.

Section 1: Participants' Descriptions of Working with Suicidal Children and Youth

Theme Cluster 1: Understanding Suicide

The participants' descriptions of working with suicidal children and youth contained their understandings of suicidal behaviour and the context in which suicidal behaviour occurs. Some participants described the disconnection or isolation the suicidal children and youth were experiencing with relationships in their lives. As well, some participants' descriptions included additional factors, beyond disconnection, that were at play and influencing the child or youth's engagement in suicidal behaviour. Factors such as mental illness and drug and alcohol use were described by participants as part of a larger systemic understanding of suicidal behaviour. Participants' descriptions illuminated how they understood the suicidal behaviour in the child or youth they were working with in relation to disconnection and additional factors in the children or youths' lives. Within this theme cluster, the following two themes emerged from the participants' descriptions: Child or Youth's Disconnection or Isolation, and Factors Contributing to Suicidal Behaviour (see Table 1).

**TABLE 1. Participants' Descriptions of Working with Suicidal Children and Youth
Summary of Theme Clusters and Themes**

<p>1) <i>Understanding Suicide as a Behaviour</i></p> <p>a) Child or Youth's Disconnection or Isolation</p> <p>b) Factors Contributing to Suicidal Behaviour</p>	<p>2) <i>Responding to Suicidal Behaviour as Crisis Intervention</i></p> <p>a) Connecting to Resources</p> <p>b) Ensuring Safety</p> <p>c) Stabilization</p>
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Theme a) Child or Youth's Disconnection or Isolation

All of the participants described a form of disconnection or isolation for the suicidal child or youth in their care. In the example from practice provided, Participant 1 described disconnection for the youth in his/her care. Participant 1 described the youth having difficulty connecting with his mother and saw the youth's suicide attempt as a form of communication.

It didn't appear that he was umm... having his needs met in terms of connection or just, you know, love. There just seemed to be a disconnect there. I don't know if I ever posed the question directly as to his thinking of suicide attempt, but it did seem to feel like he was just trying to communicate with his mom. It seemed to me that mom wasn't in the position to hear him.

Participant 1 described his/her understanding of how the disconnection for the youth led to isolation.

He was prone to isolating himself in his room. That, in combination with not having or having a disconnected parent and a single parent, probably feeling quite isolated.

For Participant 1, the youth's suicidal behaviour was described as being linked to an experience of being disconnected to his mother and the difficulty in communication between them.

I guess the learning from that...It's still, in the end, suicide is a very scary ugly decision to make and you hope that individuals don't get to that point. But it's still this idea of it stemming from this disconnect and how that current family dynamic and communication, and all those things, if they aren't there, you know.

Similarly, Participant 5 described an experience of disconnection from family for the suicidal youth s/he had in his/her care. Participant 5 described a disconnection for the youth between his sense of self and his family's expectations.

His family lived in a smaller one of our urban, rural communities and a lot of parenting conflict, and a lot of umm... issues around his identity and how he saw himself and what the parental expectations were. And so he would come in presenting that he was never going back, hated parents, and so a lot of our work was just doing the reunification with him, and this the whole depression suicidal ideation, all of that is something that was always part of him. And that was something that, in working with the family as well, was always identified.

In the description of the disconnection between the youth and his family, Participant 5 noted the youth's suicidal ideation as being always present. Participant 5 also described further the family's response to the youth's suicidal ideation and the isolation that ensued.

I do lots of work with him, but also did lots of work with the family who were really frustrated with his behaviours, wanted to... wanted him to just settle down and behave, stop this um... to the point that dad finally said, 'Just don't even call anymore. We just don't want to talk to you guys, you people, the kid. We don't care. Just stop.' Right?

Participant 5's encounter with the suicidal youth conveyed an understanding of the disconnection and isolation from family relationships he was experiencing. Participant 5 described the youth's father viewing his suicidal behaviour as "attention-seeking" and manipulative.

I could see the decline in him, and the more that family separated, and dad really controlled the family and was saying, 'You know what? We're tired of this, we're just tired of this, and don't phone us.' Had told us, you know one of his last stays with us, said, 'Don't phone us to tell us that you're welcoming him to welcome him. We don't want him to stay there, but he's of age, he can stay wherever he wants, so we don't want to know. 'You want to deal with him. You want to keep enabling him, allowing him to manipulate you like this? You go ahead, but don't call me.'

Participant 5's description of his/her encounter contained an understanding of the family's view of the youth's suicidal behaviour. Within the description, the youth was further isolated and disconnected from his family based on their view of his suicidality.

Additionally, Participant 2 described understanding the disconnection the suicidal youth in his/her care was experiencing. The youth was being moved to a new foster

placement outside the city, away from his friends and family. Participant 2 described the disconnection the youth was experiencing and his suicidal behaviours:

The youth that I worked with was being moved out of the city by his social worker and was not happy and no one would validate that. They just said, 'Well it is what it is, you have to go.' So he said as we were driving back that umm... that he was going to end his life.

Participant 2 understood the youth's suicidal behaviour in the context of the disconnection he was experiencing in his relationships with his family and friends.

He would be moving he had already lost everything his family and his friends and his social network and now he wouldn't even be close to that. He was also concerned for his grandparents' health because he was very close to them and was concerned that they were going to die while he was away.

Disconnection with family also occurred for the youth Participant 4 encountered in his/her practice. Participant 4 described an understanding of the conflict the youth experienced with her family as a "trigger" for the youth engaging in "destructive behaviours." "She'd have a horrible phone call with her mom and she'd... that would be it." In another encounter with a suicidal youth, Participant 4 described the isolation that the youth experienced and the youth's inability to keep herself safe.

Person's severely depressed, completely isolated, no friends, no family, nothing. Is going into a life changing event, doesn't leave her house, doesn't eat, doesn't sleep, has been in this state for months, like pervasive, and is talking about... You know, has had just all this stuff pile up and happen and says, 'I can't trust myself to be alone with myself anymore and I need help, like I need help. I don't want to

go to the hospital. I don't want to admit that I need help, but I need, I'm telling you that I need help.'

Participant 3's description of his/her encounter with a suicidal youth also contained an understanding of the disconnection the youth was experiencing. Participant 3 was working with a youth who was making a transition to an independent living situation and had attempted suicide. At the time of the suicide attempt, disconnection occurred for the youth in her relationship with her boyfriend, as well as with her school as she had been suspended. Participant 3 stated the youth "told the teacher in appropriate words and instructions and so she was suspended from school...and she broke up with her boyfriend."

All of the participants' descriptions contained essences of disconnection or isolation in understanding suicidal behaviour in their encounters with suicidal children or youth. The participants described disconnection occurring for the child or youth in his/her family relationships, personal relationships, or in the youth's isolation from school.

Theme b) Factors Contributing to Suicidal Behaviour

Many of the participants described understanding the suicidal behaviour of the child or youth in their care in the context of various contributing factors. For some of the participants, suicidal behaviour was described in the context of a youth's mental health status. For other participants, both the youth's mental health and their substance use was understood in relation to their suicidality.

Participant 1 described understanding that the youth in his/her care was struggling with "some social anxiety" that led to "isolating himself in his room." Similarly,

Participant 5 described factors related to mental health in his/her understanding of the youth: "There was, you know, some depression and anxiety and that sort of stuff."

Participant 2 noted that the suicidal youth s/he worked with "had drug issues that led to a psychotic break." Participant 3 also described an understanding of suicidal behaviour and the contributing factor of substance use. The youth in the encounter used substances and then attempted suicide by ingesting medication: "Used drugs and alcohol that evening and decided to... that she still had a conscious choice, five to seven pills." Additionally, the youth struggled with mental health issues. Participant 3's description conveyed an understanding of depression as a contributing factor to suicidal behaviour: "I'll ask her how she is feeling and as soon as she mentions depression, I'll start to dig into that."

Participant 4's description of his/her encounter with a suicidal youth illuminated his/her understanding of the youth's mental health status contributing to her suicidality. Participant 4 described working with a youth who was "on and off anti-depressants" and was given prescription medication "even though she was actively suicidal." Participant 4 also understood concerns about the youth's mental health diagnosis: "She goes, 'this week I think I'm borderline; last week I was bipolar. I wonder what I'll be next week.'" Participant 4's description also contained an understanding of the youth's substance use: "she was involved with like lots of addictions stuff." The participants' descriptions contained an understanding of the youth's suicidality in the context of the factors of mental health and substance use.

Theme Cluster 2: Responding to Suicidal Behaviour as Crisis Intervention

The participants in this study described their encounters with suicidal children and youth in the context of providing crisis intervention. Elements of responding to a crisis situation were expressed in all of the participants' descriptions. Participants described connecting to resources, ensuring safety, and a movement towards stabilization within their encounters. The participants' descriptions contained a tendency towards action as a response to the suicidal behaviour and an acknowledgement of the life and death crisis at hand. Within this theme cluster, the following three themes emerged from the participants' descriptions: Connecting to Resources, Ensuring Safety, and Stabilization (see Table 1.).

Theme a) Connecting to Resources

Four of the five participants' descriptions involved connecting the child or youth to an additional resource for crisis intervention. Participants connected the child or youth to medical personnel, mental health resources, or a social worker. In his/her encounter with a youth who had recently attempted suicide, Participant 1 connected with a mental health clinician as well as the youth's social worker. Participant 1 described "communicating with the [social] worker" and having "two to three phone conversations with [clinician]." In the two examples from practice Participant 2 provided, s/he described connecting the child and the youth to resources. Upon hearing the youth's disclosure of thoughts of suicide, Participant 2 connected the youth with his doctor: "He had an appointment with his doctor so we thought we would get his doctor to assess him." Participant 2 described also contacting the youth's social worker: "I phone the Ministry and talk to his social worker and he was put on 24-hour suicide watch until he

was relocated.” In his/her description of an encounter with a suicidal child, Participant 2 also “phone[d] the social worker.” The suicidal youth that Participant 3 encountered was also connected to resources: “Then he was sent back to the [custody] centre for assessment, for risk assessment with a psychologist there.”

The description provided by Participant 4 of his/her encounter with a suicidal youth similarly contained elements of crisis intervention and connecting to resources. Participant 4 described talking with a youth who was suicidal and connecting her to a community mental health resource:

So I remember going, ‘O.k. Well, yup o.k. So we’ve talked about it. We’ve talked about what you’ve done and what’s happening for you. Let’s call [mental health resource] and have a chat with them and see where you need to go.

In another encounter, Participant 4 described having coffee with the youth who disclosed to him/her her plans to kill herself. Participant 4 connected the youth to resources at the hospital:

So we talked for a little while longer and I said, ‘You know, I think it would make sense if we just went up to Emerg. and um... and kind of have a chat about it.’ And she agreed that, you know, we would go to the hospital.

Theme b) Ensuring Safety

In addition to connecting to resources, four of the participants’ descriptions included attempts to ensure safety for the child or youth often with an expressed sense of urgency. Participant 1 recalled receiving the referral for a youth who had recently attempted suicide. Participant 1 explained, “There’s an initial sense of urgency to contact

the family.” Participant 1 also described attempts to ensure that everyone is safe, acknowledging the life and death issue of suicide:

The first thing you think about is safety, of course. And you want to do your best to make sure that everyone is safe and that there's not going to be another attempt and if there is that everything is in place to, you know, hopefully save a life kinda thing.

Similarly, when Participant 2 encountered a youth who disclosed thoughts of suicide, s/he also responded with attempts to ensure safety: “So he said as we were driving back that... he was going to end his life and I just said to him, ‘Are you serious when you say that?’ And he said, ‘Yes, I am.’ And I said, ‘Well I can’t not keep you safe...’.” Participant 2 considered the safety of the youth and responded within a context of crisis intervention. After connecting with the youth’s social worker, the youth was placed on a 24-hour suicide watch. Participant 2 explained how safety was ensured through the suicide watch:

He was in care in a foster home and [agency] staff, auxiliary staff, did 3 hour rotating, 3 rotating 8 hour shifts at the foster placement, 30 minute bed checks and umm... stayed awake through the clock...

Even though Participant 2 was not involved in the staffing of the suicide watch, s/he expressed the need for safety: “I was happy that he was safe and I completely trusted my coworkers to maintain his safety.” Additionally, Participant 2’s description of an encounter with a suicidal child also contained the elements of ensuring safety. The child disclosed that he wanted to kill himself as he did not like being in care of the child welfare services. Participant 2 once again, emphasized ensuring safety for the child in his/her response: “I said, ‘Are you serious when you say you want to kill yourself?’ And

he said, 'Of course I'm serious.' It's important for me to keep you safe." Furthermore, Participant 2 described how s/he expressed his/her safety concerns to the child: "It really concerns me for your safety and I'm worried about you and I need to make sure you're going to be o.k." Participant 2 explained that the child was monitored by his foster parent in order for safety to be maintained and not taken for a suicide risk assessment at the hospital. Participant 2 later followed up with the foster parent regarding how safety was ensured for the child:

I spoke with the caregiver about the situation, just to say that umm... To ask her how she maintained his safety and how she thought of the importance of that. And she didn't, really. She just thought he'd had a bad day and he'd be fine.

Participant 2's descriptions of his/her encounter with the child also included reflections on ensuring safety due to his age and previous suicide attempt:

Because of his age and previous attempt, I felt a greater need to ensure his safety because he's a child, right? Even though I'd want to ensure safety for all children and youth, adults, anyone who presented with suicidal whatever.

Ensuring safety and a tendency to respond to suicidal behaviour seriously was also a part of Participant 2's descriptions of his/her encounters with a suicidal youth and a suicidal child. Participant 2 reflected on his/her learning after the encounter:

I guess it is my learning that I took away from both situations. The learning was that absolutely, I will always take suicide very seriously and that it's not for me to decide if they are joking or not or what their intentions in saying it is; that I will always respond in ensuring their safety.

Similarly for Participant 4, after learning of a youth's suicidal ideation, ensuring safety was paramount:

I guess that's sort of what first stands out in terms of what was sort of most helpful in coming from a place of support and safety and making sure that we were both on that page. Like I'm... this is where I'm coming from and this is what's important in this situation. So when you talk about killing yourself, umm... this is my reaction to it, is that you know, I want to make sure that you're safe.

For Participant 3, ensuring safety for the suicidal youth included attempts "to make the whole camp safe from this youth's attempt for suicide." There was also urgency for action or response in Participant 3's description of his/her encounter with the youth: "...everybody had to do something, so people were running around doing something to help this person..."

Theme c) Stabilization

Many of the participants' descriptions conveyed a movement through their response to the suicidal crisis to a place of stabilization. Four participants noted various changes in the presentation of the child or youth they were working with and their observations of the movement through the crisis. As Participant 1 shared, "His attendance went up, he re-established some connections with some peers, he started skateboarding again." Indications were observed and expressed by Participant 1 of the youth moving through the suicidal crisis to a more stable state. Similarly, Participant 3 described the stabilization of the suicidal youth s/he encountered after the initial crisis:

We were able to start up another mentorship bed to get her a placement so she had some housing and ahh... and secure place and a safe home to go from instead

of couch-surfing or the agency safe house and things like that. So that was really a big step and since then she's been accepted to an employment program where she was paid 6 weeks, and I think she's moving in the right direction.

For Participant 5, stabilization after the initial disclosure of suicidal ideation was described in the form of having the youth sign a contract not to harm himself. One of Participant 5's colleagues created a contract for the youth to sign as a means of addressing the crisis:

We all supported that contract. We all had conversations and stuff, because the last time he was there he was really, really down and had talked about you know, not sure he could do this anymore and hurting himself. And so we had talked about what do you do with a kid who's like that? And so we all knew o.k., so you contract with them and he was quite happy to enter into a contract and entered into a contract.

Participants' descriptions also expressed experiencing a movement towards stabilization after the intervention with the child or youth. Participant 1 explained: "In the sense that the crisis intervention piece, part of it is though, you know, is the family in a more stable state than when you started and that was definitely the case." There was also an atmosphere of movement through a crisis within Participant 4's description: "You kinda feel like you can just process it and go with them and be with them and get through the crisis and come through the other side." The movement through the crisis to a point of stabilization was described by Participant 4 as a shift in direction: "I know that the more we sort of leave the point of crisis there's that sort of relief around... if you can see the direction changes."

Participants' descriptions of their encounters illustrated how they understood suicidality and the meaning of the disconnection and isolation of the child or youth, and the various factors that contributed to their suicidal behaviour. The descriptions provided by participants also illuminated a process of crisis intervention in response to the suicidal child or youth. Movement through the encounter was expressed by participants as they connected with resources, ensured safety, and reached a point of stabilization.

Section 2: Knowledge Valued by Front-line Practitioners to Inform their Practice with Suicidal Children and Youth

Metatheme 1 – Educational Sources of Knowledge Informs Practice

Theme Cluster 1: Training in Suicide Intervention and Prevention

The participants described the training in suicide prevention and intervention as knowledge that guided their practice with suicidal children and youth. They discussed the various aspects of the training they received and how they used the information to respond to suicidal children and youth. Some participants discussed the inadequacies of the training they had received in being able to apply the knowledge to the specific situations they were experiencing. Within this theme cluster, the following three themes emerged from the participants' descriptions: Asking Directly about Suicide, Determining Risk, and Planning for Safety (see Table 2.).

TABLE 2. Knowledge Valued by Participants to Inform their Practice with Suicidal Children and Youth: Summary of Metathemes, Theme Clusters, and Themes

Educational Sources of Knowledge Informs Practice	Client as a Source of Knowledge	Professional Knowledge Informs Practice	Personal Experience as a Source of Knowledge
<p>1) Training in Suicide Prevention/ Intervention</p> <p>a) Asking Directly about Suicide</p> <p>b) Determining Risk</p> <p>c) Planning for Safety</p> <p>2) Epidemiological Knowledge</p> <p>a) History of Suicidality</p> <p>b) Age and Sex of Client</p> <p>3) Academic Training</p> <p>a) Child / Adolescent Development</p> <p>b) Limitations of Academic Preparation</p> <p>4) Literature and Materials</p> <p>a) Risk Assessment Forms and Checklists</p> <p>b) Contracts</p> <p>c) Agency Materials</p> <p>d) Materials from Training</p>	<p>5) Relationship with Client</p> <p>a) Connection and Being With</p> <p>b) Accessibility and Support</p> <p>6) Knowledge of Client's History and Present Circumstances</p> <p>a) Mental Health History</p> <p>b) Client's Historical Pattern of Functioning</p> <p>c) Client's Present Functioning</p>	<p>7) Professional Experience</p> <p>a) Role and Responsibilities</p> <p>b) Values, Ethics and Beliefs</p> <p>c) Professional Experience</p> <p>8) Agency Policy, Procedures, Protocols</p> <p>a) Confidentiality and Duty to Report</p> <p>b) Procedural Response</p> <p>9) Supervisor / Colleagues</p> <p>a) Involvement of Supervisor</p> <p>b) Involvement of Colleagues</p> <p>10) Resources Accessed</p> <p>a) Risk Assessments by Community Resources</p> <p>b) Discussions with Professionals</p>	<p>11) Self Knowledge in Practice</p> <p>a) Personal History</p> <p>b) Emotional Cues, Intuition and Gut Feelings</p>

Theme a) Asking Directly about Suicide

Three of the participants reported that the training in suicide prevention and intervention provided them with the knowledge to ask the child or youth about suicide in

a direct manner. As Participant 2 described, "I knew about asking the question...." For Participant 4, asking directly about suicide remained a constant thought in his/her mind as s/he was talking with the youth; "...and then in my head going I have to make sure we talk about... I have to put this question out there."

For one of the participants, based on his/her training in suicide prevention and intervention, asking directly about suicide would lead to relief for the client involved. As Participant 5 described, "...because up until then I really believed what I'd been taught that if you ask somebody they're going to go 'oh thank God... finally somebody's asked me that question,' right?" Participant 5 explained further that the training s/he had received did not give him/her the knowledge to explore suicidality if asking directly about suicide revealed a negative answer.

I had taken a couple of just workshops on what do you do if a kid says they're going to kill themselves, right? So up until then, my knowledge of suicide as far as education-base, was if somebody says they're going to hurt themselves, kill themselves, commit suicide, this is how you respond to that. Versus if somebody's putting out these cues, this is how you respond to it. Um...So the education part around dealing with a kid who was possibly presenting, because that was part of it... too, right? Is that if you did say anything about suicide, it was 'No, no way. I'd never do that.' Well, o.k. So then you back away from it. And so at that point that was the end. I wouldn't have gone any further because of the education I had around suicide.

Some of the participants were made aware of suicide being an issue either through the child or youth directly disclosing that they were thinking of killing themselves, or

through the initial referral. For three of the participants, the training they received provided them with the knowledge to inquire directly about suicide, acknowledge suicide as an issue, or to take suicide seriously. Participant 1 explained the knowledge s/he drew from the training as follows: "It was more around acknowledging that there had been a suicide attempt and that suicide was an issue and just being able to go there as opposed to not... acknowledging the white elephant in the room...". Similarly, Participant 3 describes "being comfortable with who you are, to talk about it..." as the most helpful source of knowledge s/he was drawing from. Participant 2 drew on his/her knowledge to take suicide seriously. Participant 2 states, "I knew that it was to take it very seriously and people don't typically say they're going to kill themselves."

Two of the participants noted the inadequacies of the training they had in suicide prevention and intervention in providing them with the knowledge to explore suicide directly. Participant 3 noted the "institutionalized perspective on suicide" that s/he had received in training that was not applicable to the outdoor setting where his/her practice was taking place. Participant 5 noted that the training s/he had received was inadequate in preparing him/her for talking directly about suicide if the child or youth "says no".

I still don't think that the training that was out there I don't think it was very good. I don't think it was. I think it was great if you were a person on the street just to give some basic knowledge and language. Um... I think that for professionals who are working with high-risk youth, I think it was pathetic. I don't think we were prepared at all, and I don't think... I think we did a disservice probably to a lot more than just him in that we were all equally unprepared,

right? We all had the same basic information and you know if a kid says no everything's great, they're fine, right?

Theme b) Determining Risk

Participants utilized the knowledge gained from training in suicide prevention and intervention in determining the risk of the child or youth for suicide. One piece of knowledge used by two participants included asking the child or youth if they have a plan. Participant 1 used the knowledge s/he received from the training to explore the warning signs with a mother and youth s/he was working with as a means of determining risk for suicide in the future.

So she communicated being in the event, that these warning signs were coming back. Cause, I guess what had happened, he had sort of umm... made a comment, 'It's o.k. mom. I'm going to school better, we'll talk.' And so she was feeling o.k. Things are going a little better. And we talked about the 'what if?' What are the warning signs? What do you remember the warning signs being for your son? Kinda did that a bit. And so yeah, she was to the point where o.k., if I see those again, I know to call. Or I know to at least try addressing them, or have someone addressing them to him or whatever. So we went through the emergency plan that way and possible resources that she could access, and then I did the same thing with the youth.

Additionally, Participant 4 used the knowledge from the training to assist him/her in providing information to a health professional.

But in between those times, I had also done another suicide intervention prevention course. So when we were at the hospital, made sure to really hit on the

key points in terms of her history and what had been happening, so she was admitted.

Theme c) Planning for Safety

Planning for the safety of suicidal children and youth can protect and preserve their lives. Participants used knowledge from their training in suicide prevention and intervention to conduct safety planning with the child or youth. After a suicide prevention and intervention workshop, Participant 1 explains, "I went immediately back to the family with it actually with the material from that and just used that to kinda structure and clarify safety planning..." Participant 3 states s/he used "some of the safety stuff we talked about in the... training" in his/her work with a suicidal youth. Participant 5 used the knowledge regarding contracts in safety planning from the training s/he received. S/he stated, "The training that I had said if they say no or if you contract with a kid, right? Contracts were always big." From his/her training in suicide prevention and intervention, Participant 5 believed that the youth was safe based on establishing a contract with the youth, or if the youth answered negatively if asked directly about suicide.

Theme Cluster 2: Epidemiological Knowledge

Three of the participants described use of epidemiological knowledge to guide their practice with suicidal children and youth. The statistical knowledge from research provided additional considerations for the participants in understanding suicidality and the child or youth they had before them. Of the three participants who used epidemiological knowledge, two participants described an increase in their concern for the child or youth based on specific research information they had learned that indicated

populations at higher risk for suicide. Within this theme cluster, the following two themes emerged from the participants' descriptions: History of Suicidality, and Sex of the Client (see Table 2.).

Theme a) History of Suicidality

All three of the participants who relied on epidemiological data understood the client's history of suicidality (i.e., previous suicide attempt) placed the client at a greater or higher risk of suicide. Participant 2 learned of the child's previous suicide attempt from his family members when the child stated he was going to kill himself. Participant 2's knowledge from epidemiological research of previous attempts potentially higher risk of suicide led her to increased concern and feelings of being "bombarded" by the unexpected information.

My bombardedness came from the fact that both of these adults had this previous knowledge and dismissed his statement when he made it. So the situation then to me felt surreal and I couldn't understand, and I know that previous attempts puts a suicidal notions at higher risk and I don't think... There was no intervention for the first attempt because they just calmed him down and got him back. And like I'm just there for a visit and everything usually goes fine. So the bombardment came from the fact that I didn't expect it.

Participant 1 used research data of the risk being greater with a history of suicidality in his/her work with the mother of the youth he was working with. Participant 1 stated, "I think, you know, shared that idea of the risk being greater once the first attempt had happened." In the training that Participant 3 had undertaken, the risks and possibility of attempts was the main focus of the suicide intervention and prevention training.

Theme b) Sex of the Client

Participant 2 reported additional his/her concern for the safety of both the suicidal child and suicidal youth s/he worked with based on the research knowledge of males dying by suicide more often than females.

I think because both were male... I know the statistics that females attempt suicide more often but males complete suicide more often. That 'in the back of my mind' knowledge increased my worry for their safety.

Theme Cluster 3: Academic Training

As reviewed in Chapter One, all of the participants in the study had some level of academic training in preparation for professional practice with children and youth. Three of the participants described knowledge, or limitations of their knowledge, from academic sources to their interventions with suicidal children and youth. The remaining participants did not report that they utilized knowledge gained from academic studies in the practice examples they provided. Within this theme cluster, the following two themes emerged from the participants' descriptions: Child and Adolescent Development and Limitations of Academic Preparation (see Table 2.).

Theme a) Child and Adolescent Development

Two of the participants utilized their knowledge of child and adolescent development in determining their approach and intervention with the suicidal child or youth. Participant 2 considered the age of the client s/he was working with in respect to his cognitive development and his disclosure of suicidal thoughts. Participant 2 explained, "What I went from is that as a child, his cognitive level of understanding is different and the message he sent about that disclosure is crucial." Participant 2 further

stated that her knowledge from academic course work in developmental psychology provided her with the understanding of growth and development.

I took developmental psychology, so just ages and stages from birth to adulthood: just knowing the brain's not fully developed until you're twenty-one.

Participant 1 used his/her knowledge of attachment development in understanding the context the suicidal youth was in with whom s/he was working.

You could definitely tell that he had a pull to get to know his dad better. And so he had lived with mom - well, they'd been separated when he was pretty small. So if you look at it from a separation- attachment, separation- developmental thing, that lesson was questioning this person's a part of me and I don't know who he is. So it was kinda really making sense on that level, never mind the things that were going on for him.

Theme b) Limitations of Academic Preparation

It is interesting to note the entire absence of reliance on academic knowledge by two out of the five participants. Participant 5 comments on the training in Human Services s/he received as being limited in providing him/her with the practical skills to work with suicidal children and youth.

But again I think it's because the information we were drawing on was just pretty lacking. And I look back and I think about, even up at college, what did we talk about suicide in a Human Services training. And it was... I think we did a seminar one day. Right and it was pretty limited. Just talking about the psycho-social impact and what does it look like, but there was really nothing there that

prepared us, prepared me, to go out in the field and work with these kids, you know.

Academic course work, as a source of knowledge, was reported to be used by two participants in their interventions with suicidal children and youth if it pertained to child and adolescent development. Academic preparation and knowledge was reported by one participant as “lacking” and “limited”. Furthermore, two of the five participants did not rely on academic knowledge in the intervention examples they provided.

Theme Cluster 4: Literature and Materials

The majority of the participants described using knowledge from relevant literature and materials in the examples provided of working with suicidal children and youth. Four out of the five participants reported using materials and/or literature to assist them in their interventions. The participants used materials and literature from training they received, agency forms, and resources provided by supervisors or programs they were working in. Within this theme cluster, the following three themes emerged from the participants’ descriptions: Risk Assessment Forms and Checklists, Contracts, and Agency Materials (see Table 2.).

Theme a) Risk Assessment Forms and Checklists

Two of the participants identified relying on risk assessment forms and/or checklists as sources of knowledge in their interventions with suicidal children and youth. Participant 3 received “risk assessment forms” from his/her supervisor that identified “questions we could ask” as well as “signs and numbers” that would determine the procedural response to a suicidal youth.

But you know you assign a number that would tell you where they were at low, medium, high. It was common practice for Alberta justice and the agency if we had a medium to higher risk, transport back to the centre where they could visit with counselors, psychologists and have an environment that was more monitored - back to jail. And that felt safe actually. You know, couldn't hurt themselves.

Participant 2 reported using a "suicide risk assessment chart" as a resource, or source of knowledge, for referring to in the program s/he worked in.

At the [residential program] we have a suicide risk assessment chart... and it's right on a desk. And this was what I was told to refer to if a youth comes into the [residential program] that um... says they are suicidal, they have had thoughts of self-harm and I knew that that resource was there.

Theme b) Contracts

One participant reported relying on knowledge provided within the relevant literature to assist in drawing a contract with a suicidal youth s/he was working with.

Participant 5 reported that the contract s/he and the staff team derived from the literature included various time-limited agreements that were in written form which were signed by the suicidal youth.

Because what we did was we simply look through the literature and said, 'O.k. So you agree that you'll talk to somebody, you won't do anything until at least this point in time, so tomorrow afternoon at 4 o'clock is the expiration of this contract and then we'll renegotiate. But between now and then, you agree absolutely, if you have these feelings, you're going to hurt yourself, you're going to come and talk to me. If you need to at 3 o'clock in the morning, get up and talk to the staff,

you know all of these numbers, you know all these rescues like all of that stuff is in place. You're ready? O.k., you got it. You're ok with it. ' Perfect. He signed it.

Theme c) Agency Materials

The completed referral forms that identified suicide as an issue and the program orientation package provided by the agency both proved to be sources of knowledge that two of the participants relied on in their interventions. As Participant 1 explained, the referral information “kinda opened the door in just directing us the issue that I was referred for, and I was quite open about the reason I’m here.” In the program Participant 5 worked in, the orientation to the program was provided in a “welcoming package” for all clients who accessed services. The “welcoming package” included asking the client about suicide.

Because it's part of our welcoming package that we say, 'How are you doing?' You know? Kinda thinking that if you're at the safe house and it's two in the morning and you know can't be a great situation, so let's talk about right now feelings. O.k., lets talk about...lets talk about suicide. Have you ever felt like suicide? Have you ever thought about it? Have you ever tried it? If we notice any cuts we say, 'What did you do? How did that happen?' Right? And all of that is now simply part of the opening conversation and we... every single youth that comes through the doors, we have that conversation. And so I think that that opens the doors so much more and we're just right upfront about it. There's no kidding around.

The referral information indicating the need for the participant to address suicide, and the comprehensive agency orientation package for clients accessing services was reported as

sources of knowledge used by participants in their interventions with suicidal children and youth.

Metatheme 2 – **Client as a Source of Knowledge**

Theme Cluster 5: Relationship with Client

All five of the participants highlighted the relationship as a significant source of knowledge that they valued in directing their practice with the suicidal children and youth in their care. They described talking with the child or youth, drawing on the knowledge of their relational experience with the child or youth, and responding to the suicidality from within the relationship. Some of the participants described bringing aspects of themselves forward as part of developing the relationship and serving the connection. This relational connection was a source of knowledge from which participants gained insight into how to respond to the suicidal child or youth. Within this theme cluster, the following two themes emerged from the participants' descriptions: Connection and Being With, and Accessibility and Support (see Table 2.).

Theme a) Connection and Being With

Some of the participants spoke of a connection with the child or youth. The connection reported by the participants was often in conjunction with a description of *being with* the child or youth. Participant 3 spoke of a disclosure by another professional that the youth s/he was currently working with was suicidal. Upon hearing this information, Participant 3 decided to talk with the youth even though the professional who disclosed the information had concluded the youth was seeking attention.

I wanted to talk to her about it and see where she was coming from - what her intention. Cause that inappropriate sharing disclosed to me that it closed off as an

attention thing. I wanted to make sure because I knew her a little bit and we had conversations around that where I'll ask her how she was feeling. And as soon as she mentions depression, I'll start to dig into that and ask her how the depression is lately and if she was feeling down.

Participant 3 valued the knowledge gained directly from speaking with the youth and the connection s/he had with her. Participant 2 also spoke of a strong connection with the youth s/he worked with. Participant 2 described, "We formed a strong bond and he knew that he could trust me for confidentiality unless he disclosed harm to self or others." The connection that Participant 2 described guided his/her action and response to the youth's suicidal comments.

He knew that the parameters of what I would keep confidential... And I said to him, 'You know in telling me that that I have to do something with that information.' And he said, 'Of course, yeah.' So he was safe enough to tell me that, knowing that I just wouldn't let it go. And I think he was looking for that validation of his emotions around his being moved that no one else was giving him.

Through the knowledge of the strong bond and the trust and limitations of confidentiality, the youth's disclosure informed Participant 2 that he wanted safety and validation of his emotions. Participant 1 also described the knowledge of a connection and comfort level s/he had with a suicidal youth and his mother as being the most helpful in steering his/her action.

...just being straight forward with the issue. Umm...And I think, just the feeling that they would, that they were comfortable with me from the start. So I felt like I

could, could do that quite quickly. Umm... Had a sense of humour which is always helpful, they could laugh at themselves, self-deprecating, so there was a comfort level right from the start.

Being with the client also was described by two of the participants as a source of knowledge they were drawing from in their response to suicidal youth. After a phone call from a suicidal youth, Participant 4 reported that s/he “went in to the situation and um... just, you know, got a feeling from where the person’s coming from.” Participant 3 also noted being with the client was helpful. Participant 3 explained, “Just being able to talk to her about it was the best thing, and feeling comfortable with that.” Knowledge was gained by participants from both the connection with the client, and being in the client’s presence.

Theme b) Accessibility and Support

The suicidal children and youth in the participants’ examples were provided with both accessibility and support by the front-line practitioner. The knowledge that participants had informed the children and youth of how to reach them for support was reported as helpful by participants. As Participant 3 explained, “She knew that I could be someone she could talk to and I’ll keep doing it.” Participant 3 further describes the accessibility and support s/he could provide when asked what guided his/her approach with the suicidal youth.

I guess I just drew off of instinct offering support. Didn’t force it, didn’t make the issue happen. Just wanted to make sure she was aware that I was a someone she could talk to about anything, about depression and stuff like that, and that seems to work.

Participant 5 also discussed the knowledge of the youth's awareness that s/he was accessible for support if the youth needed him/her. Knowing that s/he had made him/herself accessible to the youth was helpful to Participant 5.

I think the biggest thing was just continuing to try and open that door and continuing to put that hand out there and saying, 'Look, one of my things has always been, o.k., you know what? I get it that maybe right now you don't want to talk about this, or whatever else is going on. I want you to know that at any point if you need to, if you want to, you can phone. And you know, there's lots of great staff here, but there's also people that sometimes make a stronger connection to us. So if that's me and at 2 o'clock in the morning you wake up and go I need to talk to that person, then you get somebody to call me, and you go and talk to the other staff and I'm sure that they would do the same thing. Just if there's that connection and you really need it.' And so I think that the biggest thing that I offer, it doesn't matter what it is, it doesn't matter what you want to talk about or what you have to say or how you need to say it, you can, and I'll hear it, right? And that we're not going to freak out. I'm not going to judge on any of this but if there's something you need to talk about or... then bring it up and I'll be willing to hear it, and to listen to you, and then help you figure out where we're going to go with that.

Participant 4 also described the knowledge of the support s/he was able to offer the suicidal youth as most helpful in the context of their relationship: "I guess what first stands out is really... the relationship." Participant 4 also ensured the youth was aware that s/he was accessible if the youth needed him/her. Participant 4 explained that s/he

tried to have the youth “agree to call if you’re feeling this way.” Participant 4 emphasized further what s/he directed the youth to do: “Just call, at least call, or if you’re on the highway and you don’t know where you are and you don’t have anybody and you’re stuck, just call.” The knowledge that informed participants’ actions with the suicidal children and youth included knowing they were accessible to provide support to the client if needed.

Theme Cluster 6: Knowledge of Client’s History and Present Circumstances

The knowledge of the client’s history and the client’s present circumstances was valued by participants and guided their actions and approach to the suicidal children and youth in their care. Four of the participants reported using the knowledge of the child or youth’s mental health history to inform and guide their practice in the encounters. Some participants also reported using knowledge of the client’s general history and participants’ understanding of the client’s present circumstances to determine how they provided service to the suicidal child or youth. Within this theme cluster, the following three themes emerged from the participants’ descriptions: Mental Health History, Client’s Historical Pattern of Functioning, and Client’s Present Functioning (see Table 2.).

Theme a) Mental Health History

Four of the participants described using knowledge of the client’s mental health history in the interventions they provided to suicidal children and youth. Participants relied on information they had regarding the child or youth’s previous suicidal behaviour, involvement with mental health services, and struggles with depression or addiction issues. For example, Participant 4 used her knowledge of the youth’s previous attempts during a referral to a community mental health emergency response team.

And so I remember going, 'O.k. Well... yup o.k. So we've talked about it, we've talked about what you've done and what's happening for you. Let's call [emergency mental health agency], have a chat with them and see where you need to go.' And I remember calling them on the phone and saying, 'This is the situation. This person's attempted x amount of times and here we are today, and she's talking about attempting again.' Right?

The knowledge of a prior suicide attempt indicated on a referral form assisted Participant 1 in discussing suicide with the youth and his mother. Participant 1 explained:

So there was a comfort level right from the start I think. So it was kinda neat, kinda opened the door in just directing us the issue that I was referred for, and I was quite open about the reason I'm here. This event take place, so lets talk about that.

For Participant 5, his/her knowledge of the youth's mental health history of depression and suicidal ideation directed him/her to ask about how he was feeling at the present time.

And so a lot of the mental health issues, he um... He would acknowledge them as sort of really there but not important, and when he would discuss any of the depression or suicidal ideation it always was this whole 'I've got a grip on it. I can handle it.' So we didn't spend as much time working on that. I mean if he, when he came in, we'd do the assessment as he came in and we'd go through all of that with him... And we'd talk about what does that look like for you? And you know where is your depression level, and what about that rating? And he always would rate himself very low.

Participant 3 also drew on his/her knowledge of the youth's mental health history including depression and addictions and used his/her knowledge of the effects of substance use on a youth's depression and risk of suicide. Participant 3 explained, "Usually at night she was using some kind of drug, usually drugs and alcohol... she was just really down-spiral." Participant 3 used his/her knowledge of the youth's mental health history to then direct his/her actions. Participant 3 knew that depression would occur for the youth in the "down-spiral" and decided after talking with the youth to "send her to Child [and] Youth Mental Health for a risk assessment."

Additionally, one participant used knowledge of the youth's mental health history to enlighten him/her of the difficulties and struggles the youth had experienced. Participant 4 describes a youth who "had been completely pathologized" with many labels, coupled with a history of being in care and substance use.

She was someone that had been completely pathologized like in every medical way... You know, had been given, you know, so many labels. Like at one point she goes this week, 'I think I'm borderline. Last week I was bipolar. Wonder what I'll be next week.' Sort of that real... It was just so detrimental for her. So anyways, her history in terms of family, she was also [in care of child protection services]. And certainly some mental health concerns, and a lot of labeling. So I remember that um... we talked. We talked a lot. She was very much on the margins in terms of who she would socialize with, who she was involved with. Like lots of addictions stuff...

Participant 4 had knowledge that the youth may have an emerging mental health diagnosis, a history of disrupted family relationships in terms of being removed from

family care, was struggling with being on the margins of her social circle, and involved in substance use. After the youth disclosed suicidal ideation and a well-thought out plan to die by suicide, Participant 4 sought out emergency services. Participant 4 explains the impact of the youth's involvement in services on the intervention at the hospital:

And so I remember we waited and waited, and waited, and waited at the hospital like you always do. And ah... she talked to... But of course she was also had been in the system for quite some time and has dealt with people. And of course she just answered all the questions that the lady wanted her to answer and so regardless of what I had to say she was still released.

The knowledge of the youth's mental health history helped direct Participant 4's actions in accessing emergency resources. As well, the youth's history of accessing services and being involved in the child protection system also informed Participant 4 of the youth's ability to manage the interaction with the hospital staff she encountered. Participant 4 found that the youth's involvement in the "system" in accessing mental health services and receiving child protection services had prepared her for answering the emergency personnel's questions perhaps in a manner that minimized her own risk of dying by suicide.

Theme b) Client's Historical Pattern of Functioning

A number of the participants identified the knowledge of the client's historical pattern of functioning as information they valued in the intervention examples they provided. In the practice example Participant 2 provides of his/her work with a suicidal youth, s/he explains, "he did not typically have that attitude of suicidal behaviour" and that the youth "very much loves life actually." Participant 2 recognized the youth's

suicidal comment being “out of the blue.” Participant 5 also described his/her knowledge of the youth’s historical functioning assisting him/her in observing a difference in how he was currently presenting.

He was a very bright child, very personable, exceptionally talented, very talented musician. So to go away and think, you know, there’s something wrong there and he hasn’t touched the guitar for half the time that he’s been here which is really unusual.

Participant 5 was able to use his/her historical knowledge of the youth’s interests and talents to observe a change in his presentation. Alternatively, Participant 4 uses knowledge of his/her relational history with a client to decipher his/her approach.

Well, it would be a real combination of um... any of the history that we previously had. So sort of just knowing her response to the things that I would say and how to approach the questions I needed to ask. That was certainly a big factor because if I word things one way I know she may react this way.

Additionally, Participant 5 drew on the knowledge of the crises s/he had worked through with the suicidal youth in the past. Participant 5 found it helpful to draw on this historical knowledge to “work through” the present situation.

I mean at that point we hadn’t really had a really long relationship but we’d come through x amount of crises so far. And being able to pull on those, and being able to pull on um... what’s happened in the past and how she’s been successful... Probably that was the most really the most helpful in those situations. Just really being able to pull on the times where we had come through the other side and we

had been able to process things that had happened. And even though she may have attempted we were able to work through it.

Participant 2 also relied on his/her knowledge of the various events that had taken place in the youth's life that led to feelings of defeat and frustration. Participant 2 had the knowledge of the youth's experience of loss within his family history. The youth experienced not being able to live with his parents and being placed in the foster care system. As well, the youth experienced loss as he moved from foster home to foster home having little consistency in his placements. With this knowledge of the youth's historical experiences, Participant 2 described being able to understand in the encounter the youth's emotional experience.

I understood why he was defeated because I knew the history of all of these things in his life that had been removed from him. I could empathize with his place, his frustration.

Theme c) Client's Present Functioning

The knowledge participants had of the client's present functioning also was valued by participants in informing their actions and approach to the suicidal child or youth. Two of the participants gained knowledge of the youth's present functioning from direct observation of the youth. As Participant 5 explained, "he presented often as sort of fading and he would be sitting in a room just zoned right out, no music, no nothing." Participant 5's knowledge of how the youth was presenting led him/her to concern about the youth feeling "sad" and talking about "depression." Participant 5 used the knowledge of the youth's present functioning through his/her direct observation and reported that s/he would "invite him to talk" as well as having "talked about it at staff meeting." The

knowledge from direction observation of the youth's current presentation guided the conversations Participant 5 had with the youth. Participant 5 initiated conversations with the youth about his emotional wellness which opened the conversation to discussing the youth's suicidality.

He and I would talk about; you know there's times I think about this. There's times I think about 'you know what.' What if I just ended it? And so absolutely we'd have a conversation about suicide, and it always came down to 'Nah, I would never do that.' You know? So... so it was always on the plate. It was just kinda off to the side.

Participant 2 also gained knowledge of the youth's present functioning through observation of the youth's emotions, specifically the frustration he was experiencing in being invalidated by those in authority around him. Participant 2 was able to place this knowledge of the youth's frustration in the context of the current issue of the youth changing foster placements and understand the youth's consideration of suicide as an option.

Youth was becoming very frustrated that no one would hear him. This was very upsetting. So I think it was his way of saying that this is too much too much for me at thirteen years old to handle and I am going to just kill myself.

Participant 2 was not only aware of the emotional experience of frustration for the suicidal youth, but also the devastation he was experiencing. Participant 2 explains, "He was devastated that he wasn't living at home, he was devastated that he was in a different community where his friends weren't." Participant 2 was able to use the knowledge of the youth's emotional experience and present functioning to "empathize with his place."

Additionally, Participant 4 used his/her knowledge of the youth's present circumstances in advocating for change. The youth in Participant 4's example was prescribed medication for depression and had access to a full month's medication when she was suicidal. Participant 4 was able to use his/her knowledge of the youth's present functioning in being actively suicidal to communicate with other involved professionals and initiate decisions to limit the youth's access to the means to die by suicide.

She had been on and off anti-depressant. And then comes the next issue that they continue to give her prescriptions even though she was actively suicidal. So she would have these prescriptions that she had access to, so that was sort of another sort of compounding issue. I think we got it down to a week, like we would get a prescription every week as opposed to a month at a time.

In an additional example from practice, Participant 4 described the client's current circumstances and presentation as informing her approach. During a direct encounter with the youth, Participant 4 gained knowledge of the youth's current functioning. The youth directly disclosed her thoughts of suicide, her plan, and how she had prepared to die by suicide. Participant 4 used this knowledge of the youth's current suicidality to guide him/her in accessing emergency services at the hospital.

But I remember we were out for coffee and we were downtown. And we were sitting having coffee and she just goes, I think she had said something to the effect of 'Oh I think I'm going to kill myself today.' Really? Oh o.k. So we'll shift gears, like it had been just "oh we're hanging out for coffee" and turn into now "I'm going to kill myself.' And she had been you know sort of toying with the idea and had written notes and wanted someone to come home and find her. So it had been

going on for a while and I hadn't been aware and so we talked about what was she thinking about and she was going to. She was going to cut her wrists and be in the bath tub and she had the razors ready and she wrote a note it's in her pocket. She just wanted her roommate to find her. And so we happened to be downtown, so we talked for a little while longer and I said 'You know I think it would make sense if we just went up to Emerg. and um...And kind of have a chat about it.' And she agreed that, you know, we would go to the hospital.

The knowledge of the youth's current presentation of suicidality guided Participant 4's approach. Participant 4 described using the knowledge of the youth's current plan, and the knowledge of the youth's presentation of a level of preparedness for acting on the suicide plan to then provide support for the youth in accessing emergency services at the hospital.

Metatheme 3 – **Professional Knowledge Informs Practice**

Theme Cluster 7: Professional Role

All of the participants described bringing knowledge of their professional role in the lives of the suicidal children and youth to the encounter. For some of the participants, the knowledge of what their job entailed directed their approach. For others, the knowledge areas of their professional values, ethics, and beliefs were drawn on for direction. Four of the participants also described valuing knowledge derived from previous professional experience and familiarity with suicide. Within this theme cluster, the following three themes emerged from the participants' descriptions: Role and Responsibilities, Values, Beliefs, and Ethics, and Professional Experience (see Table 2.).

Theme a) Role and Responsibilities

Participants described knowledge of the professional role they played in the lives of the children and youth in their care. For one participant, the knowledge of his/her profession as a counselor was used to facilitate a discussion with a male youth who was struggling to discuss his emotional experience. Participant 1 explained, "The youth never really had felt that he could talk to his emotions, male youth, and I addressed them, are we doing this rah rah thing, can we talk about feelings, cause I am a counselor."

Participant 1 described his/her role of a counselor in the youth's life in an attempt to provide safety and acceptance for the youth to discuss his emotions. Participant 4 also described knowledge of her role as a support person in the youth's life and the differences between her professional role and responsibilities, with that of the social worker involved. Participant 4 described his/her knowledge of her professional role in providing support and direct involvement with the youth. Participant 4 compared his/her role to that of the social worker who was responsible for ensuring "immediate safety", organized monthly meetings, and provided service "more at arms length than direct."

So I would be a support, her counselor would be a support, her roommates obviously aware of what's happening and as supportive as she can be. But um... Yeah. I mean I guess that would have... That was more her [social worker] role was just ensuring that immediate safety and in that sense. But that the support would certainly have come from myself.

The knowledge of his/her professional role in providing direct support to the suicidal youth also created feelings of isolation in the responsibilities this role entailed for Participant 4. S/he experienced providing service to the youth with little involvement and

support from other professionals involved. Participant 4 described knowing that the professional role s/he held in the youth's life was often enacted in isolation.

It just seems like there isn't very much support. There's not that much support out there for, for the people that are in those positions, and you know that going in. Like you know that it will be you, you know? And that's all that it's ever going to be, unless they're in an ambulance. Or by some stroke of fate you get someone that's going to be there tomorrow. You know? But it's just that real feeling of I know I'm going on my own, until I call someone to debrief it. Or you know, until I call my supervisor and let them know the situation and this is what's going on.

The knowledge of his/her role and responsibility to protect and preserve life also guided Participant 3's thoughts and approach to a suicidal youth in a wilderness camp. Upon learning of the youth's thoughts and plans of suicide, Participant 3 experienced his/her professional role being to protect the youth's life. Participant 3 described having thoughts of using restrictive means, such as handcuffs, to enact his/her role to protect the youth.

I definitely got into a protective role. Pretty much put the youth in handcuffs and shackles to make sure he wasn't going to kill himself cause that was kinda a direct concrete protective thing. There was no way he was going to be able to do anything. So I remember having those thoughts the possibility of that happening.

The knowledge of the role and responsibilities Participant 2 had directed him/her to obtain additional staff support in ensuring the suicidal youth received assessment and treatment.

I knew that if I took him to the hospital or to the physician alone that that I wouldn't necessarily have the skills to ascertain what he was being told or asked.

Also because there was a risk to self-harm, I needed to be double staffed in that situation because my emotions could bias my decisions and I was very close to him and I wanted him to get the best possible assessment and treatment.

The knowledge of the role and responsibilities participants played in the lives of suicidal children and youth guided their actions. Some participants drew on the knowledge that they were alone in their responsibilities of providing support, and choose to connect with other professionals. One participant used his/her role as a counselor to give permission to a male youth to discuss his emotional experience, whereas another drew on knowledge of his/her role to protect life in his/her approach with a suicidal youth.

Theme b) Values, Ethics, and Beliefs

Two of the participants reported relying on knowledge of their values, ethics, and beliefs in their practice with suicidal children and youth. Participant 2 relied on knowledge of his/her ethics when faced with a youth who disclosed his intention to kill himself. Participant 2 explained, "I knew that doing nothing would be unethical and dangerous, so that wasn't an option." Knowing his/her ethics informed Participant 2's decision to access support and services for the suicidal youth.

Participant 5 had the knowledge of the value of respect in his/her professional role in the youth's life. Participant 5 also knew that the value of respect and adopting a developmental, normalizing approach, was interwoven with his/her belief in the youth's right to privacy. Participant 5 explains, "I had such strong values around taking a kid where they're at and you're presenting this, and that's what I'm going to work with because I'm going to value your privacy and your right to that." Participant 5 described a value of respect in his/her discussions with the youth.

You felt that you were trying to draw it out, but also my gear is always trying to be respectful around those discussions. So, taking what he would gives me and he was saying to me was, 'You know sometimes I think about it, but it's just not a big issue...'

Along with the values of respect and privacy, Participant 5 had knowledge of his/her belief in not imposing one's will on others.

How do I do this without imposing my will on this kid, right? Because sometimes it felt like it was my need for him to actually say this. You know, like he would make comments around like you know, 'Can't I just be sad? Like I'm in a fucking safe house, my family's out there, my dad won't talk to me.' Really thinking, yeah you know what? What right do I have to impose my concerns on you?

Participant 5's beliefs in not imposing his/her will on others further steered the direction of service s/he provided to the youth. Participant 5 explains, "So my belief was that you have to back off, right? And of course I know at no point I would have said 'I'm really worried that you might be thinking about killing yourself.'"

Theme c) Professional Experience

Four of the participants described professional experience and familiarity with suicide as informing their approach to the suicidal children and youth in their care. As the participants described examples from practice at any point in their professional career, some of the participants discussed the limitations of their knowledge at the time of the intervention. Participant 3 describes his/her familiarity with suicide as being "pretty green at the time", whereas Participant 5 states, "I'd already been doing it for 12 years with street kids and muddling through somehow and had other youth commit suicide."

Participant 1 reported that knowledge from experience with suicide was helpful when it presented in practice. As Participant 1 explains, “At least having a bit of experience with the issue so you’re not so uncomfortable with it when it’s there.” Having the knowledge of how to procedurally respond to suicidal behaviour based on prior professional experience guided Participant 4’s practice. Previous professional experience informed Participant 4 of what s/he needed to ask the youth, what information s/he needed to have about the situation, and what the steps were in responding to a suicidal youth.

And then certainly just experience with people in the past and having been through similar situations although none... No situation is ever the same but knowing sort of a, b, c, d, this is what we need to do, this is what we need to talk about, these are things I need to know from you.

Professional experience with the issue of suicide provided the majority of the participants with information and knowledge of how to respond to suicidality in the children and youth in their care. Prior professional experience provided participants with a level of comfort in discussing suicide with the child or youth that was not present at earlier moments in their career. Experience also guided participants in knowing what the agency’s procedures were in responding to suicidal behaviors in children and youth including what information they needed and who they needed to contact.

Theme Cluster 8: Agency Policy, Procedure, and Protocol

The majority of the participants described using knowledge from the policy, procedures, and protocols set in place by the agency they worked for. Participants relied on knowledge of the various responsibilities and obligations they had based on their profession, and their employment within the Human Service field. Some of the

participants relied on knowledge derived from policies pertaining to confidentiality, whereas others described knowledge of the procedures they were to follow should they encounter an issue related to suicide. From the participants' descriptions, the following two themes emerged: Confidentiality and Duty to Report, and Procedural Response (see Table 2.).

Theme a) Confidentiality and Duty to Report

Three of the participants relied on knowledge pertaining to confidentiality and a duty to report instances involving suicide. The knowledge of the limits of confidentiality, described by Participant 2, was helpful in directing his/her actions with a suicidal youth in his/her care. Participant 2 described knowing that the youth "could trust me for confidentiality unless he disclosed harm to self or others." Participant 2 explained further, "The policy that confidentiality is exclusive of harm to self or others... which is helpful because I know that I still could have spoken with a coworker." Participant 2 used knowledge of the parameters of confidentiality to inform her action and responses to a suicidal youth in his/her care. Beyond knowledge of the limits of confidentiality, three of the participants described knowledge of a duty to report incidents involving suicide. Participant 2 expressed a "responsibility" and a "duty to report" the incident in the agency "policies on suicide." S/he further explains:

What else informed my practice was the duty to report, and the duty to report includes phoning the [Ministry of Child and Family Development] After-hours and updating them especially since this is a child in care.

Having the knowledge of not only being able to report the incident due to the limits of confidentiality, but also the knowledge that it was his/her duty and responsibility to inform others, gave Participant 2 the confidence to act.

But that's pretty cut and dry, suicide, confidentiality and harm to self and harm to others. So that brings with it a confidence for me to act because I know that I could support my actions, right? Through policy and all of that law thing.

Participant 4 also relied on knowledge of his/her duty to report the incident of suicidal ideation with a practice example s/he provided concerning a youth with numerous previous suicide attempts.

So if the policy was if a youth was talking about suicide their guardian needs to be contacted. We need to be contacted. Their doctor needs to be contacted. So just in terms of according to policy, who would need to be in the loop around knowing.

The duty to report the incident remained in Participant 4's mind, while still maintaining his/her focus on the interaction at hand with the youth in his/her care. Participant 4 described drawing on his/her relationship with the youth while knowing that s/he had an obligation to report the youth's suicidality.

This is where I'm coming from and this is what's important in this situation so when you talk about killing yourself. Umm... This is my reaction to it is that you know, I want to make sure that you're safe. That I'm, you know... really drawing on our relationship, and ... making sure that we're coming from that place. Even though sort of in the back of my mind I know I have to tell da... And I have to

inform all these people that this is what's happening. Still focusing on that relationship is probably the most helpful.

Additionally, Participant 5 describes knowledge of a duty to report suicide-related incidents. Participant 5 explains, "If you have somebody who discloses then you have an obligation to report. So if a kid says 'I'm gonna go kill myself,' then you report that." Participants drew on the knowledge of the limits to confidentiality and the duty to report suicide-related incidents in directing their responses to suicidal children and youth in their care.

Theme b) Procedural Responses

Some of the participants described knowledge of the procedures the agency they worked for had put in place for incidents involving suicidal behaviour. The procedural knowledge described by participants included who they were required to contact, what external resources were accessed, and the direct response to the suicidal individual. Three of the participants described knowledge of who they were required to contact. Participant 2 described contacting "the physician, the social worker, and the foster parent to ensure his safety." Participant 5 used knowledge of agency procedures that directed him/her to contact his/her supervisor, and the Ministry of Children and Family Development.

So at that point in time it basically said, you know, if you have a youth who or a client who harms them self than you need to contact your supervisor. So then we would contact the [Ministry of Child and Family Development] and after-hours would take the call and we'd say this is the scope and they'd say, 'O.k.' Right?

Participant 4 also reported knowledge from agency policy that informs him/her of the procedural response to a suicidal youth in ensuring “their guardian needs to be contacted... their doctor needs to be contacted.”

Two of the participants also used knowledge of agency procedures in response to suicidality in children or youth in accessing an external community resource. Participant 4 described a protocol that included contacting a community mental health response team: “At that time the sort of protocol was you know, be with the person, contact [community mental health response team], make sure everybody’s in the loop.”

Participant 3 describes using knowledge of the agency procedures of accessing an external resource to respond to a suicidal youth when they were determined to be at “medium to higher risk.” Participant 3 explains:

But you know, you assign a number that would tell you where they were at low, medium, high. It was common practice for Alberta justice and the agency if we had a medium to higher risk, transport back to the centre where they could visit with counselors, psychologists, and have an environment that was more monitored back to jail.

Two of the participants described procedural knowledge that guided their direct response to the youth involved. Participant 4 described knowledge of a direct procedural response: “The sort of protocol was, you know, be with the person.” Participant 3 described a “suicide watch” procedure that directed him/her of how to manage the youth in their care.

Other things were putting him on what they call a suicide watch which is a jail term which people are on duty getting sharp objects from him, get his shoe laces

putting him in isolated area, cause we had some people that came from an institution background that was the protocol exactly what to do where as it didn't quite fit in our wilderness camp.

Theme Cluster 9: Supervisor and Colleagues

All of the participants described accessing their supervisors or colleagues within the practice examples of encounters with suicidal children and youth. Participants varied in the value of the knowledge supervisors and colleagues brought to bear on the incident. Some of the participants described brief involvement by supervisors and colleagues, whereas others reported greater participation. Within the participants' descriptions, the following two themes emerged: Involvement of Supervisor and Involvement of Colleagues (see Table 2.).

Theme a) Involvement of Supervisor

All of the participants reported contact with their supervisor at varying points during their encounters with suicidal children and youth. The level of contact and engagement with their supervisor varied amongst participants. Some participants reported brief contact with little knowledge shared. Participant 1 explained:

Supervisor? At the initial referral, so kept him updated on initial attempts at contacting them and when the family did access service kept him updated on that. Umm... But other than that? Not a lot of sort of supervision on what was happening in terms of umm, really talking about each of the sessions or things like that, which I think probably could have happened if I had requested it.

Participant 1 reported no transmission of knowledge to him by his/her supervisor, and the knowledge that s/he could access his/her supervisor if needed for additional information and support in the practice example s/he provided.

Participant 4 also reported brief contact and knowledge exchange with his/her supervisor. In the context of discussing the support that was available during an encounter with a suicidal youth, Participant 4 stated, "I know I'm going on my own, until I call someone to debrief it, or you know until I call my supervisor and let them know the situation and this is what's going on."

Participant 5 described contact with his/her supervisor for notification purposes and no transmission or exchange of knowledge. The extent of the protocol that went into place consisted of informing the supervisor of a child or youth's suicidality with a request for updated information as required. No additional supports were put into place for the suicidal child or youth, or for the staff person who was providing direct service.

But even then, aside from notifying my supervisor, there was nothing. We didn't phone and say, 'O.k., what do we do?', and there was this protocol that went into place. We'd notify, you know. I'd call my supervisor and they'd say 'O.k., well, keep me up to date. Alright?' And that was it. That was our protocol.

Two of the participants reported supervisor involvement that resulted in the transmission of knowledge the participants used to guide their responses to the suicidal children and youth in their care. Participant 3 described, "The coordinator did sit down and talk with the youth." In a debriefing session after his/her supervisor spoke with the suicidal youth, Participant 3 explained the knowledge provided by the supervisor: "He debriefed it really well he talked about we need to talk with the youth he brought in some

risk assessment forms questions we could ask signs and numbers.” The supervisor provided Participant 3 and the other staff with suicide risk assessment forms that could be completed with a youth contemplating suicide. Additionally, signs or indicators of a person being at risk of suicide were also provided by Participant 3’s supervisor as well as numerical indicators of low, medium, and high risk of imminent suicide.

Participant 2 also contacted his/her supervisor who provided him/her with both knowledge and directions for managing the suicidal child in his/her care. The supervisor directed Participant 2 to contact the child’s social worker, who informed Participant 2 to wait for the child’s foster parent who would take the child to the hospital for a suicide risk assessment.

Again I phoned my supervisor, who directed me to phone the social worker... And when I phoned her she said to wait with the children until the foster parent picked him up and then she would need to take him to the hospital for assessment.

Theme b) Involvement of Colleagues

Three of the participants reported involvement of colleagues in the practice examples they provided of working with suicidal children and youth. The information and knowledge shared by colleagues, for some participants, guided the direction of service with the child or youth. Participant 3 described joining with other staff at a wilderness camp in disabling a youth’s suicide plan to die by hanging himself from a tree branch.

The youth had a very elaborate plan of how he was going to do. And he sent all the staff out to kinda, in an attempt to make the whole camp safe from this youth’s attempt for suicide, we had to cut the branches higher. So we...Cause one of his

plans was to hang himself from the branches, so we had to cut them all so they were out of reach. So staff were running around this whole camp...

For Participant 3, the knowledge and actions of the other staff informed his/her response to the suicidal youth in assisting to cut the tree branches back so the youth would not have a place to hang himself. Although this may have been viewed by the staff as a viable effort to restrict the youth's means of dying by suicide, Participant 3 had questions about the staff's ability to restrict means of hanging in the middle of a forest.

...all the branches in the middle of a forest where there's hundreds of thousands of hectares in the woods so there's no way... Suddenly you cut the branches off twenty trees in the camp - it wasn't making sense.

In a practice example provided by Participant 2, s/he actively involved a co-worker in an intervention with a suicidal youth. Participant 2 received a disclosure by the youth that he was going to end his life, and elicited help of a co-worker from another agency program. Participant 2 explained: "I knew that the staff there had a greater level of training around that than I did so that helped to inform what I did next." Participant 2 valued the knowledge given by his/her colleague in the assessment of the youth's suicide risk.

My coworker, with her experience, asked him some questions. So she did a minimum, not a minimum, a moderate suicide check and so she asked him if he had plans for next week and he didn't. And he didn't have plans for tomorrow. So that's kind of how she assessed his risk because he said... she said, 'Where do you see yourself in a week?' He said, 'Well I don't.'

Although the suicide risk assessment conducted by the coworker was brief and did not encompass important issues such as the youth's reasons for dying, reasons for living, or current mental health status, being able to seek out knowledge from a colleague was described as "helpful" for Participant 2. His/her perception of being able to access competent coworkers for support and guidance in his/her approach with the youth provided him/her with feelings of safety. As s/he explains: "The most helpful was the safety I had in knowing that I had competent co-workers."

Additionally, Participant 5 described contact with his/her colleagues and discussions that guided his/her responses to suicidal youth in the program. Participant 5 described a belief regarding suicide in the residential shelter program that s/he joined with his/her colleagues around. Participant 5 reported the following:

As a team we talked about suicide in a safe place, right? Cause it just sounds so odd. And as a group we actually came up with the idea that, you know what? Nobody's going to go to a [residential program] to kill themselves.

In the practice example provided by Participant 5, the team decided together through discussions how to respond to a suicidal youth in their care. From consultation with his/her colleagues, a contract was drawn up as a response to the youth at risk.

We all supported that contract. We all had conversations and stuff, because the last time he was there he was really, really down and had talked about you know, not sure he could do this anymore and hurting himself. And so we had talked about what do you do with a kid who's like that? And so we all knew o.k., so you contract with them and he was quite happy to enter into a contract and entered into a contract.

Theme Cluster 10: Resources Accessed

All of the participants used knowledge gained from accessing community resources to inform their actions with suicidal children and youth. Participants accessed mental health services, hospitals, and other professionals such as social workers, during their encounters with suicidal children and youth. Some participants valued the knowledge derived from suicide risk assessments obtained by community resources in guiding their approach. Other participants discussed the case with community professionals. From the participants' descriptions, the following 2 themes emerged: Risk Assessments by Community Resources, and Discussions with Professionals (see Table 2.).

Theme a) Risk Assessments by Community Resources

Four of the participants accessed a community resource for a suicide risk assessment to be completed for the child or youth in their care. Some of the participants used only the knowledge that a suicide risk assessment had been completed by an outside resource, whereas other participants relied on the knowledge provided by the resource after a suicide risk assessment to direct their approach. In one of the practice examples Participant 3 provided, s/he described using the knowledge of a risk assessment being completed by a psychologist at a youth custody centre: "Then he was sent back to the [custody] centre for assessment – for risk assessment with a psychologist there and then he came back a few days later, business as usual." For Participant 3, the knowledge of the assessment directed his/her practice to resume to "business as usual." In another encounter, Participant 3 described his/her knowledge of a youth accessing a mental health resource. Participant 3 explains, "We did send her to [child and youth mental health

resource] for a risk assessment, she went in the door and that's as much as I know.”

Subsequently, Participant 3 describes using instinctual knowledge to direct his/her actions, based on knowing that the youth had an assessment. Knowledge derived from a person's inner experience of instinct, gut feelings, or intuition can be viewed as instinctual knowledge. Participant 3 recalled, “She had gone through a child and youth mental health assessment so it was just more of ahh... providing... I guess I just drew off of instinct offering support.” Participant 3 was aware that the youth had gone through a formal risk assessment conducted by a mental health clinician. Participant 3 described using instinctual knowledge to direct his/her approach with the youth in providing support as s/he was aware a formal assessment had been completed.

Similarly, Participant 1 used the knowledge of a suicide risk assessment being completed by a community resource to further inform his/her actions. Knowing a formal suicide risk assessment had been completed by a community resource guided Participant 1 to implement an approach with the youth that was derived directly from the outcome or risk rating of the assessment completed by the community resource.

My experience is that the youth had already been assessed by [emergency mental health team], usually... So there had already been an assessment there. They had done high, medium, low... Sort of follow through with whatever plan was around that.

Participant 4 also stated that s/he contacted a community resource for a suicide risk assessment. Participant 4 described sharing the knowledge s/he had about the potential suicide risk for the youth involved, and the knowledge from the community resource which further directed his/her approach. Participant 4 described his/her thought processes

around initiating contact with the community resource: "So we've talked about it, we've talked about what you've done and what's happening for you. Let's call [emergency mental health team], have a chat with them and see where you need to go." Participant 4 contacted the community resource with the intention of obtaining further direction and knowledge as to employing his/her next step with the youth: "And I remember calling them on the phone and saying this is the situation, this person's attempted x amount of times and here we are today, and she's talking about attempting again, right?" After the staff person at the community resource spoke directly to the youth, they informed Participant 4 to "check in" with them at a later time as they had determined the youth was not at imminent risk of suicide.

Participant 2 also accessed a community resource for a suicide risk assessment and received knowledge from that resource that the youth was not at risk:

He had an appointment with his doctor so we thought we would get his doctor to assess him. We went to see his doctor who said to him, 'If you don't want to move you don't have to that's stupid.' And I said, 'Could you please talk to him about his... He told me that he was going to kill himself, commit suicide.' And he said, 'Well you're not going to that's just dumb.' And then he said, 'If you don't want to move you don't have to. I'll phone your social worker and let her know.'

Participant 2 connected with the youth's doctor to assess the suicide risk of the youth in his/her care. The doctor determined the youth was not at risk and directed his attention to the youth's current placement situation.

Theme b) Discussions with Professionals

Some of the participants sought out knowledge from professionals to ascertain direction in providing support to the suicidal child or youth they encountered. Participant 1 reported having “discussions with [social] worker, discussions with mental health” that “influenced what I was doing for sure.” Participant 2 also contacted the youth’s social worker to further inform her actions with a suicidal youth: “So I phone the Ministry and talk to his social worker and he was put on 24 hour suicide watch until he was relocated.” Similarly, Participant 4 contacted the social worker for further knowledge in directing his/her approach. When asked by the researcher what the social worker did in the situation, Participant 4 explained, “Because her attempts had all been around overdosing, just ensuring that we were removing that from her environment.”

A few participants described contacting professionals as a source of knowledge to guide their encounters with suicidal children and youth, and experiencing limited feedback or direction. As Participant 5 explained, “We would contact the [Ministry of Child and Family Development] and After-hours would take the call and we’d say this is the scope and they’d say, ‘O.k.’” Right? So we wouldn’t really get any feedback from them.” For Participant 3, the contact with a professional provided him/her with knowledge that the youth’s suicide attempt was “an attention thing.” The knowledge that the professional had “closed off” the suicide attempt steered his/her approach in speaking directly with the youth about the incident. Participant 3 explained his/her contact with a professional:

...inappropriate channel of information through the grape vine. It didn't come from the youth to me. Yeah, it came from somebody else that heard through someone at mental health and it got back to me that she had attempted. I wanted to talk her about it and see where she was coming from, what her intention cause that inappropriate sharing disclosed to me that it closed off as an attention thing I wanted to make sure, because I knew her a little bit.

Participant 3 described hearing about the youth's suicide attempt from a professional in the community through sharing of information. Participant 3 desired to speak to the youth directly about the information based on his/her relationship with the youth and a wish to find out what the motivation was for the youth attempting suicide. Participant 3 did not accept the information that the youth's motivation was to gain attention from others at face value. Rather, s/he wanted to find out from the youth directly, based on their relationship and knowing her, what the youth's experience truly was. The discussion with another professional led Participant 3 to speak with the youth directly about her suicide attempt.

Metatheme 4 – Personal Experience as Source of Knowledge

Theme Cluster 11 – Self-Knowledge in Practice

Some of the participants highlighted various aspects of self-knowledge in their practice with suicidal children and youth that guided their actions or approach. They described emotional cues, intuition, or gut feelings that influenced their responses to the children and youth in their care. One of the participants in particular reported a personal history with depression that provided her with knowledge in her encounters with suicidal youth. Within this theme cluster, the following two themes emerged from the

participants' descriptions: Personal History, and Emotional Cues, Intuition and Gut Feelings (see Table 2.).

Theme a) Personal History

Participant 5 described his/her encounter with a youth who appeared withdrawn and sad. Participant 5 valued knowledge of his/her own personal history to steer his/her approach in addressing the youth's presentation and his/her concerns that the youth was suicidal. Participant 5 explained that s/he had asked the youth directly if he was thinking of suicide, and reported that the youth stated "I would never do that." Participant 5 described his/her knowledge of his/her own personal history of suicidality, and how s/he would have responded to direct questions regarding thoughts of suicide.

He just seemed so sad and there was so much withdrawal, and... And so I look at some of my history and think, you know if you had've asked me flat out, 'Are you thinking of...?' 'No! Don't be stupid. I would never do that!' And then I would have made a joke and 'Ha, ha, ha...' and ended up putting myself in the hospital a couple of times, but absolutely not. Like I would never have admitted it because you know, the masks are too big and all of it is just kept so deep a lot of the time. That it just, as a kid I know I never would have said that, unless I wanted to say that to use it for some reason, right?

Participant 5 also found the knowledge gained from his/her personal history of depression and suicide to be a "fit" with some of the youth in his/her practice. This knowledge informed him/her to use self-disclosure to connect with youth struggling with similar issues and concerns. The knowledge that his/her experience of suicidality may be similar to the suicidal youth s/he works with illustrates the use of personal history to facilitate

connection with the youth. Participant 5's increasing comfort in disclosing personal history of depression and suicide allows him/her to access and use this knowledge in his/her practice with suicidal youth.

Especially the more I learn about suicide and suicidal behaviours and recognize that some of the stuff that I know because of who I am really fits for other people who are like me, right? Umm... And that I need to be able to draw on that more and now I'm really comfortable in being able to say to kids, 'You know what? Cause they'll say somebody talked about taking meds, and I'll say, 'I take meds, I take anti-depressants you know, best thing in the world if it works for you, right?' And so I'm quite comfortable in saying that now.

Theme b) Emotional Cues, Intuition and Gut Feelings

Three of the participants reported drawing on knowledge from their own emotions, intuition or gut feelings to guide their actions in their encounters with suicidal children and youth. The participants that used knowledge derived from their own emotions, intuitions and gut feelings were mindful of their own experience in their encounters with suicidal children and youth. As these participants tuned in to their own experience, they used this self-knowledge to direct their approach. For example, Participant 2 took knowledge from emotional cues s/he experienced in his/her close relationship with the youth and accessed additional supports to prevent personal bias infringing on his/her practice being effective.

I needed to be double staffed in that situation because my emotions could bias my decisions and I was very close to him and I wanted him to get the best possible assessment and treatment.

Additionally, Participant 5 described the self-knowledge that s/he drew from as “instincts” and “gut feeling” that led his/her discussion with a suicidal youth. Participant 5 observed the youth’s presentation of being withdrawn and sad. The youth s/he worked with would state that he had thoughts of suicide, but that he would not act on them. Even though the youth minimized his risk of suicide, Participant 5 drew on his/her self-knowledge of instinct, gut feelings, and how s/he observed the youth to continue to discuss the youth’s level of suicidality with him.

I have pretty good instincts here. And you know that was the sort of thing that I'd say to him. Really you know, I've done this sort of thing for a long time and really I go a lot by my gut feeling and stuff and really this is what I'm reading from you.

Participant 3 also accessed knowledge through his/her instincts and gut feelings about his/her encounter with a suicidal youth in the wilderness camp. Participant 3 stated that s/he “drew off of instinct.” In a more recent practice example that Participant 3 provided, the self-knowledge of “being comfortable with who you are, to talk about it... and feeling comfortable with that” represented a shift. Participant 3 explained, “It’s kinda a shift from being all instinct and gut reaction.” Participant 3 still relied on self-awareness and intuitive knowing as a source of knowledge in his/her approach, however s/he relied less on instincts and gut feelings in the recent practice example provided. Instead of full reliance on a gut response to the encounter, Participant 3 described relying on self-knowledge and being comfortable to discuss suicide with the youth s/he was working with.

The participants’ descriptions of the knowledge they valued in their encounters with suicidal children and youth indicate the vast sources of information they were

managing in the intervention. Knowledge from educational sources, from the client themselves, professional knowledge, as well as knowledge from participants' personal experiences, were used to guide and inform their approach in their encounter with a suicidal child or youth.

Many participants brought knowledge from specific training in suicide prevention and intervention to their encounters with suicidal children and youth in asking directly about thoughts of suicide, determining the child or youth's suicide risk, and developing a plan to keep the child or youth safe. For some participants, epidemiological knowledge pertaining to populations who are at greater risk for suicide influenced the level of concern for the suicidal child or youth. A small number of participants relied on their knowledge of child and adolescent development derived from academic sources. The majority of participants used knowledge from agency forms, materials, risk assessment checklists, and development of safety contracts in their encounters.

The knowledge gained from direct experience and observation with the child or youth guided the practice of all of the participants involved in this study. The relationship they fostered with the child or youth in the context of providing support, connection, and being accessible and physically present provided participants with knowledge of the current functioning and level of psychological pain the child or youth was experiencing. Knowledge of the child or youth's history and mental wellness also guided the majority of the participants in their approach in their encounters.

The majority of the participants also relied on knowledge derived from their professional role in the children and youths' lives and their previous professional experience. Professional experience with the issue of suicide provided participants with a

degree of comfort in their discussions with suicidal children and youth and the knowledge of the agency's procedure for responding in these encounters. For three of the participants, knowledge of their duty to report incidents where there is a risk of suicide or self-harm guided their response to the encounter in informing others of the situation. All of the participants contacted their supervisor, and some of the participants also informed their colleagues of the child or youth's suicidality. Some participants also used knowledge gained from accessing additional community resources, such as the hospital or mental health professionals.

Some of the participants relied on knowledge of their own personal experience to guide their approach to suicidal children and youth. Only one participant described a personal history with suicidality that informed his/her approach. Other participants described sensory knowledge of their own emotions and gut feelings that influenced their encounters with suicidal children and youth.

These themes will provide the context for understanding the participants' emotional and physical responses to the encounters that were at play in the midst of the sources of knowledge participants' were drawing from.

Section 3: Participants' Physical and Emotional Responses to Suicidal Children and Youth

Theme Cluster 1: Initial Indicator of Suicide

The participants described intense responses within the initial moments in their encounters with suicidal children and youth. For the majority of the participants, the responses they experienced were emotional. Some participants also described physical responses to their initial involvement with a suicidal child or youth. The initial moments include both obtaining the initial referral or statement from a child or youth that

indicated suicide as an issue, as well as the first moments in meeting the child or youth face. For some of the participants, the initial referral occurred in written form, whereas other participants received a phone call, information was passed on by an involved professional, or the child or youth disclosed thoughts of suicide. The initial referral impacted participants emotionally and physically from their descriptions. Emotions experienced by participants included fear, urgency, disconnection, isolation, confusion, and a sense of responsibility. Physical responses to the initial indicator of suicide included anxiety, stress, and a rush of adrenaline, sick, nervousness, and feeling bombarded. The physical and emotional responses to obtaining the initial indicator of suicide were intertwined in the descriptions provided by participants. Within this theme cluster, the following four themes emerged from the participants' descriptions: Fear and Anxiety, Urgency, Responsibility, and Isolation, Adrenaline and Sick Feelings, and Bombarded and Surprise (see Table 3.)

TABLE 3. Participants' Physical and Emotional Responses to Suicidal Children and Youth Summary of Theme Clusters, and Themes

<i>1) Initial Indicator of Suicide</i>	<i>2) Connecting</i>	<i>3) Providing Service</i>
<ul style="list-style-type: none"> a) Fear and Anxiety b) Urgency and Responsibility c) Bombarded and Surprise 	<ul style="list-style-type: none"> a) Scared b) Relief c) Awkward d) Relaxation and Decompression 	<ul style="list-style-type: none"> a) Relationship with Client b) Assessment and Risk Management c) Aftereffects of Encounter

Theme a) Fear and Anxiety

Two of the participants described responses of fear and anxiety in the receiving the initial indicator of suicide being an issue for the child or youth. Participant 1 described receiving a written referral for a youth who recently attempted suicide. In the example provided by Participant 1, s/he described an experience of “fear and anxiety”. Participant 1 explained, “Definitely fear and anxiety at first, like holy smokes!” Anxiety and stress were additionally experienced by Participant 1 as s/he had difficulty contacting the youth or his mother.

Yeah, without making phone contact, no one was home at that point so you feel sort of... yeah. And again saying to the [Social] Worker ‘Yup, haven’t reached her, messages, swung by the place no answer.’ Yeah... so there’s a little bit of anxiety there. Yeah, so that was a few days before actually speaking to someone who knew the family so that was very stressful.

Participant 1 further described the emotional and physical response to the referral that were perpetuated by his/her thoughts: “Like most referrals, it’s been a roller coaster ride, so you have the initial and you try not to do it, but you always, sort of that worst case scenario thinking, when you first get a referral. So that creates its own sense of anxiety.”

Anxiety, or feeling anxious, was also described by Participant 4 in combination with other responses to the initial referral. Participant 4 explained, “So the going into is that real, just sick, yeah, nervous, anxious.” Upon receiving the referral that the youth was struggling with suicidality, Participant 4 experienced a range of emotions and physical sensations. Sensations of feeling sick, nervous, and anxious overwhelmed Participant 4 at the prospect of a life and death crisis at hand.

Theme b) Urgency, Responsibility, and Isolation

Emotional responses of urgency and a sense of responsibility were described by three of the participants. In Participant 1's description of obtaining the initial referral, urgency was present to "make sure that everyone is safe and that there's not going to be another attempt." Participant 1 also expressed a sense of responsibility for the life of the youth.

You want to try and handle this one as best you can and your safety. The first thing you think about is safety, of course. And you want to do your best. And if there is that everything is in place to you know hopefully save a life kinda thing. So you feel that way when you have that type of referral.

Participant 3 also described a feeling of urgency to talk with a youth and responsibility to protect the youth that s/he had heard attempted suicide. Participant 3 explained, "Yeah, I wanted to make a connection with her and see what I got. Get a protective kinda thing, make sure it was o.k."

Similarly, Participant 4 also described feelings of responsibility for responding to the suicidal youth. Participant 4 explained:

I would be the person that would be responding, like nine times out of ten. So it was, yeah, it was just always that sort of feeling I know other people know and I know other people are trying to be supportive, but it will still be me.

The emotional responses to the phone call requesting his/her service for a suicidal youth also included emotions of isolation and feeling alone particularly for Participant 4. Participant 4 made several statements indicating an emotional response of feeling alone that also indicate feelings of responsibility: "There's not that much support out there for,

for the people that are in those positions, and you know that going in, like you know that it will be you, you know and that's all that it's ever going to be." Participant 4 later reports, "Just that real feeling of I know I'm going on my own." Even though others were aware of suicide being an issue for the youth, Participant 4 still described feeling isolated. Many resources provide service in a limited capacity to suicidal children and youth depending on the child or youth's imminent risk of suicide. For Participant 4, service was not limited by the youth's level of crisis, but rather encompassed a wider level of support in the context of an ongoing daily relationship. Participant 4 experienced isolation in providing service to the youth as s/he had more direct involvement with the youth than other professionals on the periphery.

I guess I think that when I think back it was it was just... although people are involved like although people know and people are aware of the situations it still it still pretty... it's still pretty isolating cause you knew it would come to me.

Theme c) Adrenaline Responses and Sick Feelings

One participant described additional physical responses to a phone call requesting service for a youth who was suicidal including adrenaline rush and feeling sick.

Participant 4 experienced an initial adrenaline response to the phone call:

I couldn't tell what was going to be next so it was that real adrenaline sort of (gasp) you know, 'Ah!' Is this it? Is this going to be the time? Is this going to be the day? You know and am I going to get there and is she going to leave and is she going to... is she going to want to process this, is she going to... you know?

For Participant 4, the adrenaline response was coupled with physical feelings of being sick: “Just that sort of sick, that sick feeling in my pit of my stomach... that sick feeling not knowing what to expect.”

Theme d) Bombarded and Surprised

Two of the participants described a response of surprise or feeling bombarded upon learning of a child or youth's suicidality. In the practice example provided, Participant 2 encountered a suicidal child. S/he reported that s/he learned of the child's thoughts of suicide in a direct statement made by the child: “One child, 8 years old, said that he was going to kill himself... he didn't like being in care and he was going to kill himself.” When faced with this initial indicator of suicide being an issue for the child, Participant 2 described an emotional response of feeling “bombarded by that information.” This emotional response included a physical response of surprise as the other family members present responded. Participant 2 explained:

I just sat there for a moment because his mother and his grandmother were present, and his mother said, 'oh you don't mean that.' And his grandmother just goes, 'He did try before, he climbed up to a 10 story building and walked up to the ledge and was going to jump off of the roof.'

When first learning of suicide being an issue for the child, Participant 2 “sat there for a moment” as s/he absorbed his/her emotional and physical responses. Participant 2 was surprised when s/he learned that the child had previously attempted suicide as he was only eight-years-old, and that the family had not responded with a high level of concern to the child's suicidality.

I think that my bombardedness came from the fact that both of these adults had this previous knowledge and dismissed his statement when he made it. So the situation then to me felt surreal and I couldn't understand.

Participant 2 could not comprehend the lack of response the boy's mother and grandmother had to his direct disclosure of thoughts of suicide. Participant 2's surprise at the dismissal of the boy's suicidality by the family led to feelings of being bombarded by the information. Participant 2 needed to act on the information that the child had thoughts of suicide and that no one was responding which may have led to feelings of being bombarded by this knowledge and surprise that it had been dismissed up until that point.

Participant 4 described a response that indicated surprise upon learning directly from a youth that she was thinking of suicide. Participant 4 explained his/her unexpected encounter:

Hadn't talked about suicide in the past, but I remember we were out for coffee and we were downtown and we were sitting having coffee and she just goes, I think she had said something to the effect of, 'Oh I think I'm going to kill myself today,' Right? Really? Oh o.k., so we'll shift gears like it had been just oh we're hanging out for coffee and turn into now I'm going to kill myself.

Even though Participant 4 experienced surprise at the youth's disclosure of suicidal thoughts s/he was able to respond

Theme Cluster 2: Connecting

Some of the participants identified emotional responses to an initial meeting or contact with the child or youth after having learned of the child or youth's suicidality. In addition to experiencing an emotional response to connecting with the child or youth, one

participant in particular also described having physical responses as well. Emotional responses that were described by participants included feelings of being scared, feeling relief, and feeling awkward or hesitant. Physical responses described by Participant 4 included decompression and relaxation. Within this theme cluster, the following four themes emerged from the participants' descriptions: Scared, Relief, Awkward, and Relax and Decompression (see Table 3.).

Theme a) Scared

One participant in particular expressed feeling scared. Participant 3 described emotions of feeling scared in the encounter with a suicidal youth while still remaining in the connection.

I just remember the emotions at the time, I was scared, so my approach was if I was told to go do something, I did. But otherwise, I sat and tried to talk with the youth and stayed with that.

Theme b) Relief

Participants also described emotional responses to connecting with the suicidal child or youth that included a sense of relief. After having made contact with a youth who had recently attempted suicide and his mother, Participant 1 described his/her emotional experience: "It's like, oh good, they're alive. So there's a relief there." Participant 4 also noted an emotional response to being able to see the youth alive when they were able to connect.

Once I get in the door than it's a different response because I can see her I can you know, I can sort of see where she's at, I can hear how she's speaking, you

know? It's a different; it's just a different reaction it's just being... I'll be there with her to get through what ever it is going on right now.

Participant 1 experienced relief, or “feeling better” once the direct contact with the youth and his mother occurred. Participant 1 had some initial difficulty connecting with the youth and his mother after receiving the initial referral that requested follow up for the youth’s recent suicide attempt. Once Participant 1 was able to meet the youth and his mother face to face, s/he observed that they were motivated to address the issues in their relationship. Participant 1 observed energy between them that brought a sense of relief over him/her.

Then their little bit of scheduling jostling to get that first initial meeting, but then again once I got the face to face um... There was enough fire in both of their eyes. They were fighting for something. Didn't know what, but they were motivated. There wasn't that blank apathetic look. There was... They were alive, so I felt better too.

Participant 1 further explained his/her relief in being able to connect with the youth and his mother. Participant 1 experienced feeling “better” once a relationship had begun and a connection occurred and s/he was able to see the mother and the youth as people, not simply a referral on a piece of paper that indicated a youth’s suicide attempt.

Then you generally meet with the family and ok you feel a little bit better cause you know the people, you know that they are more than what ever the issues are and that there's other stuff.

Theme c) Awkward

In connecting with the suicidal youth, Participant 1 also described “awkward” feelings and emotions. Participant 1 displayed hesitancy in addressing the youth’s suicide attempt. Participant 1 noted, “I was tempted not to cause I was thinking that this was my first meeting, so should I sort of not go there yet, and found myself doing that a bit. And then I thought, I just got to say it.” In the initial connection with the youth, Participant 1 experienced emotional responses that delayed bringing the issue of suicide to the discussion that created feelings of awkwardness and doubt as displayed by his/her questioning.

We had started off on that positive humour, sort of 'I'm o.k., you're o.k.' foot. So it was sort of ... If you're in that space, making the transition to a fairly serious issue feels sort of awkward. So I delayed it a bit talked around some of the other stuff first and then just finally got it out. And I think part of that is helpful with our program orientations too just going through, here's what I know, part of the reason why I'm here. We can always choose to delay that, if we think that for some reason you know sharing that information is going to completely damage whatever connection we have you know the thought crossed my mind you know do I want to do this right now? Do I want to go through this stuff now? Should I wait?

Participant 1 was able to navigate through emotional responses of awkwardness by using the program orientation package to bring the issue of suicide to the discussion. The program orientation package included informing the mother and youth the reason for the referral to the program Participant 1 worked in. Participant 1 was able to introduce the

issue of suicide through the process of explaining the program and the services it offered to the family. Even though Participant 1 experienced awkward feelings in bringing the issue of suicide forward, the program orientation provided an opening to the discussion.

Theme d) Relaxation and Decompression

Participant 4 described physical responses to connecting with a suicidal youth that included experiencing relaxation and decompression. After connecting with the youth and listening to her reasons for dying, the youth was able to release some of the pain she was experiencing and relax. Participant 4 observed this shift within the youth, and described his/her relaxation and decompression that occurred once they had connected.

Participant 4 explained:

At that point I'm talking about her talking about her wanting to be dead, and you kind of get that sort of immediate reaction, but then sort of being able to talk around and just look at the pieces surrounding it and decompress. And as she relaxed more, then of course then I would relax more.

As Participant 4 connected with the youth in person and addressed the issue of suicide, Participant 4 experienced the physical response of him/herself relaxing and decompressing.

Theme Cluster 3: Providing Service

Participants described emotional responses to suicidal children and youth in their care throughout the provision of service. No specific physical responses were noted by participants in their descriptions of providing service to the child or youth. Emotions were experienced by participants in response to the relationship with the client and during the process of assessing risk of suicide for the child or youth. Participants also expressed

emotional responses to the plan for service, as well as physical and emotional aftereffects of providing care. Within this theme cluster, the following three themes emerged from the participants' descriptions: Relationship with Client, Assessment and Risk Management, and After-effects of Encounter (see Table 3.).

Theme a) Relationship with Client

Four of the participants described experiencing emotions particularly in response to engagement in relationship with the suicidal child or youth. For a number of the participants the relationship was noted in the context of connection. Connection was experienced as both being present physically with the client and emotional closeness. Participant 2 noted his/her emotional connection to a suicidal youth in acknowledging her relationship with him: "My emotions could bias my decisions and I was very close to him." Participant 3 reported an emotional response of connection in his/her description of what was most helpful in his/her approach: "Just being able to talk to her about it was the best thing." Participant 1 described a process of making connection through humour with a youth and his mother and experiencing relief as his/her relationship with the clients grew:

And sort of keyed on her humour right away too so that felt o.k., so that felt much better. And of course she described that Joe's here and he's doing ok, he's actually doing a little better, we're still having our issues, starting to go down there. But it was o.k. He's alive though.

Alternatively, Participant 4 described his/her relationship with a suicidal youth as the physical presence s/he had in providing support: "She just really stands out for me because there was just several times, there was a lot of times, where I was more at the

hospital than I was at home.” In providing direct service and support to the youth within the context of physical proximity, Participant 4 found that s/he spent a lot of her time with the youth in the hospital setting due to the youth’s suicidality. The relationship Participant 4 fostered with the youth included being physically present and available for the youth during her suicidal crises.

The context of the experience of connection also was included by some participants as the disconnection or lack of closeness they experienced. Participant 2 described emotional responses to the loss of physical connection when the youth s/he was working with was placed in a foster home with other staff providing support for him. Participant 2 experienced feelings of loss in the relationship as disconnection occurred.

I felt that he had brought this to me because he trusted me, and then I was removed from that situation. So then that could be my own ego, but if I had had... If I had been able to have more contact with him, because he and I were the ones that had the relationship I don't know how that would have played differently, but I felt that I had been removed.

Furthermore, Participant 2 described mixed emotional responses to disconnect in the relationship with the youth as other staff took over the care of him. Participant 2 expressed a desire to be present with the youth and a sense of loss, while at the same time having emotions of happiness that the youth is safe, feelings of trust in the staff to care for him, as well as allegiance to his/her profession.

So I was happy that he was safe and I completely trusted my coworkers to maintain his safety, I just wish that I could have been more present for him because I didn't want him to think that I that that was something that I couldn't

handle. And when he left, when he was moved, there was a sense of loss because I had no contact with him, and ... We're not supposed to in this profession – once service ends in this profession you can't maintain contact for two years or something along those lines.

Theme b) Assessment

Participants experienced various emotional responses to the process of assessing suicide risk for the child or youth they encountered. Descriptions included emotions in response to their own assessment of suicide risk, as well as responses to accessing outside resources to assess risk. Emotions ranged for participants from relief and comfort, to worry, anger and frustration.

An emotional response of relief was experienced by Participant 3. In one of the practice examples Participant 3 provided, a female youth had been assessed for suicide risk at the hospital and determined to be at “low risk.” Participant 3 experienced relief knowing the assessment had been completed and described being able to focus on how to support the youth.

In this case I felt that... umm... a bit of relief that she wasn't in that state because I am hoping that, she was admitted if she was at higher risk. So because she wasn't then umm... she was at low risk. She just was lost, and didn't know what to do, and that is something that supports in her life can draw on or else provide her some direction. She needs the terms to know what to do. So now she's not lost anymore, she knows what to do.

Participant 3 also experienced an emotional response of a sense of urgency in his/her encounter with the female youth. Participant 3 explained that s/he had a “real

sense to get the successes happening...We actually ended up doing some really creative funding through the [Ministry of Children and Family Development] to make some successes happening.” This sense of urgency was echoed by Participant 2 during his/her initial assessment: “I knew that this could be a temporary solution that he would... if it passed and if he was safe while he got through this that he could be successful so my goal then was to get him there.” The sense of urgency for Participant 3 and Participant 2 may have stemmed from suicide being a decision that includes the finality of death. Participant 3 and Participant 2 were able to envision a future beyond the immediate crisis the youth was experiencing and felt the urgency of increasing the youth’s options beyond suicide.

Feelings of curiosity and doubt were experienced by Participant 1 when trying to discuss with a youth the current risk of suicide and how the youth understood his previous attempt. Participant 1 experienced confusion in understanding how the youth could now be presenting with clarity as s/he conducts an assessment of suicide risk. Participant 1 queried the youth on his thoughts and feelings prior to his suicide attempt. The youth was not able to provide Participant 1 with a clear explanation of what was happening for him at that time. Participant 1 was confused by the youth’s current presentation of being clear in his thinking and the youth’s inability to provide an explanation for his suicide attempt.

He still couldn't, you know the whole time there he wasn't able to go there with me in terms of really in the moment, why? At that real cross roads and where you've got that bottle, and you're, should I do this or not? Not that he needed to and he apparently didn't, although throughout service that was my curiosity.

What was that like? How'd you actually do that, like you know? Cause you know at this point in time you're presenting as someone who's pretty clear, has a lot of clarity in their thinking.

Participant 5 also experienced emotions of doubt during an assessment with a youth who disclosed to him/her that he was not presently suicidal. Participant 5 knew the history of the youth's depression and suicidal thoughts and described concern about the youth's presentation. Participant 5 experienced a response of doubt upon hearing the youth's repeated negative answer to questions of suicide. Participant 5 explained, "If he says no, shouldn't I just respect that? You know I can tell you over and over and over again, this is really what I'm feeling from you, but if you keep telling me, 'you know what you're wrong.'" Some of the emotional response of doubt was mediated by discussions with his/her colleagues and supervisor the following day after his/her assessment of suicide risk.

At times usually I'm, you know, I'd be back to work the next day and talk to my colleagues and talk to my supervisor and maybe even talk to him about it and that often would help lift some of that.

Two of the participants discussed accessing medical assistance in assessing suicide risk for the children or youth. Participant 2 described taking a youth who had just disclosed thoughts of suicide to his physician. Participant 2 reported s/he "felt awful" and "disheartened" after accessing the physician who reportedly invalidated the youth's experience and emotions.

We went to see his doctor who said to him, 'If you don't want to move, you don't have to. That's stupid' And I said, 'Could you please talk to him about his... he

told me that he was going to kill himself, commit suicide.' And he said, 'Well you're not going to that's just dumb.' And then he said, 'If you don't want to move you don't have to I'll phone your social worker and let her know.' So that was very disheartening because my hope was that he would, knowing this youth for years as a patient like he... I don't know... He invalidated... I don't know what he did but it was awful.

The physician did not seriously consider the youth's suicidal comments as needing focus and directed his concerns towards the issue of the youth's change in foster placement.

Participant 2 experienced the physician as not validating the emotional experience of the youth and the level of psychological pain he was going through.

Participant 4 also accessed medical services in the assessment process for a suicidal client. Participant 4 experienced emotions including futility, frustration, and disconnection in his/her attempts to convey to the medical personnel at the hospital the client's risk of suicide.

Like I was at the hospital last night and ah...And the doctor...And so you know you wait of course you always do. And then the crisis is over cause you've waited so damn long that people are just tired now, right? And so we wait and we get in and the nurse does her assessment. And then the doctor comes in and the doctor was like, 'Hey what do you want me to do for you tonight?' in this tone. And we're all kind of like, 'Is this for real?' ... And um...We tell the situation. The situation is already documented. We know he's read the notes, so we tell the situation again and you know the question is, 'So are you going to hurt yourself?' And the person says, 'Oh god no.' 'Well alright then, I've got people out there

with heart attacks and car accidents so if I can't do anything for you then... ' Data... right? And so this is the system... That's the exact... I haven't had a different experience. It's so frustrating and ah... It's just frustrating... It is so frustrating. And like I said I'm not an advocate for people going to [psychiatric ward]. I don't always think that it's the place to be, but there's this significant disconnect around what is out there.

Participant 4 brought a suicidal client to the hospital for further assessment of suicide risk. After a long wait in the emergency room, the youth was seen by a doctor. Participant 4 described the physician's quick response in assessing the risk of suicide. The youth stated that he was not going to hurt himself, which ended the physician's assessment. The physician informed Participant 4 and the youth of the other patients concerns of accidents and heart attacks and did not provide any further service to the youth. Participant 4 experienced accessing a suicide risk assessment from the hospital as frustrating as the youth's suicidality was not taken seriously, even though it had diminished due to the long wait in the emergency room.

Participant 2 also experienced disconnection after eliciting assistance from a foster parent in determining and managing a child's risk of suicide. Participant 2 explained, "I did have a sense of powerlessness for his safety when I gave his needs to others... then I had to take a back stage to the [Ministry of Children and Family Development] and the foster parent." Feelings of anger and sadness were also emotions Participant 2 described in response to others' determination that the child was not at risk of suicide.

With the 8 year old, when I gave that to his caregiver, they didn't handle it in the way that makes sense to me; they dismissed it as did his parents, right? And I felt horrible...angry maybe, but mostly really sad for this child cause he was really... hurting and again was not validated for his experience.

Participant 2's anger and sadness in response to the lack of follow up with the child who had expressed thoughts of suicide perhaps stemmed from differences in understanding of the risk to the child's life. The level of psychological pain the child was experiencing may not have been understood by the foster parent and social worker involved. As well, Participant 2 did not have professional authority in his/her relationship with the foster parent and social worker, and may have experienced an emotional response in not being able to determine how the child's suicidality was addressed.

Theme c) After-effects of Encounter

Some of the participants described emotional and physical responses that occurred after their encounters with suicidal children and youth in their practice. Participants described physical responses including stress and fatigue. Emotional responses after the encounter described by participants included self-doubt, worry or fear, loss, and frustration.

The physical effects of fatigue were reported by three of the participants. Participant 4 noted his/her physical response of feeling tired after the encounter. Participant 4 explains that his/her fatigue stemmed from the events in accessing outside resources for the client.

So by the time we had sort of come through this day, I was tired. I was super tired but I felt like... And because it's been so ongoing that I really felt that I was in an

o.k. place around the conversations that we had. I was not in an o.k. place about the whole series of events around our health care and mental health care system because it's a nightmare.

The aftermath of a life and death crisis may result in physical effects of fatigue due to the intense emotional experience Participant 4 had in his/her encounter with the suicidal youth. As well, Participant 4, similar to all of the participants, were drawing on various sources of knowledge, and was in contact with other professionals in attempting to provide care to the suicidal youth over a number of hours.

On the other hand, Participant 5 reported physical after-effects of sleep disturbances after his/her encounter with a suicidal youth. Participant 5 noted, "Just having those weird dreams where you wake up feeling really unsettled." Participant 2 also experienced physical responses to the encounter that included loss of sleep. Participant 2 stated, "I cried about it, I may have lost sleep just thinking about what I could have done differently and just reflecting on that and what I will do differently in the future."

The physical response of stress was also reported by two of the participants. After leaving the encounter, Participant 4 described carrying the stress related to the incident home and into the days ahead.

After the initial, it's still you carry that stress home, you know, for me. I'm sure not everybody does but I do. And I carry that and I take it home and I think about it and umm... yeah... Could I have said this differently? You just process, process and kind of... I do over process things, but um.. Yeah I definitely carry that until...

until we're sort of seemingly back into some sort of routine that isn't around a crisis, right?

In the aftermath of an encounter with a suicidal client who had very limited resources, Participant 4 described the stress of understanding the nature of the client's situation. Participant 4 explained, "I carry that, like I know that this is really pervasive and this person's extremely isolated... so I definitely carry that."

Participant 5 also described "carrying" the encounter with a suicidal youth home and the difficulty in alleviating the stress:

...knowing it's because you're carrying this. I was self-aware enough to know that that it was work related that the differences you know... Be able to say to my friends and my colleagues, 'You know what? I'm really having a hard time with this,' but not be able to do a lot with it, right? That was a big part of it, was just feeling like I didn't know what to do with this stuff, for him, for me, it was messy.

Some participants also described emotions of self-doubt in the aftermath of an encounter with a suicidal child or youth. Participant 4 discussed the drive home after leaving an encounter with a suicidal youth when s/he questions the quality of support s/he provided: "But then there's that driving home, God did I? Was I supportive? Did I support the way she needed to be supported? Did I...? Am I going to get a call in an hour?" Questioning the approach taken in the encounter after it was over also was described by Participant 5. Participant 5 explained, "There were times that I'd go home and just have this weight on my shoulders cause it just felt like I'd missed something."

An emotional response of loss was also described by some participants after the encounter with the child or youth. Participants longed for opportunities that were lost in

the moments with the youth. Participant 1 described trying to understand the youth's suicide attempt with the youth, and his unwillingness to explore the incident: "I tried different sort of angles, you know, at talking about or trying to see if I could get him talking about what his thinking was to attempt." In the time after his/her work with the youth and no exploration of the attempt occurring within the encounter, Participant 1 noted, "I just felt like it's a missed opportunity, a lost opportunity." Participant 2 also described feelings of loss: "I just wish that I could have been more present for him because I didn't want him to think that that was something that I couldn't handle." In the example provided, Participant 2 was replaced by other staff members after attempts were made for the youth to be assessed for suicide risk. In the aftermath of this encounter, Participant 2 described his/her emotional experience: "To visualize it it's like you know when someone just pushes you aside and then everyone gets involved in chaos, that was what it was like."

Two participants also reported emotions of worry or fear as after-effects of their encounter with a suicidal child or youth. Participant 5 described working with a youth who struggled with depression and thoughts of suicide within a residential program. The aftereffects of practice with the youth of fear and worry were experienced particularly when s/he would return to the program the following day and the youth had left.

...just that feeling, that consistent feeling there. And then to go back and have him not there. So I couldn't even sort of check in with him or anybody else, 'Well you know he went out at 4 in the morning and he hasn't come back.' Crap... you know? And then you have that fear as well, what if I missed something and he goes and does something stupid.

Participant 4 also described experiencing fear after leaving an encounter with a suicidal youth and believing that s/he and the youth were “at the same place” as far as the risk of suicide. Participant 4 believed that s/he and the youth had reached an understanding or agreement of a plan to keep the youth safe. Additionally, as the encounter progressed Participant 4 described a movement through the initial suicidal crisis and was now at a place of lessened risk of suicide. The fear remained for Participant 4 that his/her understanding of their agreement or movement through the encounter was different than the youth’s understanding. Participant 4 explained:

Once you get to that point it’s that sort of feeling like o.k., we’ve gotten through this for this moment anyways. But it always ends up with, what happens after I leave? Then there’s always that like, that fear of well, that’s great, so we’ve come here and we’re - I think we’re at the same place, it seems like we are...

Feelings of frustration were also experienced by Participant 4 in the aftermath of an encounter with a suicidal client. In the encounter, Participant 4 brought the youth to the hospital for a suicide risk assessment. The medical personnel determined that the youth was not at risk for suicide, and sent Participant 4 and the youth home. Upon learning that the youth was struggling with issues related to suicide, the youth’s roommate brought the youth to the hospital again and she was admitted. Upon leaving this encounter, Participant 4 described her response to the incident:

I don’t know how she got her admitted, but she got admitted... for a couple weeks. It was actually a fairly long stay that she was in. And at that moment I think it was not a horrible idea. I think that she got more out of being there than not, and I spent a lot of time with her while she was in the hospital. I just remember going

what the hell? Like what the hell? Like why do we have a system that doesn't do anything? I remember leaving and going this is an absolute, like what, gong show. But that's always been my experience; I always have these experiences where we go it's like, laid out, people have expressed exactly what they're going to do, get to the hospital, they're assessed by [emergency mental health team], they're assessed by the hospital, and they're not at risk. This is a nightmare, it's a nightmare. And it's never... I can't say never, the only time I've had a different experience is when someone has arrived in an ambulance because they've already attempted. That is the only time I've had a different experience, and it's because yeah, they have attempted, like they are seen by the... there's action. Like outside of that, like forget it.

Feelings of frustration are evident in Participant 4's description in the aftermath of his/her encounter with a suicidal youth and in his/her attempts to access emergency resources. Participant 4 described a pattern of experience in accessing support for suicidal youth who s/he feels is at risk for suicide and being informed by other professionals with greater authority that the youth is not at risk and no support would be given. Participant 4's emotional response to the encounter may have less to do with his/her engagement with a suicidal youth, and more about the minimal response from other resources who s/he attempts to connect with to support the youth.

Participant 4 also describes feelings of worry and uncertainty when s/he discussed the aftereffects of an encounter with a suicidal youth. Participant 4 noted:

I don't think I ever sort of leave with the feeling of knowing that things will be good tomorrow. I don't think I've ever left with that feeling of things will be fine and we'll carry on and keep working on what we're working on.

Summary

This chapter introduced the five participants and their unique and common experiences related to encounters with suicidal children and youth in their practice. In Chapter Four I have attempted to present the participants' experiences in a rich and detailed manner as they were collected during the process of this study. The meaning of working with suicidal children and youth has been examined through considering how participants' described their encounters, the knowledge they used to inform their actions, and the physical and emotional responses they experienced during and after their encounters. The sixteen theme clusters that emerged through analysis of the data were presented using the words of each of the five participants with the purpose of illuminating and describing the essence of the experience. In the following chapter, I will discuss the significance and implications of these findings within the context of relevant literature, future research, and Child and Youth Care practice.

CHAPTER FIVE

Discussion and Implications

*These are the last words I write
Because I will take my life tonight.
A good son I was not
A good son you have always sought
I could have been a better friend
Instead I was all pretend
I was a horrible lover
Such that I could never recover
I could have been someone better
I wish I could have been someone better
Now I've taken the pills
And I'm starting to get the chills
The knife gleams
And my blood streams
I'm getting tired
Hatred is all I've inspired
After my eyes close
My blood no longer flows
Because my heart needs a jump start
I wish I could wait and see
What I must be*

Luke age 17 (Berman, Jobes, Silverman, 2006)

Introduction

In Chapter Five I will discuss the findings of the present study in relation to the relevant literature, the limitations of the study, and the future implications for research, and to Child and Youth Care practice as a whole. This chapter will encompass three main

sections. First, a discussion of the main themes in the context of the relevant literature on professionals' experience of working with suicidal clients will be presented. Secondly, the limitations and future possible directions for further research will be discussed. Finally, the significance of this study and the implications for Child and Youth Care practice will be explored.

The primary purpose of this phenomenological inquiry was to explore the essence and meaning of front-line practitioners' experience of working with suicidal children and youth. A deeper understanding of the front-line practitioners' experience and perspective of working with suicidal children and youth provides an opportunity for enhancing the effectiveness of professionals' response and intervention through advancing the knowledge base that informs direct practice. The five participants shared their unique stories of their encounters with suicidal children and youth within semi-structured interviews. The study offered participants an opportunity to explore their encounters in practice. Through their sharing and exploration, sixteen common themes emerged that describe the nature of the encounter and response to suicidal children and youth for the participants in the study. The findings from this study provide insight into front-line practitioners' experience of working with suicidal children and youth, the knowledge they use to inform their approach, and the emotional or physical responses to their encounters.

The experiences, opinions, and insights are based on the five participants interviewed for the present study. Therefore, assumptions that the findings are representative of all front-line practitioners' experience of working with suicidal children and youth should be exercised with caution. It is possible, however, to obtain a

phenomenological essence of the experience of front-line practitioners' encounters with suicidal children and youth, which will inform our understanding of other front-line practitioners who have experienced this phenomenon in their practice.

Findings Related to Previous Literature

The present study explored front-line practitioners' experience of working with suicidal children and youth. The results of this study indicate that encounters with suicidal children and youth evoke intense emotional and physical responses from front-line practitioners. As well, the results indicate that front-line practitioners draw on multiple sources of knowledge to inform their approach in the encounter and understand the suicidal behaviour in the context of disconnection or isolation for the child or youth and other contributing factors. The findings also demonstrate that front-line practitioners work through their encounters with suicidal children or youth within the elements of responding to a crisis. Additionally, the findings suggest that participants' therapeutic relationships with the suicidal children and youth were vital to their approach and intervention in the encounters. Through semi-structured interviews, the five participants described encounters with suicidal children and youth from their practice experience. Across the participants, experiences can be grouped into the following general categories: Encounter with Suicidal Child or Youth Evokes Emotional or Physical Response, Various Sources of Knowledge are Valued and Inform Approach, and Understanding Suicidal Behaviour in the Context of Contributing Factors, Crisis Intervention, and Relationship.

Encounter with Suicidal Child or Youth Evokes Emotional or Physical Response

All of the front-line practitioners in this study were clear that their encounter with a suicidal child or youth in their practice evoked an emotional or physical response. As noted in the literature review, research on practice with suicidal clients has found there to be a significant impact on professional caregivers when faced with suicidal behaviour (Jacobson et.al., 2004; Kleespies et al., 1993). Pfeffer (1987) notes, "Working with a suicidal child elicits intense responses in a clinician that can strongly influence the process of intervention" (p. 175). The participants in the present study described their experience of strong emotional or physical responses to their encounters with suicidal children and youth at various points in the intervention. For example, after receiving a phone call from a suicidal youth s/he was working with, Participant 4 described experiencing anxiety, nervousness, and feeling sick as s/he traveled to meet with the youth. Other emotions experienced by participants included fear, urgency, disconnection, isolation, and a sense of responsibility. Participants' physical responses to their encounters included anxiety, stress, adrenaline rush, sensations of sickness, nervousness, and feeling bombarded. These findings are not dissimilar to emotional and physical responses of other professionals working with suicidal individuals. Researchers in the field of Suicidology have documented emotional and physical responses by professionals to client suicidal behaviour. Kleespies et al. (1993) found predoctoral interns in the field of Psychology experienced stress in response to client suicidal behaviour. Similarly, Rodolfa et al. (1988) found that suicide attempts or suicide statements were second only to a physical attack as the most stressful client behaviours for therapists. After an attempted suicide by a patient, Psychology interns and trainees reported emotional

responses of shock, sadness, failure, guilt, disbelief, self-blame, depression, and shame (Kleespies et al., 1993). In the same study, feelings of fear were reported in response to patients with suicidal ideation and suicide attempts. Pope and Tabachnick (1993) also reported emotional responses of fear that clients may die by suicide amongst therapists. Over half of the therapists in the study reported that the emotional response of fear affected their physical selves as well. Similar to some of the participants in the present study, therapists experienced disruptions in their eating and sleeping patterns. Some of the participants in the present study reported experiences of “weird dreams”, fatigue, loss of sleep, and crying after their encounters with suicidal children and youth.

The participants in this study also reported experiencing feelings of responsibility for the suicidal child or youth. These front-line practitioners felt responsible for the child’s or youth’s life, and experienced professional isolation in the encounter. Participants reported feeling they needed to protect and safeguard the child or youth’s life. For some participants, they experienced feeling solely responsible for this endeavor which led to the emotional experience of feeling professionally isolated as they worked directly with the suicidal child or youth. Fox and Cooper (1998) note feelings of professional isolation in working with suicidal patients. One way of understanding this finding is within the context of previous literature, which proposes that professionals experience feelings of responsibility for the client’s welfare (Rodolfa et al., 1988). Similarly, Roose (2001) noted a belief amongst clinicians that “if you do the right thing” with a suicidal person, “the patient will stay alive” (p. 155). In a review of relevant literature, Mishna et al. (2002) also found that practitioners may experience feeling responsible for stopping an individual from dying by suicide while at the same time

feeling powerless to stop it. Spiegelman and Werth (2005), in a review of a case from their practice, also indicate feelings of responsibility for a client who had attempted suicide.

Another possible explanation for the participants' emotions of feeling responsible for the child or youth in their encounter is linked to the emotional responses some of the participants experienced as they attempted to connect with other resources. The findings in the present study suggest that some participants' experienced negative emotions such as frustration, powerlessness or feeling disheartened, when connecting with resources. It is important to consider that for some of the participants their descriptions of how to respond to the suicidal behaviour represented elements of crisis intervention, including connecting to resources. Participants may have been endeavoring to respond to the suicide crisis in accessing resources and assistance for the child or youth, while simultaneously experiencing an emotional response of feeling responsible for the child or youth's life. This finding has been previously reported in research on professionals providing home visitation services for at-risk families. LeCroy and Whitaker (2005) noted that home visitors reported an emotional response of frustration when attempting to connect families with services, particularly mental health services. This may indicate the need for further links amongst professionals within communities to be established within a context of a multi-disciplinary approach to suicidal children and youth. Linkages between service providers including front-line practitioners, mental health personnel, and emergency services are needed to provide a comprehensive intervention for suicidal children and youth. The first-responder may be the front-line practitioner who practices in the daily living environments of children and youth. Front-line practitioners may make

attempts to connect with community mental health resources based on employing a crisis model of intervention, upon the direction of their supervisor, or based on following procedures outlined by the agency. From the participants' perspectives in the present study, mental health personnel and emergency services were considered part of the overall continuum of service for suicidal children and youth. Participants described accessing resource persons who then determined the risk of suicide for the child or youth from an "expert" position rather than a collaborative- decision making approach. A common language and collaborative approach in which mental health and emergency personnel worked with front-line practitioners to care for suicidal children and youth may be needed to address the negative emotional experience of accessing resources described by participants in the present study. Therefore, the findings of this study would suggest the need for opportunities created for front-line practitioners to debrief their emotional experiences with others, as well as the need for collaborative approaches to suicide intervention. Further discussion of the implications related to Child and Youth Care practice will be considered later on in this chapter.

Various Sources of Knowledge are Valued and Inform Approach

A significant finding in the present study centered on the broad spectrum of sources of knowledge participants used to inform and direct their approach to suicidal children and youth. Eleven theme clusters of sources of knowledge were identified in the study that encompassed the following; Training in Suicide Prevention/Intervention, Epidemiological Knowledge, Academic Training, Literature and Materials, Relationship with Client, Knowledge of Client's History and Present Circumstances, Professional

Experience, Agency Policy, Procedures, Protocols, Supervisor/ Colleagues, Resources Accessed, and Self Knowledge in Practice.

Participants sought out information from the client, their supervisors and colleagues, and community resources. Participants relied on tangible materials such as risk assessment forms and materials from training they had taken. Participants in the present study were also aware of their internal world in their encounters with suicidal children and youth as they tuned into their gut feelings and intuition. Although the descriptions of participants provided a wide range of knowledge-bases to inform their approaches, participants did not report using any specific theoretical structures, such as Shneidman's Cubic Model of Suicide (Shneidman, 1987) or Sabbath's theory of the "expendable child" (Sabbath, 1996), in their interventions. Shneidman provides a psychological understanding of suicide that demonstrates the connection between psychological pain (psycheache), stress (press), and perturbation (agitation). From a Family Systems theoretical perspective, Sabbath's theory emphasizes "the suicidal influences of a dysfunctional family system" (Jobes, 2006). This finding suggests a need amongst front-line practitioners for foundational knowledge on the theoretical considerations of suicide. Theoretical structures of suicide can "provide understanding, direction" and "order and structure to what we aspire to know" (Jobes, 2006). Further implications of this finding for Child and Youth Care practice will be considered.

An interesting and encouraging finding in the present study across all of the participants' descriptions was the value of knowledge from training, specifically in suicide prevention and intervention, in determining their approach to the suicidal child or youth. Participants drew on their knowledge from suicide prevention and intervention

training in asking directly about suicide, determining suicide risk, and planning for safety. As indicated in the presentation of the demographic information in Chapter Three, the participants in the present study all reported having at least 15 hours of didactic training in suicide prevention and intervention primarily through professional development learning opportunities within the workplace and community. Participants not only reported receiving training, they also reported using and valuing the knowledge gained from their training in their encounters with suicidal children and youth. This finding is important for front-line practitioners in the context of relevant research which has demonstrated limited suicide prevention and intervention training amongst professionals. Kleespies et al. (1993) noted that only 55% of the Psychology interns and trainees in their study reported receiving minimal didactic instruction (e.g., one or two lectures) on suicide in their graduate programs. Amongst graduate-level social workers, research has demonstrated limited training in suicide intervention and prevention (Feldman & Freedenthal, 2006). Over half (61.2%) of social workers had received instruction through their field placements, with the majority receiving under four hours of training. Ramberg and Wasserman (2003) found that less than half of psychiatric nurses and assistant nurses consider themselves sufficiently trained to work with suicidal patients. Participants in the present study reported a significant level of didactic training in suicide prevention and intervention and subsequently valuing knowledge from the training to inform their practice with suicidal children and youth.

Some of the participants in the present study reported valuing and using knowledge from program materials during their encounters with suicidal children and youth. Agency materials and risk assessment forms were used by some of the participants

to determine the level of suicide risk for the child or youth in their care. Quantitative and qualitative tools for suicide risk assessment purposes are discussed earlier where Berman et al. (2006) provide a comprehensive review of various risk assessment tools that can be used with adolescents. Jobes (2000) suggests a collaborative approach to risk assessment using qualitative methods to discover the experience of the suicidal client. In the present study, participants valued various sources of knowledge, such as training materials, epidemiological knowledge, and agency policy, to guide their actions in encounters with suicidal children and youth. This suggests willingness amongst front-line practitioners to use different methods and draw on multiple sources of knowledge to assess and determine risk of suicide.

A consistent theme across all of the participants' descriptions of their encounters with suicidal children and youth was the involvement or contact with their supervisor. Participants described a range of supervisor involvement from initiating brief updates to their supervisor directing their approach in the encounter. When asked what was *most helpful* in the encounter, none of the participants in the present study reported that it was their supervisor's involvement. Previous research has also explored the involvement of supervisors in practice with suicidal clients. Psychology interns and trainees in Kleespies et al. (1993) reported involvement with their supervisor in managing patient suicidal behaviour. Additionally, Kleespies et al. (1993) found that the majority of participants sought or received support from their supervisor and rated the supervisor's involvement as moderately helpful to very helpful. The majority of nurses and assistant nurses also reported receiving supervision in their work with suicidal patients (Ramberg & Wasserman, 2003). Yet, in the same study, only 34% of psychiatrists reported receiving

supervision. Participants in the present study, and previous research, suggest that many professionals are accessing their supervisors during their encounters with suicidal clients. The quality and nature of the supervision provided to practitioners may require further investigation. Implications for Child and Youth Care practice will be discussed further on in this chapter.

The majority of the participants in the study reported using knowledge from their previous professional experience in their encounters with suicidal children and youth. The demographic information presented in Chapter Three indicated that four out of the five participants had provided care for a suicidal person in their personal and professional lives on at least six occasions. Previous professional experience with suicide was reported by participants as being linked to a degree of comfort with the issue and the procedural knowledge of what actions to take in the encounter. Kleespies et al. (1993) also found a connection between professional experience with suicidal clients and actions in future encounters. Psychology interns and trainees in the study reported increased acceptance of patient suicidal behaviour as well as an increased sensitivity to signs of suicide risk. This finding suggests professional experience with suicidality may increase efficacy amongst front-line practitioners as well. As the present study did not explore directly the previous experience with suicidality for participants, future research may provide valuable insights into this phenomenon.

Understanding Suicidal Behaviour in the Context of Contributing Factors, Crisis Intervention, and Relationship

All of the participants in the present study described disconnection or isolation for the suicidal child or youth in their care. Participants noted disconnection occurred for the child or youth in their family relationships, social connections, and with significant

others. This finding is consistent with the relevant literature in the field of suicidology. In a recent literature review, Hazler and Denham (2002) found that social isolation promotes depression and hopelessness. Furthermore, the authors state that negative social relations, such as the family conflict in the encounter described by Participant 5, can compound the effects of isolation on the suicidal person. In Hendin et al.'s (2001) study on therapists' recognizing and responding to a suicidal crisis, isolation or disconnection was noted as signals for a patient's deterioration. "Socially, the patients' deterioration was expressed in frequent arguments, break-ups in relationships, or social withdrawal" (p. 121). Bearman and Moody (2004) also found increased likelihood of suicidal thoughts amongst female youth who were socially isolated. A fearful or preoccupied attachment style has also been associated with suicide ideation amongst youth (Lessard & Moretti, 1998). Youth with a fearful or preoccupied attachment style internalize a negative view of self as impotent and undeserving of love. The finding in the present study that participants' understanding of suicidal behaviour as occurring in the context of disconnection or isolation for the child or youth supports the findings of previous research on attachment, isolation, and disconnection in occurrences of suicidality.

Participants' descriptions of their encounter with a suicidal child or youth in the present study also conveyed an understanding of suicidal behaviour occurring in the context of other factors beyond disconnection or isolation. All five of the participants noted the mental health status or substance use issues in their descriptions. Participants' considerations of additional factors beyond the suicidal behaviour are warranted according to research. Grossman et al. (1991) found an association between a history of mental health problems, alienation from family and community, alcohol use and suicide

attempts amongst Native American adolescents. Bearman and Moody (2004) also found increased suicide attempts amongst youth who frequently drank alcohol to the point of intoxication. Similarly, Wu et al. (2004) found "...youth with suicidal behaviours are more likely to use and abuse substances than youth without suicidal behaviour" (p. 413). Within their descriptions, three of the participants in the present study noted the factor of substance use of the suicidal youth.

Additionally, research on professionals' view of the factors contributing to suicidal behaviour has found a reliance on a mental health diagnosis. Tzeng and Lipson (2005) found that health professionals' perspectives of suicidal patients were characterized by determining their mental health diagnosis. Alternatively, nurses and doctors in Anderson et al.'s (2000) study did not support the notion that suicidal behaviour reflects mental illness. Similar to the participants in the present study, mental illness was described as a factor contributing to suicidal behaviour. Participants' descriptions in the present study noted mental health issues such as depression or social anxiety for the suicidal youth they encountered.

A consistent theme across the participants' interviews was that the experience of encountering a suicidal child or youth contained elements of crisis intervention. Newhill (1989) states "the basic intervention model for psychiatric emergency work is crisis intervention" (p. 247). Additionally, Hendin et al. (2001) note the importance of recognizing a suicide crisis that signals immediate danger of suicide. The majority of the participants in the present study connected with resources, made efforts to ensure the safety of the child or youth, and moved into a period of stabilization. Participants contacted mental health emergency services, social workers, foster parents or guardian,

colleagues, or supervisors in response to the suicidal crisis at hand. Some of the participants reported knowledge of agency policies and procedures that directed them to contact specific mental health or emergency resources. A central theme was clear across all of the participants' interviews of the need to connect with resources, or have discussions with colleagues or other professionals, when working with a suicidal child or youth. Similarly, in a study on the nursing care of suicidal patients, psychiatric nurses reported it was essential to connect and share information with their colleagues (Sun et al., 2006). Secondly, the majority of participants responded to the suicidal child or youth with actions to ensure safety. Ensuring patient safety and providing protection was also reported by psychiatric nurses as actions in the care of suicidal patients (Sun et al., 2006). Many of the participants' interviews in the present study described a movement through the suicidal crisis to a point of stabilization. Participants described changes in the child's or youth's presentation, success in gaining social relationships, re-engagement in activities, or a change in direction leaving "the point of crisis." Perhaps this finding relates to Shneidman's (1998) theory on suicidal behaviour. Simply, Shneidman views suicide as the result of thwarted psychological needs which manifest into intense psychological pain. The needs to affiliate, enjoy others, and experience closeness, to protect the self, and to make sense of the world, are a few of the psychological needs Shneidman suggests. As unmet needs are addressed, the pain that the suicidal patient is experiencing lessens. Many of the participants' interviews in the present study described addressing some of the possible unmet psychological needs of the suicidal child or youth during the crisis. For example, all of the participants described engagement and working within a context of relationship with the child or youth which may lessen the

psychological pain of disconnection and meet the need of affiliation. One participant described a movement towards stabilization through the use of a safety contract with a youth. The psychological need to protect the self may have been met with such an action by the participant. The finding of participants experiencing a movement through the suicide crisis to stabilization suggests, in the context of relevant literature, a reduction of the level of psychological pain for the child or youth.

A very interesting and positive finding in this study is that despite the emotional and physical challenges of working with suicidal children and youth, all participants reported drawing on their relationship with the child or youth in the encounter. Participants used their connection and relationship as a source of knowledge in their encounters. All five of the participants also noted their relationship to the child or youth as a significant source of knowledge they valued in providing care. As well, the majority of participants' descriptions also conveyed they provided service in the context of connection and relationship to the child or youth. Participants connected with the child or youth through physical proximity and accessibility, engagement, and described being with the child or youth. These findings appear to align with the work of Paulson and Worth (2002). The authors investigated suicidal clients' perspectives of what was helpful in counselling. Findings indicated that the therapeutic relationship, interpersonal connection, and acknowledgement by the counsellor of the intense emotions underlying suicidal behaviour were helpful for suicidal individuals. Furthermore, "participants described the existence of an affirming and validating relationship as the catalyst for reconnection with others and with oneself" (p. 91). Sun et al. (2006) found similar results for suicidal patients being cared for by nursing professionals. Patients and nurses in the

study reported a therapeutic relationship “has a definite influence on patients’ perceptions of protection from self-harm and on their sense of hope for the future” (p. 687).

Furthermore, the authors indicate the importance of being present physically, emotionally, and “being there” with patients (p. 688). Being present with patients gave the nurses in the study opportunities to “work with patients therapeutically and to listen attentively” (p. 688). All of the participants in the present study valued their relationship with the child or youth as a source of knowledge to guide their approach, and the majority of the participants experienced emotional responses as a result of their engagement and “being there”.

Limitations of the Study

First, the front-line practitioners who participated in this study chose to participate voluntarily to share their stories of working with suicidal children and youth. The participants represent a group of front-line practitioners who were comfortable discussing the topic of suicide and may have overcome to some degree, the stigma that is attached to suicide (Pompili, Tatarelli & Lester, 2005). The participants’ comfort in exploring their practice with suicidal children and youth may or may not be representative of typical front line practitioners in the field.

Second, the findings of this phenomenological study are solely based on the experiences shared by the five participants and may not necessarily represent the experiences of front-line practitioners’ encounters with suicidal children and youth as a whole. The purpose of this study was not to generalize to the larger population of front-line practitioners, but rather to gain understanding of the essence and meaning of the experience for the participants involved.

Third, participants were invited to share their experiences from practice with suicidal children and youth. There was no distinct timeframe for when the encounter occurred, or the degree of relationship with the child or youth (i.e., length of relationship). Participants drew on experiences that were as recent as the day before their interview, and as distant as ten years prior to sharing their story. Kleespies et al. (2000) notes:

...with serious suicide attempts in which staff feelings can run high, clinical experience suggests that such reviews or conferences are best done some time (possibly three to six months) after the acute impact has receded and a good deal of emotional processing has been completed.

Although common themes emerged across all the lived experiences of participants, delineating and clarifying the participants' experiences according to the timeframe in which their encounter occurred might have extracted further insights.

Fourth, a limitation of this study is that the participants' own attitudes and beliefs towards suicide were not explored. Large numbers of caregivers of suicidal clients have been found to have attitude barriers that can influence their response to suicidal behaviour (Lang, Ramsay, Tanney & Tierney, 1989). The attitudes held by participants about suicide may have impacted how they described their encounters with suicidal children and youth, the knowledge they drew on to inform their actions and their emotional or physical response during and after the encounter. Future research that investigates the attitudes and beliefs of front-line practitioners about suicide and suicidal behaviour may provide additional insights in understanding this lived experience for front-line practitioners.

Fifth, the participants were not asked to specifically identify the severity or nature of the suicidal behaviour the child or youth was demonstrating in their encounter. The

participants were simply asked to share their experiences of working with suicidal children or youth. Death by suicide was not included in the study and the suicidal behaviour described by participants was not specified by suicide ideation, suicide threats, or suicide attempts. Identifying the specific suicidal behaviors that the child or youth had engaged in within the encounter may have provided further knowledge in examining the nature and range of practitioner responses. Previous research has examined the range of professionals' responses to suicidal behaviors based on the severity exhibited by the suicidal patient. Kleespies et al. (1993) found an increase of stress in therapists with increasing severity of suicidal behaviors. Therapists experienced less stress with patients who expressed suicidal ideation than with patients who attempted suicide. As this study focused on the experience of front-line practitioners working with suicidal children and youth, and did not distinguish the suicidal behaviour itself, participants' emotional or physical responses may be influenced by the severity of the child or youth's suicidal actions in ways that were not evident in the data.

Finally, the participants in the present study, when providing demographic information, were asked about their level of personal and professional experience as a caregiver for a suicidal person. Frequency of interventions in their current practice was also recorded but participants were not asked if they had experienced a death of a client in their care by suicide. In previous research Kleespies et al. (1993) found that participants who had experienced a death of a patient by suicide reported significantly higher levels of anxiety when encountering future suicidal patients. It is not known if this was a factor in the present study.

Implications for Child and Youth Care Practice

The present study explored the experience and perspective of front-line practitioners working directly with suicidal children and youth. The study examined the nature and range of practitioner responses and how they made sense of their encounters. The study explored how front-line practitioners describe and conceptualize their encounters with suicidal children and youth. Front-line practitioners have a unique position in the lives of children and youth as they practice within their daily living environments, develop therapeutic relationships as the main modality of treatment and intervention, and position themselves in close proximity to children and youth. Child and Youth Care literature describes front-line practice occurring within these dimensions (i.e. Anglin, 1999; Beker, 2001; Maier, 1991). Undoubtedly, a phenomenological inquiry into the experience of front-line practitioners working with suicidal children and youth has implications for Child and Youth Care practice. Implications include directions for future research, planning by supervisors and educations for emotional wellness and support amongst front-line practitioners, and improving the efficacy of Child and Youth Care practice with suicidal children and youth.

Future Research Directions

Research into professionals' experience of working with suicidal individuals has grown in recent years; however, there are many aspects of the experience that still remain to be explored (Hendin et al., 2001; Jacobson et al., 2004; Kleespies et al., 2000).

The experience of encountering a suicidal person in the helping professions of Social Work, Psychology, Psychiatry, or Nursing is likely. Feldman and Freedenthal (2006) reported that 92.8% of social workers in their study had worked with at least one

suicidal client. Ramberg and Wasserman (2003) reported 43% of psychiatric nurses and 74% of psychiatrists, worked with suicidal patients on a regular basis. Chemtob et al. (1988) reported 22% of psychologists experienced a death by suicide of a patient. Child and Youth Care practitioners are also likely to experience suicidal clients in their care. The relevant literature within other professions highlights the prevalence of suicidality amongst those accessing services. Future research may help identify and highlight the prevalence of encounters with suicidal children and youth specifically amongst Child and Youth Care professionals. The present study did not address the previous experience or the degree of suicidality (e.g., suicidal ideation, suicide attempts, death by suicide) of participants. Previous research has identified responses to suicidality differing in respect to previous professional experience with specific suicidal behaviours (Kleespies et al. 1993). Further investigation of the prevalence and level of previous experience with suicidal clients may provide further insights into how front-line practitioners make sense of their encounters with suicidal children and youth. In identifying the frequency and prevalence of this experience, the need for additional training, support, and education may be emphasized as well.

The findings in the present study of the participants' value of knowledge derived from training in suicide prevention and intervention is encouraging. All of the participants in the present study had received at least fifteen hours of didactic training in suicide prevention and intervention. This level of training may be unique to this group of participants. Previous research literature has demonstrated the minor amount of suicide education professionals have received (Feldman & Freedenthal, 2006; Kleespies et al., 1993). Future research with Child and Youth Care practitioners may be designed to

examine two areas: the current level of training in suicide prevention and intervention amongst Child and Youth Care practitioners, and the application of training in practice amongst Child and Youth Care practitioners.

Future directions for research on the experience of front-line practitioners working with suicidal children and youth may also include the accounts by significant others in the lives of practitioners. The current study has relied on self-reports of the participants as they relayed their encounters with suicidal children and youth. The perspective of those closest to the front-line practitioner, such as the supervisor, spouse, or close family member, may provide another view of the response and impact of client suicidality on Child and Youth Care practitioners.

Child and Youth Care Practice

The findings of this study and the participants' descriptions of their lived experiences working with suicidal children and youth can provide meaningful insights and implications for Child and Youth Care practice. The data that the participants provided affirms the capacity for front-line practitioners to meet the needs of suicidal children and youth. Participants in the present study described maintaining their relationship with the suicidal child or youth in the midst of experiencing intense emotional responses. Participant 2 described emotions of feeling "disheartened" and "awful" as s/he attempted to access medical supports for the suicidal youth s/he was working with. Even though the physician in his/her encounter responded to the youth's suicidality by invalidating his emotional experience, Participant 2 maintained a therapeutic relationship, sought out further resources, considered his/her knowledge of adolescent development and agency policy, and knew of tangible tools (i.e., suicide risk

assessment chart) that could inform his/her approach to the youth in his/her care. This participant's description of his/her encounter suggests that front-line practitioners have the capacity to manage and intervene with suicidal children and youth.

The findings also suggest some general implications that may be helpful in improving efficacy of front-line practitioners' approach to suicidal children and youth in their care. Limitations of academic training and transmission of knowledge from supervisors are a few of the general implications that will be discussed further in relation to previous research.

The present study offers support for previous research that has highlighted professionals' intense responses to and experiences of working with suicidal clients (Aish et al., 2002; Jacobson et al., 2004; Kleespies et al., 1993; Spiegelman & Werth, 2005). Participants in the present study experienced a range of physical and emotional responses to their encounters with suicidal children and youth that are similar to those found in previous research with practitioners in allied disciplines. This finding suggests that Child and Youth Care practitioners, similar to other professionals, need to have both an awareness of their responses and coping strategies in place to manage emotional and physical self-care. Figley (2002) suggests that therapists often view themselves as others view them: "someone who is an expert at helping others cope with life's challenges" (p. 1439). Child and Youth Care practitioners may also experience limited supports in which they are able to express emotions, needs, and responses to challenging practice situations as others may be relying on them to be the 'helper' in the relationship. As well, for some practitioners, admitting intense emotional responses to a suicidal child or youth may be

difficult for fear of judgment. In an investigation into therapists' emotions of anger, hate, fear, and sexual feelings, Pope and Tabachnick (1993) explain:

For some, acknowledging to self or others that they have experienced such strongly negative feelings as "hate" toward those who have come to them for help may be extremely difficult, especially if their training has not encouraged them to recognize, accept, and examine such feelings (p. 149).

Implications for Child and Youth Care practice include acknowledging during training and supervision that emotions may occur in response to suicidality, and ensuring support systems are in place for the practitioner to express and identify their responses to encounters with suicidal children and youth.

One of the findings in the present study was the feeling of responsibility participants had for the suicidal child or youth. A second related finding was the effort participants made to connect with resources, obtain knowledge from resources, and the intense experience of frustration when resources were unsupportive or invalidating to the child or youth. The first implication of this finding is the importance of connecting with resources that can offer support to the Child and Youth Care practitioner as s/he maintains the therapeutic relationship with the child or youth. Connecting with resources offers the opportunity for a shared-responsibility amongst professionals for the lives of suicidal children and youth. Adopting a collaborative approach and building community partnerships have been previously suggested by White (2005). Family members or alternate caregivers, such as front-line practitioners practicing within a group home setting, can provide one-on-one supervision and minimize access to potential means for attempting suicide for high risk suicidal children and youth. Additionally, White suggests linkages are invaluable between family members, caregivers, child and youth mental health services, and other community resources for ongoing monitoring of suicidality.

Integrated case management and wrap-around care for children and youth that involves all service providers, clients and families can provide coordinated and integrated system of care for suicidal children and youth that “cuts across organizations, the community, and families” (White, 2005, p. 59). If Child and Youth Care practitioners are able to foster partnerships with mental health service providers, social workers, or foster parents, the intense experience of feeling responsible for the lives of suicidal children and youth may be lessened. As well, feelings of frustration may be mediated if practice occurs within pre-existing partnerships where, as White (2005) suggests, roles are clarified, services are coordinated, and joint decision-making is developed and supported.

The finding in the current study of participants' relationship with the child or youth being central as a source of knowledge, means of engagement, and as what was helpful in their encounters also has implications for Child and Youth Care practice. As Participant 2 explained, “We formed a strong bond and he knew that he could trust me for confidentiality unless he disclosed harm to self or others.” The working therapeutic relationship, described as a “strong bond” by Participant 2, demonstrated the closeness and proximity s/he experienced with the suicidal youth. Participants in the present study demonstrated accessibility, proximity, connection, and engagement with the child or youth in the context of a relationship. This finding has implications for Child and Youth Care supervisors and teachers. The therapeutic relationship can be considered as the context for intervention with suicidal children and youth in which actions, knowledge, and responses originate. The capacity to meet the challenge of working with suicidal children and youth can be best met through relationships that practitioners develop and nurture. Support from supervisors and training Child and Youth Care practitioners to

respond based on their relationship with the child or youth is needed and may be the vehicle to address the disconnection or isolation they are experiencing. The role of the supervisor in encounters with suicidal children and youth may be to provide support for the Child and Youth Care practitioner in maintaining and enhancing the therapeutic relationship they have created with the child or youth. Encounters with suicidal children and youth in the present study and in previous research have evoked strong emotional responses in professionals. Along with ensuring agency policies and procedures are followed, supervisors need to develop an openness to inquire, engage, and explore with the Child and Youth Care practitioner their emotional experience as it relates to their practice. A safe, non-judgmental approach to the supervisor-supervisee relationship is required for such exploration to occur. This may be challenging for both the supervisor and the Child and Youth Care practitioner due to the power imbalance in their relationship, however such a relationship may ultimately enhance the effectiveness of front-line practitioners' response and intervention with children and youth in their care. As the Child and Youth Care practitioner experiences support and validation, they are better able to connect and maintain their relationship with the suicidal child or youth. The therapeutic relationship with the child or youth may be the means of addressing the child or youth's disconnection or isolation from other supports in their lives. The child or youth may experience connection through their relationship with the front-line practitioner. As the front-line practitioner engages the child or youth, listens, is physically present and in direct contact, the child or youth may begin to feel less isolated in their world.

Further implications for supervisors and teachers in Child and Youth Care practitioners exist in the findings of the present study. Across all participants' interviews

it was noted that supervisors were contacted or sought out at various points in the encounter with the child or youth. Participants had varied responses as to the degree of helpfulness supervisors were able to provide to them during the suicide crisis. What is clear in the findings of the present study is that all of the participants sought out their supervisors and informed them of the situation but the response was not always seen as helpful. Supervisors of Child and Youth Care practitioners have to be ready and able to assist practitioners in their encounters with suicidal children and youth. Furthermore, an opportunity for supervisors to discuss emotional and physical responses to suicidality, as well as opportunities to assist in connecting to resources and working on community partnerships exists in their contacts with practitioners. Supervisors and teachers in Child and Youth Care practice have a strong influence on the professional development and academic training of practitioners and need to provide suicide education to a greater degree than currently exists.

Concluding Thoughts and Reflections as the Researcher

This research study has provided rich insights and experience to me as a researcher, a Child and Youth Care practitioner, and as a professional who has worked with many suicidal children and youth. I have learned from each one of the front-line practitioners who chose to participate in this study and share their unique stories from practice with suicidal children and youth. I believe their work has saved lives and will provide opportunities for other Child and Youth Care practitioners to express their experiences, their emotions, their fatigue and frustrations when faced with suicidality in children and youth in their care. The front-line practitioners who have participated in the present study may support their colleagues during future encounters with suicidal

children and youth by creating space to examine their experience similar to how they shared their stories in the present study. Many of the participants reported after the interviews that this was the first time they really had thought about their experience with the suicidal child or youth and that the experience of sharing their story was beneficial. This positive experience may invite participants to elicit their colleagues' experiences and sharing as well.

Additionally, Child and Youth Care practitioners and supervisors who read the present study will have an opportunity to reflect on their own experiences, emotions, and frustrations when working with suicidal children and youth. Supervisors may provide space, safety and openness to discussing their supervisees' experiences.

The impetus for this study came from my experiences as a front-line practitioner, a supervisor, and a behavioural consultant in working with children and youth who are suicidal. I experienced emotions and responses first-hand that participants in this study described in my own practice such as when a youth stated she had taken a bottle of pills, or when a child told me he wanted to kill himself. Prior to this research study, I had relied on the procedural responses outlined in agency policies to direct my approach to working with clients or to supervising front-line practitioners. I had also found few colleagues or personal supports who were interested in discussing suicide or the impact of working with suicidal persons. For many of the participants, sharing their story in this study was the first time they had spoken in-depth of their encounters and discussed with another person the impact of being faced with suicidal children and youth in practice. Hopefully, sharing their story in the research study will invite other practitioners to talk about their experiences of suicidal children and youth as well.

Suicide and talking about contemplating death is not encouraged in society. As recent as 1993, suicide was considered a crime in Ireland (Jamison, 1999). Religious or cultural beliefs and attitudes may also influence discussions on suicide. Beliefs that suicide is a sin or that if someone dies by suicide they are going to hell are examples of religious beliefs that may influence a practitioner's willingness to engage in a discussion on suicide. Suicidal behaviours have the potential to create a response within the front-line practitioner that has moral issues at the core due to the likelihood of a deadly consequence without intervention. The front-line practitioner's moral views on the individual's right to choose to die or attempt death may influence his/her perspective and experience of this behaviour and the ability to handle the situation effectively. Moral issues may stretch further to the front-line practitioner's beliefs on what capacity of children and youth have to initiate a decision or choice to die or attempt death. Practitioners may not believe children have the understanding of the finality of death based on their cognitive level of functioning and stage of development. Due to this assumed lack of understanding of what suicide and death mean, front-line practitioners may believe they have a moral obligation to protect children and choose life for them. Emotional and physical responses to encounters with children and youth may be intensified for front-line practitioners if they hold moral beliefs and a sense of obligation or responsibility for the child or youth continuing to live. Although participants in the present study were not asked specifically about their beliefs and attitudes regarding childhood or adolescent suicide, the present study provides foundational knowledge of the front-line practitioners' experience and invites further research and discussion on how practitioners' beliefs influence direct practice.

It is difficult to bring the topic of suicide forward. Many lives have been touched by suicide. Front-line practitioners and other professionals may have experienced the death of someone in their professional practice, experienced encounters with suicidal children and youth, or experienced someone's suicidality in their personal life. Undoubtedly some practitioners have faced and battled their own thoughts of killing themselves, such as Participant 5 in the present study. I believe that when faced with someone who is suicidal; our awareness of our own mortality is heightened. Questions appear about what happens at death, what beliefs are held about an after-life, and what is worth living for, have the opportunity to be asked and reflected on in our own lives. Is life worth living? The ultimate goal of Dialectical Behaviour Therapy is to "move the client from a life in hell to a life worth living" (Dimeff & Linehan, 2001, p. 12). Acknowledging the experience of intense pain and agony, and perhaps a hellish life experience as well, while battling thoughts of dying is vital.

Front-line practitioners may not understand how a child or youth reaches a decision to choose death. In the present study Participant 1 described a curiosity about the decision to die by the youth and tried to reach an understanding of how the youth choose death in the moment he attempted suicide: "You know the whole time there he wasn't able to go there with me in terms of really in the moment why... at that real cross roads and where you've got that bottle... and you're should I do this or not...". Suicide is about death as well as life and choosing death can be confusing and hard to understand.

I am committed personally and professionally to open the dialogue around suicide and explore professionals' feelings and responses to those who are contemplating ending their lives. Through this research study I have had the opportunity to connect with other

practitioners who have experienced challenging circumstances with suicidal clients beyond the front-line practitioners in the present study. The topic of my research study provided my colleagues with a comfort-level in initiating discussions about suicidal clients they were currently working with and the difficult emotions they were experiencing. I have endeavored to continue to invite these discussions and create safety in talking about suicide and how to manage these life and death experiences.

Susan Rose Blauner (2002) lived with suicidal thoughts for eighteen years. She wrote a guide to suicide prevention entitled *How I Stayed Alive When My Brain Was Trying to Kill Me*. Blauner provides wise words for Child and Youth Care practitioners and helping professionals that convey the life and death decision faced by the suicidal person, the emotional response that can occur for the professional, and the context of relationship that can heal:

Whenever you feel exasperated by the situation (and you will), try to remember that the suicidal thinker is living on an internal battlefield in addition to navigating everyday stress. I wanted to be alive, accepted, loved, and understood, but for one or many reasons my brain tried to convince me I was useless, worthless, unloved, pathetic, and that I really wanted to die. The goal is to accept the suicidal thinker – suicidal thoughts and all – rather than judge or try to fix him. What you can offer is non-judgmental compassion as he stumbles down the road to freedom. You can be there when he trips and falls, and when he finds relief. You can embrace him with outstretched arms, saying, “I love you. I am here for you.” (p. 261)

In closing I would like to offer encouragement, support and respect for those who courageously engage in relationship with suicidal children and youth and effectively balance multiple sources of knowledge to inform their approach while often concurrently experiencing emotional and physical responses within themselves. You are saving lives.

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APPENDIX A

Recruitment Poster

Looking for research participants within Interior Community Services!

A study on

**“The front-line practitioner’s experience of
working with children or youth engaged in
suicidal behaviour”**

is recruiting front-line practitioners

**(i.e. family support workers, specialized contracts with
children/youth, residential child and youth care workers, crisis
intervention workers, etc.)**

**who have practice experience with
suicidal children or youth**

INTERESTED?

Send a confidential email providing a contact phone number to:

pranahan@uvic.ca

APPENDIX B

Recruitment Script

“The front-line practitioners experience of working with children or youth engaged in suicidal behaviour”

You have indicated an interest in participating in a study entitled “The front-line practitioners experience of working with children or youth engaged in suicidal behaviour”. The purpose of this research is to develop a deeper understanding of the front-line practitioner’s experience working with suicidal children and youth. As the researcher, I may have a relationship with you as a co-worker within Interior Community Services, but your participation in this research must be completely voluntary. 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 will not be used in the research and be subsequently destroyed by the researcher. The potential benefits of your participation in this research include an opportunity to reflect on your practice, contribution to the existing state of knowledge pertaining to suicidal children and youth, and further awareness of the role of the front-line practitioner as a suicide first-aid responder for suicidal children and youth. There are no known potential risks to you by participating in this research. In the unlikely event that you experience stress in response to the interview, you will be offered assistance in accessing counseling supports. If you agree to voluntarily participate in this research, your participation will include ongoing informed consent, and participation in an individual 60 minute audio recorded interview after office hours at Interior Community Services on 765 Tranquille Road. If you are interested in participating in the research, please provide me with your mailing address and a copy of the Consent Form will be mailed to you for your review. Should the information contained in the Consent Form meet with your approval and you wish to participate in the research you are asked to contact me to schedule the interview.

APPENDIX C



University
of Victoria

British Columbia
Canada

Participant Consent Form

“The front-line practitioner’s experience of working with children or youth engaged in suicidal behaviour”

You are being invited to participate in a study entitled “The front-line practitioner’s experience of working with children or youth engaged in suicidal behaviour” that is being conducted by Patti Ranahan.

Patti Ranahan is a graduate student in the School of Child and Youth Care at the University of Victoria and you may contact her if you have further questions by calling (250) 682-0615.

As a graduate student, I am required to conduct research as part of the requirements for a master’s degree in Child and Youth Care. It is being conducted under the supervision of Dr. Roy Ferguson. You may contact my supervisor at (250) 721-7983.

The purpose of this research project is to develop a deeper understanding of the front-line practitioner’s experience working with suicidal children and youth.

Research of this type is important because it has the potential to enhance the ability and capacity of front-line practitioner to respond to suicidal children and youth through advancing the knowledge base that informs direct practice. Interior Community Services’ commitment to providing suicide prevention training to all child and family service front-line staff underscores the importance of this issue.

As a front-line practitioner involved in direct service with children or youth, you are being asked to participate in this study.

If you agree to voluntarily participate in this research, your participation will include a review of the Letter of Information, ongoing informed consent, participation in an individual 60 minute audio recorded interview at the offices of Interior Community Services.

Participation in this study may cause some inconvenience to you, including transportation to and from the interview location, time requirements for the interview, or child care arrangements for the duration of the interview. Interviews will be scheduled after office hours at the convenience of participants.

It is possible that participants may experience emotional discomfort, stress, or fatigue as a result of participating in the research. In the unlikely event that you experience stress, emotional discomfort, or fatigue in response to the interview, you will be offered assistance in accessing counseling supports.

The potential benefits of your participant in this research include a heightened sensitivity or awareness to suicidal children or youth as you will be given an opportunity to reflect on your practice. As well, participation may be of benefit to you and other front-line practitioners as there

is an opportunity for the contribution of those involved in direct practice to add to the existing state of knowledge pertaining to suicidal children and youth. The larger society may also benefit from your participation as medical personnel, clinicians, and educators may increase their awareness of the front-line practitioner as the suicide first aid responder for suicidal children and youth.

The researcher may have a relationship to participants as a co-worker within the research site but your participation in this research must be completely voluntary. 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 will not be used in the research and be subsequently destroyed by the researcher.

In terms of protecting your anonymity, no identifying information of participants or of the clients they may describe will be included in the thesis.

Efforts to maintain your confidentiality and the confidentiality of the data will be undertaken by conducting the interviews after office hours to minimize the possibility of your attendance at the interview being observed by fellow staff members of Interior Community Services. Any identifying information in the data collected will be omitted, and the data will be stored in a locked cabinet in the researcher's office.

It is anticipated that the results of this study will be shared with others through the production of a thesis, a presentation at a professional conference, and/or a published article in a professional journal.

Data from this study will be held for a period of five years, after which time all paper copies of the data collection will be shredded, and any electronic data (i.e. tape recordings, computer files) will be erased or fully deleted at that time.

Individuals who may be contacted regarding this study include the researcher, Patti Ranahan at (250) 682-0615, or the academic supervisor, Dr. Roy Ferguson at (250) 721-7983.

In addition to being able to contact the researcher and the supervisor, at the above phone numbers, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Associate Vice-President, Research at the University of Victoria (250-472-4545).

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

Name of Participant

Signature

Date

A copy of this consent will be left with you, and a copy will be taken by the researcher.

APPENDIX D

DEMOGRAPHIC INFORMATION

Please indicate answer by check-mark or "X" on the line to the RIGHT.

Basic Demographics

Male ___ Female ___

Age: 20 – 24 ___ 25 – 29 ___ 30 – 34 ___ 35 – 39 ___ 40 – 44 ___

45 – 49 ___ 50 – 54 ___ 55 – 59 ___

Education (check highest level completed)

High school ___ Post-secondary Certificate ___ College Diploma ___

University Degree ___ Graduate Degree ___

Area of Study

Social Work ___ Child and Youth Care ___ Psychology ___

Sociology ___ Criminology ___ Human Services ___

General Arts ___ Other (please identify): _____

Years of Human Service Professional Experience (including practicum experience)

Under 1 year ___ 12 – 24 months ___ 25 – 60 months ___ 5 – 7 years ___

8 – 10 years ___ Over 10 years ___

Current Professional Role/Title

Family Support Worker ___ Child/Youth Care Worker ___

Crisis Intervention Worker ___ Supervisor/Coordinator ___

Early Childhood Educator ___ Residential Care Aid ___

Other (please identify): _____

Primary Practice Environment (identify environment where the majority of your practice occurs)

Residential Setting ___ Family/Caregiver Home ___
 School ___ Community/Outreach ___ Day Treatment/Program ___
 Hospital ___ Community Health Centre ___ Community Drop-In ___
 In-Office ___ Other (please identify): _____

Population Served (check as many that apply)

Children Under 6 ___ Children Ages 6 – 12 Years ___
 Youth Ages 13 – 18 ___ Youth Ages 19 – 24 ___ Families ___

Hours of Training in Suicide Prevention (including workshops, academic course work, etc.)

No Training ___ 1 – 3 hours ___ 4 – 7 hours ___ 8 – 10 hours ___
 11 – 14 hours ___ 15 – 20 hours ___ Over 20 Hours ___

Number of Times You Have Helped a Person at Risk for Suicide (include occurrences within professional practice only)

0 ___ 1 – 3 ___ 4 – 5 ___ 6 – 9 ___ 10 – 15 ___ Over 15 ___

Frequency of Issue Related to Suicide in Your Professional Practice (i.e. client with suicidal thoughts, death by suicide, suicide attempts, self-harm with clear intent to die)

less than once per month ___ 1 – 3 times per month ___
 4 – 5 times per month ___ 6 – 10 times per month ___
 Over 10 times per month ___

Feelings of Preparedness in Working with Suicidal Children or Youth

Well Prepared

Somewhat Prepared

Not Feeling Prepared



Indicate by placing a mark on the continuum.

Paul Sibley
Chief Executive Officer
Interior Community Services
396 Tranquille Rd.
Kamloops, B.C.

Monday October 9, 2005

RE: REQUEST FOR APPROVAL FOR CONDUCTING RESEARCH

Paul,

I am writing to request approval for Interior Community Services as a potential research site for studying front-line practitioners' experience of working with suicidal children and youth. This request is in accordance with the Interior Community Services universal policy "Research Protocols". The researcher is embarking on this study for fulfillment of the requirements for a Master of Arts, Child and Youth Care through the University of Victoria. An academic thesis supervisory committee has been established, and an application is in process to the University of Victoria Human Research Ethics Board.

It is my hope to recruit a minimum of six front-line practitioners as participants in the study from the staff pool within Interior Community Services. Participation in the project will be voluntary and potential participants will be thoroughly informed of the possible benefits and inconveniences that may occur as a result of their participation. Participants will be requested to attend an individual interview of approximately one hour. In order to ensure confidentiality, interviews will occur after office hours. The study will be designed to protect the identification of any clients or families. Participants will be asked to sign a Consent Form that acknowledges their right to withdraw from the study at any time.

In order to document your authorization of the study, your signature is requested below. Please sign and return. Should you require additional information, please do not hesitate in contacting me.

Patti Ranahan
1230 Raven Dr.
Kamloops, B.C.
V2B 8P3
(250)682-0615

Signature of Approval:

Paul Sibley, CEO

APPENDIX G

Interview Sample Questions

“The front-line practitioners experience of working with children or youth engaged in suicidal behaviour”

- **Tell me about a time you have worked with a child or youth engaged in suicidal behaviour**

***Prompt:* Who else was there, and what did they do?**

- **What knowledge did you draw from to inform your actions in the example you provided?**

***Prompt:* What influenced your action?**

***Prompt:* What was the most helpful in determining your action?**

- **What did you notice within your physical and emotional self after your encounter with a suicidal child or youth?**