A Saskatchewan Perspective of Psychologists’ Quality of Professional Life as a Determinant in Responsiveness when Working as Suicide Interventionist - A Mixed Methods Study

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ABSTRACT

Psychologists’ professional quality of life, defined by healthy supportive work environments and satisfaction derived from work, is one factor for determining positive client outcomes (Stamm, 2010; Figley, 2002). Self-care is essential to maintain psychologists’ fitness to practice and work quality (Smith & Burton-Moss, 2009; Skovholt, 2001; Radeke & Mahoney, 2000). Competence and fitness in practice, the demonstration of knowledge, skills, and capabilities to work responsively, safely and effectively, is a professional and ethical expectation pivotal in suicide intervention and ongoing suicide work (Neimeyer, Fortner, & Melby, 2001; Schmitz, Allen, Feldman, Gutin, Jahn, Kleespies, Quinnett, & Simpson, 2012).

This concurrent mixed methods study considers Saskatchewan psychologists’ quality of professional life as a determinant in responsiveness when working as suicide interventionist. Quality of professional life and responsiveness to suicide-ideated clients was examined. In the quantitative research, 61 Saskatchewan psychologists participated in an Internet survey, responding to the ProQOL5, Professional Quality of Life Scale - 5th Edition (Stamm, 2010), and the SIRI-2, Suicide Intervention Response Inventory - Revised Edition (Neimeyer & Bonnelle, 1997). Increased responsiveness to suicide-ideated client statements was correlated with practical experience-based suicide-specific training (such as supervised internships with a focus on suicide work and Applied Suicide Intervention Skills Training-ASIST). Ratings of higher compassion satisfaction (from ProQOL5) were correlated with lower caseloads and increased self-care. Clinical psychology graduates demonstrated increased appropriate responsiveness to suicide-ideated statements over Educational psychology graduates.
In the qualitative methods, developed from 61 open-ended survey responses and interviews with 5 psychologists, it was uncovered that quality of professional life and fitness to practice cannot be the sole responsibility of the psychologist. Employers are responsible for workload expectations that can become unrealistic for psychologists to sustain best practices in suicide work. Psychologists identified that responsiveness in suicide work improves when: they have more control over caseload content, diversity and volume; supervisors and teams are collaborative and therapeutically knowledgeable in suicide work; stigma related to psychologists accessing professional and personal help is removed; self-care is engaged at a personal level and in the professional setting; support focused on psychologists’ needs after client suicide are engaged; and employers recognize the intensity of suicide work.

The study offers understanding of workplace and professional dynamics that influence competent, adequately responsive suicide work. The quantitative results have generalizability limitations, as the sample was limited to 61 Saskatchewan psychologists, which represents 11.5% of the total population of registered psychologists invited to participate through the Saskatchewan College of Psychologists. Themes derived from the open-ended responses of the 61 and the narrative essences derived from the 5 interviews will be helpful to psychologists and support discussion related to how regulatory bodies, training facilities, employers, supervisors, and organizations generate support for client suicide work.

Keywords: psychology practice, quality of professional life, compassion satisfaction, fitness to practice, responsiveness to suicidal ideation, ASIST, ProQOL5, SIRI-2
Life is filled with powerful learning and marvellous connections.

Gentle loving patient understanding allows

relationships and outcomes to be fruitful and filled with hope.

Living this life is a collaborative effort.

I thank my parents for the wisdom to show me what it means to live.

Their example to take on life’s challenges with loving kindness, grace, and

persistent patience has been a blessing.

I dedicate this work to my father, who demonstrates daily, despite challenges, that there

is always hope and strength for a new day.

I dedicate this work to my mother whose sweet thoughtful

encouraging words spurred me onward through all things. The entirety of my mother’s

life was grounded in faith, hope, love, and understanding.
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I am deeply grateful for the participation of the psychologists who took time out of their schedules to contribute their thoughts, experiences and voices to this work. Understanding and growth begins with a desire to participate.

Appreciation for my clients through the years has been astounding. The learning about persistent and patience from their stories of strength and resilience has sustained my work and endeavours.

To all my dearly and deeply beloved ones, you profoundly matter when it comes to instilling hope and perseverance. With warm loving words, generous prayers, and grounded thinking, you helped to sustain me during challenge. Each of you is amazing in your demonstrations of endurance and love. I have been exceedingly blessed.
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CHAPTER 1 - INTRODUCTION

Statement of the Problem

Client presentation often includes suicide-related ideation, communication, and behaviour therefore psychologists must demonstrate appropriate responsiveness to intervene with the risk of suicide (Chiles & Strosahl, 1995; Neimeyer, et al., 2001; Lang, Ramsay, Tanney, & Kinzel, 2014; Schmitz, et al., 2012). Psychologists’ responsiveness to suicide ideation depends on numerous factors including: effective non-judgmental communication, appropriate caregiver attitudes related to suicide, absence of stigma-based barriers that influence caregiving, competent skill to recognize and intervene, and fitness to practice (Lang, et al., 2014; Leenaars, Maltzberger, & Neimeyer, 1994; Neimeyer, et al., 2001). Fitness to practice, the demonstration of knowledge, skills, and character to practice as a psychologist safely and effectively, is a professional and ethical expectation of the profession of psychology (Canadian Psychological Association, 2000; College of Registered Nurses of British Columbia, 2008; Sinclair & Pettifor, 2001).

Various factors contribute to professional competence and fitness, including physical and mental health, awareness of effectiveness in client work, strong knowledge and capabilities, and quality of professional life - encompassing compassion fatigue, burnout, and compassion satisfaction (Figley, 1995, 2002, 2007; General Medical Council, 1983; Stamm, 2010). Very limited information is available to describe the position of Saskatchewan psychologists with regard to their responsiveness to suicide-ideated clients. Little information was located in the literature with regard to
effectiveness of work supports, regulatory body advocacy, and access to suicide-specific training for Saskatchewan psychologists. Factors influencing quality of professional life as a determinant in the responsiveness of psychologists’ to suicide ideation also were not found.

**Priming - Research Questions**

Two questions were pivotal in conceptualizing and developing this study:

1) What is the experience of Saskatchewan psychologists with regard to their professional quality of life?

2) According to the Saskatchewan psychologists themselves, how do their professional experiences and professional quality of life, influence ethical competent responsiveness to suicide-ideated clients?

From these questions a multitude of layers began to unravel.

This mixed methods study focused on registered psychologists in Saskatchewan. Psychologists’ quality of professional life as an influencing factor, a possible determinant, in the effectiveness of suicide intervention with clients was investigated. Concurrent exploration of quantitative and qualitative data was pursued. The quantitative data examined the quality of participant psychologists’ professional life, with the constructs of compassion satisfaction, burnout, and secondary traumatic stress, as assessed with the use of the instrument, ProQOL5- Professional Quality of Life Scale, 5th edition (Stamm, 2010) and psychologists’ effective responsiveness to suicide ideation was measured with the SIRI-2, Suicide Intervention Response Inventory, 2nd edition (Neimeyer & Bonnelle, 1997). Numerous influencing factors are also examined
in addition to the previous two measures, including caseload volume, self-care, education, years of practice, and suicide-specific training.

Qualitative exploration included theme development from psychologists’ written responses to open-ended questions and from a narrative developed through the stories of psychologists who provided one on one interviews. Themes that emerged develop understanding of: psychologists’ experiences of professional quality of life; the influence of self-care on responsiveness; the impact of suicide intervention and therapeutic work on psychologists; organizational pressures that detract from quality of life and responsiveness; stigma within psychologists and their employers related to accessing personal and professional support; personal reactions to client suicide; and recommendations for organizations related to client suicide and psychologists’ ongoing suicide work. Psychologists’ awareness of how the quality of their professional quality of life influences responsiveness to suicide work is developed. The quantitative and qualitative results are converged in interpretation.

Why this Topic?

Phenomenon selected for study has unique significance to a researcher. The research topic is central to personal and/or professional interests and, therefore, the researcher already has knowledge before entering the research process (Tesch, 1987). Observations made by colleagues, and, my own professional and personal experiences, brought wonderings about how to better support psychologists’ practice related to suicide work when balancing workplace demands, professional expectations, and personal needs. Being fit and well in practice as a psychologist is paramount to providing good work with clients (Sinclair & Pettifor, 2001; Baker, 2002; Skovolt,
During and following workshops that I had facilitated across Saskatchewan and North America, various mental health caregivers raised fears about inadequate employer and professional supports to sustain best practices in suicide work. A common concern expressed was that work environments were not providing the setting to be able to sustain the energy necessary for comprehensive effective long-term suicide work. Many psychologists voiced their concerns that the ability to be fully present and responsive in suicide work was challenged by work constraints around limited client time, caseload pressures, and lack of supervisory or collegial supports. Respected, competent and conscientious practitioners expressed deep fears and doubts related to being adequately responsive in suicide intervention and ongoing suicide therapy work. Work-life challenges were identified as a contributing factor in limiting their responsiveness. Their concerns were compelling and, clearly, very real.

The worries openly shared and intimated by these practitioners revealed that client safety from suicide might not have been adequately supported because work pressures, limited self-care, and isolation from supervisory and/or collegial support had eroded the practitioners’ abilities to listen and respond as appropriately as they knew they should have responded. These conversations activated significant personal and professional reflection, with regard to my experience as a psychologist. I could relate to their experience. I became conscious of how I, too, experienced work situations where the professional environment was less than adequate to provide support for sustained suicide work. The message that was becoming increasingly clear to me, through the wisdom expounded by the caregivers providing suicide intervention and ongoing suicide work, was that there is a need to explore and understand the experience
of the quality of professional life for psychologists and appreciate the impact on responsiveness to suicide ideation and ongoing suicide work.

**Intention of the Researcher**

Saskatchewan psychologists’ shared experiences of suicide responsiveness and the influence of their work-lives sparked hope - my hope was to understand their fears and activate change. I hoped that such worries, related to a limited responsiveness to suicide ideation or limited professional structures and supports, could be allayed. I hoped that professional communities, employers and psychology organizations would be fully engaged. Hence, the intention of this research is to enhance and add to the understanding of the demands of suicide work, raise awareness of the stress involved, and increase knowledge about Saskatchewan psychologists’ professional experiences working with suicide-ideated clients. Exploring determining factors that contribute to the quality of psychologists’ suicide-related work, or psychology practice, will be helpful in building better interactions, stronger resources, and supporting increased competence for caregivers. Identifying these factors can prove to be useful in encouraging psychology regulatory bodies, training facilities, and employers to engage practices that advocate for and support psychologists’ professional practice fitness. Employers can benefit by recognizing where their organizational structures are strong or require strengthening to encourage a healthy work environment for psychologists’ work with suicide-ideated clients.

Every effort has been put forward to try to reflect the psychologists’ experiences, responsibly and carefully ensuring that the findings and themes shared are representative of those who participated in the research (Toporek, 2011; Saldana, 2013;
Tesch, 1987). Sharing their voices is an honour. It is hoped that this study’s findings will be used to support psychology work environments and psychologists who seek to create adequate balance when providing suicide work. Interpretation of meaning can resonate within a reader activating learning, which may generate movement toward action to support suicide safer practices.

**Onto-epistemological Position**

Epistemology refers to the study of knowledge, how a researcher connects with reality, and ontology captures the study and conceptualization of the nature of the world or reality - these ideas are interconnected (Vasilachis de Gialdino, 2011). There are different ideas around how knowledge is acquired and integrated into thought. The study presents varied layers of meaning specific to quality of professional life as a determining factor in suicide work. Instrument measures are one way of understanding. Another is through the experiences of psychologists. Stories are layered in their social, temporal, individual, historical, and subjective ways of making meaning (Moen, 2006). Experience can be multi-faceted by connecting with another person, finding common ground, seeing differently than through one’s own view, and appreciating outcome measures. My way of understanding and acquiring knowledge takes into account various ways of knowing. Situational and relational contexts, impact and meaning of events and communications, scientific and logical measures, and physical-emotional states are integral in appreciating meaning and developing or activating learning for knowledge formation.
Ways of Knowing, Contextual and Constructivist

To know and understand a person is specific to that individual and their context. Contexts can include but are not limited to: history of experiences, culture, norms, social dynamics, emotional and physical health, interpersonal connections, and the setting (King & Horrocks, 2010; Larkin, Watts, & Clifton, 2008). Contextualism seeks to acquire knowledge through the participants’ understandings, the researchers’ interpretations, and cultural meanings in context (King & Horrocks, 2010). Social, cultural and historical ways lives are experienced and understood influence understanding – these are contextual layers (King & Horrocks, 2010). Elements of realism, scientific positivist ways of knowing, are one epistemology. Contextualism and constructivism posits there is room for many views - therefore quantitative and qualitative ways of knowing can work in tandem. Reflective of Heidegger’s philosophy, “it is impossible to ignore the subjectivizing influences of language, culture, ideology, expectations or assumptions…the human individual [is] a part of reality…” (Larkin, et al., 2008, p. 105). Unraveling instrument measures, narrating psychologists’ stories and sharing parts of my personal story are all valued based on the tenet that “all knowledge produced is dependent upon the context, including the perspective or standpoint taken when formulating the research” (King & Horrocks, 2010, p. 22).

Constructivist ways of knowing do not necessarily conflict with contextualism. The intent of constructivism is to understand “the world of human experience” (Cohen & Manion, 1994, p. 36). There is a range of human experiences, some constructed in quantitative and qualitative contexts. Experiencing and understanding must be
approached through the varied ways individuals learn - objective and subjective. Certainly, qualitative data tend to “generate or inductively develop a theory of pattern of meanings” (Creswell, 2003, p. 9). There are constructions of what we come to know understand and share based on constructivist approaches that recognize value in mixed methods (Mackenzie & Knipe, 2006). Meaning comes from within – through interpretation, based on the context we have lived and experienced.

This subjective construction, based on my external and internal meanings, connections, and contexts makes sense for me. I began with study and work in Fine Arts and then shifted my focus to caregiving, studying, and working in the field of Psychology. In some ways there is opposition from an emotive-creative leaning to a logic-scientific pole however there is richness in thinking through and learning from differing perspectives. I understand best with both ways of knowing together. The role of the researcher and the subjectivity that comes with analysis is part of contextualism as well as constructivism – this resonates as a situated constructivist way of knowing (Mattar, 2010). A personal leaning in interpreting and writing about the research is anticipated but is not determined as being a threat to validity or reliability of analysis (King & Horrocks, 2010).

**Considering the “Whole” – Mixed Methods**

The whole picture in this study will be developed through mixed methods design. Mixed methods inquiry, as Jennifer Greene is quoted saying, “is an approach to investigating the social world that ideally involves more than one methodological tradition and thus more than one way of knowing, along with more than one kind of technique for gathering, analyzing and representing human phenomena, all for the
purpose of better understanding” (Johnson, Onwuegbuzie & Turner, 2007, p. 199).

Two ways of thinking and knowing, one is quantitative and the other qualitative. Both are equally important and substantiate one another:

Complementarity allows the researcher to gain a fuller understanding of the research problem and/or to clarify a given research result. This is accomplished by utilizing both quantitative and qualitative data and not just the numerical or narrative explanation alone to understand the social story in its entirety.

(Hesse-Biber, 2010, Chap 1., p. 15)

These poles, quantitative and qualitative, allow for a dialectic that can demonstrate movement toward a larger understanding - there is not contradiction but rather interaction.

The compilation of the quantitative information creates a partial framework to understand what is or has happened with psychology practitioner’s quality of life and their responsiveness behaviour – this is an explanation of what is (Hjelmeland & Knizek, 2010). The quantitative information provides an objective, value-neutral, reflection of psychologists’ quality of professional life and responsiveness to suicide-ideated clients, this serves as one reflection of understanding (King & Horrocks, 2010). Development of the quantitative perspective would require the complement of ‘what it is like’ to see the whole picture (Larkin, et al., 2008). The complementary perspective is the qualitative description and interpretation, which offers a story of what it is like for Saskatchewan psychologists providing suicide work.

Additional development and history will be provided on mixed methods as a research design in the methodology section.
Research Paradigms

Choosing to consider multiple views is “use of...theoretical lens[es] or perspective[s] to guide the study” (Creswell, 2003, p. 136). A contextual worldview, as engaged by a researcher, indicates that there are multiple ways of knowing therefore interpretations can be changeable based on the context in which they are experienced and shared. A constructivist thought would be that subjective learning builds from within through interactions that are internal and external. With consideration for a pragmatic research paradigm for approaching this study, a few points were reflected upon: a) knowledge comes in various forms, including facts, procedures and values; b) we act and react in a world that is bio-physical, socio-cultural and subjective; c) there is interaction between what we know and what we are reacting/acting in and, as a result, our experiences are determined by these interactions; d) looking at goals, interest, values and consequences are valued in learning; e) there are no absolutes and certainties as knowledge is provisional, we build and understand more as we go; and f) the role of the inquirer, researcher, is key where interpretations are a building block as a result of learning from experiences (Hjorland & Nicolaisen, 2006; Wakkary, 2009).

An equally weighted mixed methods design leans on the value that knowledge comes from various vantage points and can be blended to create understanding and depth. A theoretical orientation of pragmatism offers the freedom to embrace both quantitative and qualitative data (Gray, 2013), along with various contextual ways of knowing, and does not get caught in the details of what is not quite right or what is absolutely right (Hjorland, 1997). If this theoretical approach works in real life, then use it (Johnson, et al., 2007). As Creswell (2003) notes, a pragmatist researcher focuses
on “what works” recognizing that “the problem is most important”, and “Truth is what works at the time” (pp. 11 & 12). It seems that a pragmatist paradigm leaves room to consider different worldviews, assumptions, paradigms, mixed methods, and embraces that there are not absolutes (Creswell, 2003).

The previous description is a pragmatist conceptualisation, considering multiple ways of approaching life, events, experiences and research to fit specific means of study to the need or problem. I am conscious that I also tend to lean into sociocultural theory in many ways. When considering voices of the participants in this research (Wertsch, 1991; Connelly & Clandinin, 1990), particularly in the development of the narrative work, I am aware that their stories are a shaping of their cultural, historical and social contexts (Vygotsky, 1978). The collection of voices and varying parts of stories, from unique contexts, shape a larger means to understanding - there is past, present, and future reflections of individuals’ beliefs, including my own voice, which allows the multidimensional aspect of many, this is narrative (Moen, 2006; Connelly & Clandinin, 1990). Development of narrative is a collaborative discussion and development of meanings, subsequently the restorying, via the researcher, is a means to share the mutually constructed event of the research (Connelly & Clandinin, 1990).

**Researcher’s Position**

My way of seeing and knowing will be different from that of the research participants but may have moments of overlap. In many ways the participants are my peers - they are psychologists. My context shapes the way in which events are seen and experienced by me. Regardless of this subjective framework, views and experiences of a researcher can be revealed and placed in a position of awareness before and during the
research (Wall, Glenn, Michinson, & Poole, 2004). It is useful to be critically aware that interpretation of data and results lie in the researcher’s control (Hesse-Biber, 2009). A researcher being open about her experiences allows for a transparent process. Husserl indicates that pure phenomenological research, free of hypotheses or preconception, offers a rich description rather than an explanation – with that said, most researchers identify that it is impossible to completely drop all biases and preconceptions (Lester, 1999; Smith, et al., 2009; Wall, et al., 2004). To be able to acknowledge biases and preconceptions openly allows for increased awareness when making effort to describe the informant’s stories (Smith, et al., 2009). Qualitative researcher, Laurel Richardson, highlights that notes capture the researcher’s observations, methodological points, hypotheses, and feelings which offer understanding around content, researcher, and participants, thereby supporting descriptions and foundations for interpretation (Hesse-Biber & Leavy, 2004).

To really listen and understand as researcher, I must know where my story ends and where the participants’ begin. Articulating context of myself, as researcher, helps to create clarity in capturing the participants’ experiences as they are (Wall, et al., 2004). A researcher “can remain ‘objective’ by bracketing preconceptions or acknowledging them as part of the research process” and still make effort to interpret the accounts that were described (Pringle, Hendry, & McLafferty, 2011a, p. 11). I have intended to keep myself in the process of the research but ensure the reader is conscious of where my experiences are situated. The intention in bracketing - note taking, journaling, situating and personally narrating with context - is to bring light upon what views are from the researcher and what views are from the participants. When reading
this work, please be mindful, “all texts are biased, reflecting the play of class, gender, race, ethnicity, and culture, suggesting that so-called objective interpretations are impossible” (Denzin, 2004, p. 459).

**Context of Researcher**

Professional experiences and work backgrounds are varied – I am very fortunate to have many contexts that have supported my learning. I have worked providing psychology assessment and therapy with children, youth and adults. Work has included provision of services for: war veterans through art; child and family work within a child-protection framework; open-custody residential work; work with youth in clinical, inpatient and outpatient systems; forensic assessment and treatment for youth; university-student counselling; psychiatric unit work; and, now, private practice with teens, adults and couples. I provide ongoing suicide-work to clients who require this focus. I know the sting and grief that comes as a result of client suicide. Suicide awareness, alertness, and intervention training is a passion for me.

As a result of this work, I have developed a specific lens related to intervention. This work has informed me of prevention, intervention and postvention strategies related to suicide. Training, awareness of personal attitudes, and adhering to best practices can create safety in suicide intervention. Stigma has been observed to create blocks in social, occupational, medical, religious, and cultural arenas such that suicide is not fully acknowledged. Suicide of both clients and loved ones has acutely heightened my awareness of how to listen, be active in and engage suicide work. For personal clarity while interviewing, unpacking themes and evaluating data, I took time to always
be cognizant of the value of a variety of methods in suicide-intervention, therapeutic work, and lessons from suicide.

My therapeutic positioning is such that a biopsychosocial, cultural and spiritual framework is seen as important in understanding overall health and mental health. I lean into nonjudgmental humanistic unconditional positive regard and empathic listening for understanding – which, I believe, fosters openness and self-disclosure to support self-actualization. Several therapeutic strategies are engaged and are selected based on client fit. While in the research process, there was no intention to judge which therapy, style, or engagement is best.

Power relationships have been revealed to me in various domains. Paternalistic and hierarchical systems have been observed to squelch new ways of knowing, stifling different paradigms and losing consideration for individuals. Being part of several majority dominant groups, privilege is acknowledged through being white, middle-class, holding graduate education, having gainful employment, and, speaking the language of majority. Hence, in the interactions with participants, there was effort to ensure a peer relationship. Throughout the research, conscious efforts were made to receive and be open to new knowledge and push beyond my paradigm.

My personal framework is also significant in this research. Personal lived experiences include suicides of loved ones and supporting loved ones during suicide ideation. I have survived depression and anxiety and understand suicide ideation from an insider perspective, having had suicide thoughts of my own. I am thankful that I have thrived beyond personal trauma. The value in experiencing personal traumatization has informed me that internal mechanisms change how one is in the
world. Learning from pain and trauma has increased my resiliency, heightened my awareness of injustices, increased how I advocate for those traumatized, and has increased my efforts in thoroughness related to suicide work. Some of the research participants may have experienced trauma. Conversely, they may not have. Whatever their experience, their stories are important and unique.

As researcher, I value various ways of acquiring knowledge, through objective research, subjective experiential means, social and cultural teachings and contexts, and through narrative. Growth comes through challenge, experience, and appreciating the other. There is value in doing, living, listening, facilitating, and in researching.

**Limitations**

Despite several efforts to elicit interest in the population of registered Saskatchewan psychologists to participate in the quantitative study, the response rate was low (11.5% of registered psychologists from the membership of the Saskatchewan College of Psychologists responded). Sample error and sample bias could have occurred as a result of the low response rate (Nulty, 2008). Generalizability of the quantitative results may be considered limited. Demographic characteristics of those that responded to the survey may be similar and, conversely, dissimilar to the non-respondents, which may also influence quantitative and qualitative survey data (Goyder, 1987; Nulty, 2008). In regard to the quantitative data, correlation was utilized as a tool and correlation is not representative of causation. Hence, there may be factors unaccounted for that may be influential in correlations.

The qualitative research gathered from the open-ended participant responses and from interviewing is developed by the researcher’s interpretation and analysis.
Interpretation and analysis of a researcher is a subjective tool. The manner in which readers are situated, within their own context and understanding, may provide different ways in which they see, know and understand—there are various possibilities in interpretation of the study (Denzin, 2004). The researcher interpreted thematic content, from the open-ended survey responses—there was not a team to cross check coding. Although collaboration did occur with interview participants regarding their intentions, stories, and quotations, the researcher derived themes, interpretation and restoried their narratives and so the work remains contextual, subjective and, potentially, biased (Saldana, 2013; Creswell, 2012; Denzin, 2004). Lastly, the qualitative interviews were held at different times of day and in different environments. Different contexts between time of day, and home or workplace have influence over responses provided from the interview participants (Creswell, 2012).

**Delimitations**

The study is focused on psychologists that are registered with the Saskatchewan College of Psychologists. There are a number of professionals in Saskatchewan that provide suicide intervention, some of whom may have a psychology-based clinical or educational background but have not met criteria for registration with the Saskatchewan College of Psychologists. Those not registered with the Saskatchewan College of Psychologists may not be governed by the same standards of practice, may not have met similar minimum educational requirements, nor have the same ethical expectations as those who have been vetted and licensed as psychologists in the province.

The study was not open to all caregivers who provide suicide-intervention. There is a broad range of suicide-interventionists but the variance in education,
background, and work is too broad to have commonality of practice experience found in psychologists.

The study does not focus on nor determine which therapy models are most useful in therapy practice with suicide-ideated clients. The study does not consider all variables that influence personal wellness in psychologists. Further, there is recognition that not all university psychology programs offer the same course content.

**Significance of the Study and Contribution to Knowledge**

No previous Saskatchewan research could be located to consider the connections between quality of professional life and responsiveness to suicide ideation. No studies were located for the population of Saskatchewan psychologists specific to use of either instrument, the ProQOL5 or the SIRI-2. Research discussing Saskatchewan psychologists’ fitness to practice had not been examined specific to the influence on suicide work. Saskatchewan psychologists’ narrative descriptions of the impact of suicide work had not been found in the literature review. This study will identify a snapshot of some of the lived experiences of Saskatchewan psychologists with regard to influencing factors in: responsiveness in suicide work; elements determined necessary in maintaining healthy professional quality of life, and supports needed when providing suicide work.
CHAPTER 2 – PREFACE TO LITERATURE REVIEW

Supporting Literature

In order to review adequate literature to support the premises of this investigation, it was necessary to seek literature that would be relevant to work roles of those that provide care to individuals with suicide-related ideation, communication and behaviour. The reviewed literature took into consideration those that provide care to people with mental, emotional, interpersonal or environmental problems. Provision of care to persons with suicide ideation and behaviours extends far beyond the scope of psychologists. Various care providers such as nurses, psychiatrists, physicians, social workers, counsellors, therapists, clergy, hospice workers, and psychologists have been the focus of the literature that is being utilized as reference in the ensuing discussion.

The practice areas, educational backgrounds and acquired competencies of psychologists vary (e.g., clinical, forensic, educational, counselling, organizational, industrial). Similarly, varied educational backgrounds are identified in the roles of counsellors, therapists and other varied caregivers who intervene with suicide. Parallels developed from the literature are helpful to understand the influence of self-care, quality of professional life, fitness to practice, and responsiveness to suicidal clients. Literature from varied professions related to suicidology, the multidisciplinary study of the causes and prevention of suicide behaviour, along with information about caregivers’ self-care, fitness to practice, and quality of professional life undergirding this study are acknowledged as useful to form the literature review extrapolating that similarities in other caregiver populations are applicable to the population of Saskatchewan psychologists.
Terms and Definitions: Preparation for Literature Review

To allow for meaning to be clarified for the reader, the following section is an overview of the terms and definitions from supporting literature. The terms to be defined are: psychologists and caregivers; suicide ideation, communication and behaviours; caregiver self-care; burnout, compassion fatigue and compassion satisfaction; and fitness to practice.

“Psychologists” and “Caregivers”

The term *caregiver* is used representing the discussion drawn from the variety of literature sources specific to professionals responsible to provide mental health care or suicide-related counselling, assessment, treatment, therapy, or intervention. Varied caregivers contribute to knowledge in the areas to be discussed around impact of caregiving as related to suicide intervention, as many caregivers are called upon to support suicide-ideated persons (Lang, et al., 2014).

The term *psychologist* is used when specific literature cites ‘psychologists’. A psychologist is prepared, through their education, in assessing, diagnosing, treating, providing therapy, studying and/or researching behaviour, emotions, and thinking processes, with the intent to help people understand and move toward change in their behaviour (American Heritage, 2014; American Psychological Association, 2014; Canadian Psychological Association, 2014). Psychologists’ work focuses across the lifespan and across all human experiences with identified speciality areas across science/research, school/educational, counselling, clinical, clinical neurological, health/mental health, injury/rehabilitation, forensic/correctional, workplace,
community/societal and to industrial/organizations – this list is not comprehensive as
additional speciality areas may exist and continue to develop (Saskatchewan College of
Psychologists, 2014). Some psychologists providing treatment, or therapy, may also be
referred to as therapists.

**Suicide Ideation, Communication, and Behaviour**

The term *suicidal ideation*, *suicide ideation* or *suicide-related ideation* occurs
when individuals are experiencing thoughts or ideas about suicide with or without
intention to act upon the thoughts (O’Carroll, Berman, Maris, Moscicki, Tanney, &
Silverman, 1996; Silverman, 2006; Silverman, Berman, Sanddal, O’Carroll, & Joiner,
2007a). *Suicidal communications or suicide-related communications*, with or without
intention to die, are described as verbal or non-verbal (which can include drawings,
writings or notes), passive, active or covert, suicide threats and/or suicide plans, that
describe action that can lead to suicide-related behaviour (Silverman, Berman, Sanddal,
O’Carroll, & Joiner, 2007b).

*Suicide-related behaviour* refers to action that stemmed from thoughts of
suicide, however a clear intention to die may or may not be present, there may or may
not be injury or fatal outcomes (O’Carroll, et al., 1996; Silverman, et al., 2007a). In
some suicide-related behaviour there may be *instrumental behaviour* (where there is an
effort to communicate or achieve a particular outcome through the suicide behaviour –
one example may be demonstrating how serious the situation is for the individual to
receive help) while in other suicide-related behaviour, there is clear intention to die
(O’Carroll, et al., 1996). Instrumental suicide-related behaviour may end in a death;
however, there was not intent to die – such occurrences should be identified in
autopsies, or be reported, as accidents (O’Carroll, et al., 1996). Despite, the more apt classification as accidental, death by instrumental suicide-related behaviour is often difficult to class as determining intention after death, is unlikely, unless there is a written record found or such information had been communicated in throes of death.

A suicide attempt is identified as a suicide-related behaviour acted upon with the intention to suicide, however, the individual may survive if interrupted or if there was not lethality—conversely, the individual may die as a result of the suicide attempt (O’Carroll, et al, 1996; Silverman, 2006). Death by suicide and suicide are terms that should be used interchangeably (Silverman, 2006). Suicide refers to death resulting from self-inflicted suicidal actions where there is intention to die (Silverman, 2006; World Health Organization, 2012). Risk-taking or altruistic actions that unintentionally end in death are not considered suicide (Cutcliffe, 2003; Moscicki, 2001). Suiciding is the action form of suicide, while suicided is the past tense form of suiciding (Lang, et al., 2014).

Caregivers’ Self-Care

A caregiver has varied definitions across personal and professional domains. Within personal domains, a non-paid non-professional, caregiver can be identified as a person who provides care and support through parenting, or helping a family member or friend when they cannot manage their own needs independently whether the need is based on physical or emotional illness or developmental disability (Work and Family Researchers Network, 2014). Conversely, a professional caregiver is one who is typically paid to provide care to an individual requiring support related to emotional or physical illness, decline, or challenge and the range of support can span professionals
from health, education, psychology, social work, crisis, or spiritual domains in either inpatient or outpatient realms (Skovolt, 2001; Lang, et al., 2014). The literature for this study is drawn from that specific to professional caregivers.

*Self-care* has been acknowledged across the literature as being care for oneself within context of activities of daily living (Godfrey, Harrison, Lysaght, Lamb, Graham, & Oakley, 2011; Roper, Loper, & Tierney, 1980). Activities of daily living, originally identified in nursing care as an assessment tool to identify the independence, wellness and health of a patient, are influenced by biology, psychology, sociocultural, environment, and the politicoeconomic factors (Roper, et al, 1980). Although activities of daily living are referred to generally with patient assessment, activities of daily living can be a reflection of individual health and does not preclude caregivers. Professionals providing care to others physically, medically, emotionally, mentally, or behaviourally require special attention to their own self-care as professionals to maintain their ability to be healthy and well so as to continue care for others (Baker, 2002; Figley, 1995; Norcross & Guy, 2007; Rothschild & Rand, 2006; Schwartz & Flowers, 2006; Weiss, 2004). A reduction in the therapist’s level of self-care interferes with physical or mental health (Baker, 2002; Figley, 1995; Lang, et al., 2014; Norcross & Guy, 2007; Skovholt, 2001; Weiss, 2004). For caregivers to remain psychologically fit and physically well, practicing competently, ethically, and morally, self-care must be actively pursued (Figley, 1995, 2000, 2005; Norcross & Guy, 2007; Schwartz & Flowers, 2006).

For the purposes of this discussion, self-care will be identified as the specific and intentional care given to oneself, an identified caregiver of persons with suicide ideation, communications, and/or provider of mental health support and/or services to
clients. Self-care is the direct effort to intentionally care for oneself, as mental health caregiver, to offset the demands of providing care to others (Baker, 2002). Self-care activities are defined broadly in the literature, but, include efforts to enhance one’s health physically, spiritually, vocationally, socially, emotionally, interpersonally, mindfully, and cognitively with the acknowledgement that providing care to others can create a depletion and negative effect on the caregiver’s overall physical, spiritual, emotional, relational, vocational, ethical, moral, cognitive, and mental health (Alkema, Linton, & Davies, 2008; Baker, 2002; Case & McMinn, 2001; Figley, 1995, 2002, 2007; Godfrey, et al., 2010; Norcross, 2000; Norcross & Guy, 2007; Schwartz & Flowers, 2006; Schwer Canning, 2011; Thomyangkoon, & Leenaars, 2008; Wityk, 2003).

**Burnout, Compassion Fatigue and Compassion Satisfaction**

There is an extensive amount of literature related to burnout, secondary traumatic stress, vicarious trauma, and compassion fatigue for health professionals. A more recent construct in the literature is compassion satisfaction (Stamm, 2010). Secondary traumatic stress and vicarious traumatization are discussed interchangeably with compassion fatigue.

High achievers having “pushed themselves too hard for too long” can experience burnout (Freudenberger & Richelson, 1980, p 11). The concept of burnout, with general reference to occupation stress, was first coined by Dr. Herbert Freudenberger in 1974, burnout symptoms are described as exhaustion, detachment, cynicism, boredom, impatience, heightened irritability, sense of omnipotence, feeling unappreciated, suspicious of environment, disorientation, depressed, having psychosomatic problems,
and denying feeling (Freudenberger & Richelson, 1980). With regard to caregivers, burnout is correlated with lack of support from the work environment, overloaded or repetitive caseloads, extreme emotional exhaustion, perfectionistic distress, feelings of incompetence, depersonalization, lower productivity, and stress from the work role resulting from dissatisfying outcomes with clients (Devilly, Wright, & Varker, 2009; D’Souza, Egan, & Rees, 2012; Figley, 2002; Jenkins & Baird, 2002; Malzman, 2011; Maslach & Leiter, 1997; Salston & Figley, 2003; Steven & Higgins, 2002).

Compassion fatigue is described as the cost of caring, where ongoing work with traumatized persons leaves the caregiver’s ability to react compassionately in a diminished state (Figley, 1995). Compassion fatigue is posited to be a measurable construct arguably encompassing burnout (Stamm, 2010). Burnout has underpinnings of organizational, excessive workload, and persistent over-achievement pressures (Stamm, 2010). Compassion fatigue is more persistently demonstrated as the excessive empathic wearing out of the caregiver through traumatically stressful exposure in client care (Figley, 1995, 2002, 2007; Stamm, 2010).

Secondary traumatic stress or vicarious traumatization are repetitively described and noted as the same construct, or very similar constructs as compassion fatigue - the caregiver, repeatedly exposed to second-hand trauma, internalizes the stress of the client (Figley, 1995, 2002, 2007; Stamm, 2010). Fear is an added element in the description of secondary traumatic stress (Stamm, 2010). Exhaustion, persistent arousal, unwanted recall of client experiences, avoidance of talk of trauma in session, numbing of feelings and distancing from the client can all be observed in secondary traumatic
stress (Baird & Kracen, 2006; Figley, 1995). Following is the diagram representation of Figley’s Compassion Stress and Fatigue Etiological Model (2002).

![Diagram of Compassion Stress and Fatigue Model](image)

Figure 1. Etiological model of compassion stress and fatigue (Figley, 2002, p. 1437)

Disturbance to professional identity, sense of spirituality, view of others, disruption to worldview, reduced sense of safety, trust, esteem, intimacy and control are also reported in compassion fatigue (Arvay, 2001; Baird & Kracen, 2006; Berzoff & Kita, 2010; Devilly, et al., 2009; Kadambi & Ennis, 2008; Pearlman & Saakvitne, 1995; Salston & Figley, 2003; Stamm, 2010). Compassion fatigue results when no benefits are identified from working the caregiver role, thereby high emotional empathic caring continues without feedback of reinforcement (Stamm, 2010; Figley, 2002).

Adequate supportive discussion, evaluative support, supportive crisis debriefings, appropriate reinforcing supervision (Azar, 2000; Schultz, 2004; Talbot, Manton, & Dunn, 1992), appropriate workloads, varied caseloads along with new opportunities (Grant & Campbell, 2007), training and awareness readying for trauma work and suicide-related therapeutic work (Kleepsies & Dettmer, 2000; Linley &
Joseph, 2007), activation of self-care efforts (Baker, 2002; Rothschild & Rand, 2006), engagement in personal therapy (Arnold, Calhoun, Tedeschi, & Cann, 2005; Digiuni, 2011; Norcross & Guy, 2007; Linley & Joseph, 2007; Weiss, 2004), and using adequate case consultative resources and supports (Chiles & Strosahl, 1995; Lang, et al, 2014) help to prevent compassion fatigue. Illness, excessive responsibilities, overloaded schedules, heightened work demands or pressures can amplify compassion fatigue (Figley, 2002; DeAngelis, 2002).

Compassion satisfaction, seen as an opposite construct to compassion fatigue, is the positive aspects of being a caregiver wherein there is vicarious posttraumatic growth, increased therapist resilience, adversarial or stress-related growth and satisfaction from the compassionate empathic caring work because the client outcomes are seen as positives with improvement, adaptation or resolutions being observed (Arnold, et al., 2005; Grant & Campbell, 2007; Kadambi & Ennis, 2008; Linley & Joseph, 2007; Radeke & Mahoney, 2000; Stamm, 2010).

The following diagram represents the Theoretical Path Analysis: Professional Quality of Life as defined by Stamm (2010).
Figure 2. Theoretical Path Analysis: Professional Quality of Life (Stamm, 2010, p. 10)

Therapists can experience positive growth professionally, personally and interpersonally, and increase their capacity for empathy, compassion, sensitivity, and optimism when there are positive client outcomes (Arnold, et al., 2005; Figley, 2007; Radeke & Mahoney, 2000; Stamm, 2010). Compassion satisfaction has been identified as a means to ensure continued client care giving. Factors that influence reduction of compassion fatigue and burnout when monitored positively for healthful balance in caregivers have potential to enhance compassion satisfaction (Arnold, et al., 2005; Azar, 2000; Digiuni, 2011; Devilly, Wright & Varker, 2009; Figley, 1995, 2000, 2007; Jenkins & Baird, 2002; KIeepsies & Dettmer, 2000; Linley & Joseph, 2007; Maslach & Leiter, 1997; Norcross & Guy, 2007; Salston & Figley, 2003; Schultz, 2004; Stamm, 2010; Steven & Higgins, 2002; Talbot, et al., 1992; Weiss, 2004).
Fitness to Practice

*Fitness to practice* is the ability to physically, mentally, vocationally, and ethically deliver care competently, maintaining relationships that respect client autonomy, and conducting therapeutic works that are worthy of the trust being placed in the role of caregiver (College of Registered Nurses of British Columbia, 2008; General Medical Council, 1983; Sofronoff, Helmes, & Pachana, 2011). Conversely, if one is not fit to practice, there may be impediment, recognized or unrecognized, that interferes with provision of competent care, and enforcement of standards, expectations and competencies specific to the caregivers’ discipline (Lawson, 2007). Caregiver burnout and compassion fatigue have negative impacts on fitness to practice (Figley, 1995, 2002, 2007; Sinclair & Pettifor, 2001; Stamm, 2010).

Within the context of lack of fitness to practice would be such matters as caregivers being incompetent, unethical, or impaired (General Medical Council, 1983; Laliotis & Grayson, 1985; Sinclair & Pettifor, 2001). Psychologists not having sufficient current dated contextual training, not matching standards, having an uncaring attitude, and being ill where lack of insight prevents adequate client care may be ways in which a psychologist may not be fit to practice (Sinclair & Pettifor, 2001). Fitness to practice is the responsibility of the caregiver (CRNBC, 2008; GMC, 1983; Sinclair & Pettifor, 2001) however colleagues or regulatory bodies are involved in duty to support and/or report impairments in psychologists (Smith & Burton-Moss, 2009; Sinclair & Pettifor, 2001). Appropriate supervision can be helpful to ensure that any vulnerability or impairment is offset before unethical issues arise or fitness to practice erodes (Cummins, Massey, & Jones, 2007).
CHAPTER 3 - LITERATURE REVIEW

Context for Suicide Ideation, Communication and Behaviours

Meaning in conversation can only be interpreted from the conditions and circumstances referenced from within the individual who is listening (Strong & Sutherland, 2007). To listen and understand an ‘other’s’ situation and feelings without laying the film of one’s own personal bias, or way of seeing and knowing, over that other’s experience means one must know their own subjective experience and understanding, context, well enough to know where one individual ends and the other begins (Toporek, 2011). Being conscious of what one knows and does not know is important to develop meaning with another (Gurevitch, 1989; Toporek, 2011). Being able to name and appreciate what is not understood from one individual to another enables a richer and less conflictual discussion – one need not defend if it is clearly stated that there is not understanding just yet, rather, it can be a real discussion of *tell me more, I want to understand* (Gurevitch, 1989). Active listening and responding to a speaker in a manner that allows for depth of understanding through the listener’s use of nonjudgmental undistracted focus, ongoing clarification with summary and rephrasing, empathic responses, encouragement to speak and elaborate, and reflection of the meaning of the speaker’s message, allows for identification of suicide communication so that intervention matching the speaker’s needs can occur (Weger, Castle Bell, Minei & Robinson, 2014; Lang, et al., 2014).

Within psychology practice the idea of really knowing one’s own context, as both person and professional, and learning the experience of the other, the client, is an important exploration so the client’s presentation and outcomes are not blurred by the
listeners’ interpretations (Weingarten, 1992). As psychologist identifying, clarifying and placing into awareness one’s own paradigm helps to prevent getting in the way of the understanding of the other (Wall, et al., 2004). Caregiving, specific to client suicidal ideation, requires listening, understanding and communicating with reciprocity toward a built meaning (Chiles & Stroshal, 1995; Lang, et al., 2014; Weingarten, 1992). A suicide interventionist must recognize, explore, name, and understand suicide ideation in order to shape necessary ambivalence to turn an individual’s mind from suicide thought to the possibility of life, hence moving toward safety (Chiles & Stroshal, 1995; Lang, et al., 2014). Without initial recognition and appropriate responsiveness to suicide communication, it is impossible to intervene effectively. Effective safety planning is developed from the interventionist understanding and appreciating the perceptions of the individual’s distress and collaboratively developing changes to environment, resources and factors to support safety (Chiles & Stroshal, 1995; Lang, et al., 2014).

Such considerations are about the psychologist-client communication, psychologists’ insight and awareness of their client, and caregiver knowledge of effective suicide intervention. Rates of suicide, at risk populations, communication around suicide, caregiver ability to be responsive, and cultural factors create a background of the contextual factors that shape interaction related to suicide work.

**Diverse and Unique, Saskatchewan**

In the Canadian province of Saskatchewan demographics are diverse - there are urban/cities, rural/small town, and isolated rural settings with an ongoing decline in rural and isolated rural settings since the early-eighties (Bollman & Clemenson, 2008).
The decline in rural population also describes losses in relationships, culture, and community (Hirsh, 2006). These losses change how individuals are supported. Adequate recognition and access to supports is critical in protecting against suicide (Lang, et al., 2014).

Based on the Statistics 2006 Census, Saskatchewan data reported 81.6% of the population is white (with many influences from various European backgrounds), 3.6% of the population is a visible minority (including South Asian, Chinese, Black, Filipino, Latin American, Arab, Southeast Asian, West Asian, Korean, and Japanese), and 14.9% of the population is Aboriginal (including First Nations, Metis, and Inuit). The census noted within First Nations that Algonquian-Cree and Ojibway, Athapaskan-Dene, and Siouan-Dakota/Sioux were identified as languages spoken (Statistics Canada, 2006). Because of the variants from Eurocentric cultures, other immigrants along with the varied cultural dynamics of the Aboriginal peoples of Saskatchewan, the population is richly diverse¹.

Within the realm of Saskatchewan there are many differences spanning heritage, language, finances, and housing (Statistics Canada, 2006). Oppression and privilege are to be noted in Saskatchewan, as anywhere, resulting from varied socioeconomic conditions, class of majority versus minority differences, racism, sexism, ageism or any other variable that create hierarchy and power in a human system (Israel, 2012). Role, gender, age, illness, and wellness are additional layers of differences to consider more closely at individual levels (Choi, Rogers & Werth, 2007; Goldston, Molock, Whitbeck, 2006).

¹ This 2006 data was well broken down in the Statistics profile for Saskatchewan, but a more recent break down was not found.
Murakami, Zayas, & Hall, 2008; Israel, 2012). Considering the differences that are highlighted, it can be noted that such lived experiences are unique to individuals and historical experiences of peoples are unique in shaping paradigms and ways of engaging the world (Fischer, 1972; Israel, 2012; Weinrach & Thomas, 2002).

Suicide and death-related attitudes are additional contextual layers to be appreciated in responding to suicidal ideation (Chiles & Strosahl, 1995; Gagnon & Hasking, 2012; Goldston, et al., 2008; Lang, et al., 2014). Cognitive and diagnostic issues (including physical, mental and substance-abuse issues) also influence the context in which a client experiences the world and may develop suicidal ideation (Ellis & Goldston, 2012; World Health Organization, 2012). Suicide is multidimensional and suicide ideation, communications and behaviours can only be understood and intervened with through hearing the experiences of the individual (Cutcliffe, 2003).

**Rates of Suicide in Canada and Saskatchewan**

Worldwide, almost one million people suicide yearly (WHO, 2012). Over the last three decades, approximately 100,000 Canadians died by suicide (CASP, 2012). Canada has no national suicide prevention strategy despite efforts over the last decade to implement best practice recommendations. The Canadian Association for Suicide Prevention - National Suicide Prevention document initially released in 2004 offered a template for the development of national prevention strategies (Canadian Association for Suicide Prevention, 2009). December 14, 2012 was a historical turning point when Bill C-300, an act representing a federal framework for suicide prevention, was passed by Canada’s Parliament (Parliament of Canada, 2012). This initiative, if pursued fully would have established formalized standards and monitoring of suicide prevention
activities in Canada. Despite the framework being offered, a national suicide prevention strategy has not yet been finalized. British Columbia, Alberta, Manitoba and Nunavut have established regional suicide prevention strategies however Saskatchewan has not developed a cohesive province-wide suicide prevention strategy (Canadian Association for Suicide Prevention, 2015).

In 2009\(^2\) it is estimated that 3890 suicides occurred in Canada - a suicide rate of 11.5/100,000 people specific to non age-standardized data (Health Statistics Division, Statistics Canada, 2012). In these 2009 statistics it is noted that: male to female suicide is at a ratio of 3 to 1; persons 40-59 years of age demonstrated the highest rates of suicide; and the leading cause of death for ages 15-39 years was suicide (Statistics Canada, Health Statistics Division, 2012). In 2011, 3728 suicides occurred in Canada (Government of Canada, 2014). Rural and very isolated rural - frontier Canada, has a suicide rate nearly 4 times higher than the rate for the rest of urban Canada (Hirsch, 2006). The need for suicide intervention occurs within all demographics, suicide is not observed to occur in a select group (Pritchard, 1995; WHO, 2012).

Suicide rates are underreported (Lang, et al., 2014; WHO, 2012). Various factors have influence over underreporting such as uncertainty around cause of death or that the influence of stigma can change how the coroner interprets information in identifying a suicide (Lang et al., 2014; WHO, 2012). Family and friends may feel judged and scrutinized, an influence of stigmatization, and subsequently identify death as accidental in rural or farm suicides (Sturgeon & Morrissette, 2010). For each suicide

\(^2\) Suicide rates in Canada for 2009 and 2011 are both referenced, the most recent 2009 suicide rate for Saskatchewan is shown on the following page but there is not a 2011 Saskatchewan statistic published as yet. Both Canadian statistics were included for a cross reference to 2009 while the 2009 Canada and Saskatchewan data are used for a cross-reference specific to year comparison.
there are estimated to be between 20 (Statistics Canada, Health Statistics Division, 2012) upward to 40-100 times more suicide attempts (Lang, et al., 2014). Since 156 persons died by suicide in 2009, the range of suicide attempts could have been 3,120–156,000 (considering 20–100 times more behaviours compared to deaths). About 6% of the population across Canada experience thoughts of suicide at any given time (Lang, et al., 2014).

When considering suicides in Canada, it may be useful to consider the province and territory that have higher suicide rates. Most recent age-standardized Saskatchewan data from Statistics Canada (2012) reported that in 2009, 156 suicides occurred at a rate of 15.5/100,000, this being the highest rate among all the provinces. Among the territories, Nunavut reports the highest suicide rate in all of Canada as 57.1/100,000 (Statistics Canada, 2012). In Saskatchewan, based on the 2014 population estimate of 1,117,503, if 6% of the population experience suicidal ideation there would be an estimated 62,050 individuals at risk of suicide. Considering that Saskatchewan suicide rates are counted as the highest in the Canadian provinces, perhaps 6% of persons experiencing suicide ideation in Saskatchewan may be an underestimate, especially considering that under-reporting of suicide masks the actual suicide rate. With potentially so many individuals estimated to be experiencing suicide thinking, it would be important to know that enough interventionists are available. Certainly, this information supports the need for psychologists to pay careful attention to their clients, as risk of suicide is common.

Canadian suicide statistics are not broken down specifically to ethnicity, so it is difficult to ascertain rates among ethnic groups. Chandler, Lalonde, Sokol and Hallett
(2003) identified that Canadian Aboriginal adolescent suicide rates are the highest compared to other identified ethno-cultural groups worldwide. The estimated rate of suicide among Aboriginal people is 2.1 times the Canadian rate (Kirkey & Fekete, 2013). In Aboriginal males, 15-24 years of age, the suicide rate was 126/100,000 compared to 24/100,000 in Non-Aboriginal males (Canadian Institute of Child Health, 2000 as cited in MacNeill, 2008) – this is 5 times the overall Canadian rate of suicide. “15.8 percent of the First Nations adults on-reserve report having attempted suicide at least once in their lifetime, compared to three percent of the general Canadian population” (Kirkey & Fekete, 2013, p.1). Social, political, and historical oppression have inflicted ongoing lived traumas (such as racism, residential schools, abuses, familial displacement, and language, spiritual and cultural losses) for First Nations peoples – the oppression and traumas continue to resonate in today’s generations (Tatz, 1999). Causal factors for higher Aboriginal suicide rates may be cultural disconnection, through colonization and loss of familial and individual identity, historical trauma, socioeconomic poverty, poor environmental conditions, and adverse childhood experiences (British Columbia Mental Health, 2007; Chandler & Lalonde, 1996, 2008; Chandler, et al., 2003). Adverse childhood experiences (i.e., sexual abuse, domestic violence, neglect, parental mental illness and substance abuse) increase health risk for individuals in social, emotional and cognitive function, mental illness, and suicide-related ideation and behaviours (Anda, 1998; Beautrais, 2006: Collin-Vezina, Dion, & Trocme, 2009; Feletti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks, 1998; Fergusson, Beautrais, & Horwood, 2003; Goldney, 2002; Suicide Information and Education Centre, 2008; WHO, 2012). These adverse childhood experiences along
with a number of risk factors in the First Nations population of Saskatchewan have influenced elevated rates of suicide and efforts to avert risk of suicide must be put in place early through programs and initiatives that offset potential risk factors that can lead to suicide ideation (Government of Canada, 2012). Adverse childhood experiences can be tracked worldwide and are not specific to any ethnic or cultural group, nor are they only specific to particular historical experiences (Feletti, et al., 1998; WHO, 2012).

Further, with consideration to rural Saskatchewan, rates of suicide are higher in small communities and farming areas; farmers demonstrate one of the highest rates of suicide (Fraser, Smith, Judd, Humphreys, Fragar, & Henderson, 2005; Hirsch, 2006; Hossain, Eley, Coutts, & Gorman, 2008). Rural Saskatchewan people are more likely to be stigmatized and shamed regarding mental health or suicide-related matters (Judd, Jackson, Komiti, Murray, Fraser, Grieve, & Gomes, 2006; Sturgeon & Morrissette, 2010). Isolation in physical geography and from other people, lack of access to mental health services, financial, economic and socio-political stressors are additional factors increasing risk for suicide in rural communities (Judd, et al., 2006; Hirsch, 2006), along with accessibility to more lethal means for suicide such as firearms, chemicals, or dangerous equipment (Hirsch, 2006).

Risk factors for suicide vary from individual to individual but can include presence of mental and physical illness, alcohol or drug abuse, chronic illness, acute emotional distress, violence, a sudden and major change in an individual’s life, such as loss of employment, separation from a partner, loss of a valued life role, removal from cultural values, disruption of cultural values, or any adverse events perceived to be distressing by the individual (B. C. Mental Health, 2007; Fergusson, et al., 1999;
Hoffman, 2000, p. 563; Lang, et al., 2014; WHO, 2012, p. 4). The challenges of farm families could be many; certainly, ongoing disruption to rural structure, such as limited farm incomes forcing more work to be sought off the farm, lessening of cultural and/or supportive relationships, or crop failures could be a challenged to emotional well-being.

The magnitude of suicide-related ideation, communication, behaviours, and deaths in Saskatchewan is concerning. Would-be suicide interventionists’ responsiveness to suicide is pivotal in creating safety. Caregivers’ responsiveness to suicide may be challenged by various contextual differences.

**Practice Variances: Shaping Responsiveness**

Saskatchewan psychologists’ practice context varies based on whom they provide services for and where they practice. Urban, rural or frontier practices will look very different and present unique ethical considerations to support client needs and for wellness of the caregiver (Shank, Helbok, Haldeman, & Gallardo, 2010). Private and public funded practices demonstrate differences around accessibility. Training and supervision can prepare caregivers for better practice with suicide intervention.

**Urban, Rural and Frontier**

Urban and rural practices differ. Urban practices have access to numerous resources, for both clients and caregivers when suicide is a focus. Urban-based caregivers require insight into rural clients’ backgrounds in order to appreciate context (Barbopolous & Clark, 2003). Urban caregivers sent into rural settings are unlikely to be engaged for services because rural populations develop a sense of their own normal, where outsiders may not be seen as a helping resource regardless of training (Cates, Gunderson, & Keim, 2012). Conversely, rural caregivers who are connected to the
community have challenges to maintain ethical boundaries specific to multiple
relationships, confidentiality, clarity of roles, personal privacy, and accessing the
supports required both for their own self-care and for the resourcing to support clients
(Shank, et al., 2010; Weier & Davidson, 1999). Adequate help for suicide risk can be
more challenging when there are fewer professional resources available. Depending on
the level of rural isolation, virtually no direct services may be accessible, and other
professional resources to offer additional collaboration and support may be nonexistent
(Barbopoulos & Clark, 2003).

Confidentiality can be problematic in rural settings, neighbours know one
another and talk can happen - stigma in small communities prevents help seeking
(Cates, et al., 2012; Barbopoulos & Clark, 2003; Hirsch, 2006; Judd, et al., 2006;
Shank, et al., 2010; Sturgeon & Morrissette, 2010; Weier & Davidson, 1999).
Additionally, multiplicity of relationships is common in rural settings such that the
client and psychologist may share more than that one relationship simply by virtue of
various roles needing to be filled in order to make the rural setting work (Barbopoulos
& Clark, 2003; Cates, et al., 2012; Shank, et al., 2010; Weier & Davidson, 1999).
These roles may have an uncomfortable overlap or, an unethical overlap in some cases,
where power might be perceived and a subsequent change in therapeutic connection
may occur (Sinclair & Pettifor, 2001).

Professional resources in smaller communities may be limited and the weight of
care giving can be more intense (Shank, et al., 2010). Personal support for the caregiver
can be virtually non-existent if there are attempts to avoid multiple relationships with
clients or if there is effort to keep caregivers’ personal lives private (Chipp, Dewane,
Brems, Johnson, Warner, & Roberts, 2010; Shank, et al., 2010). Increased stress can occur for the caregiver when every day lived in a rural community is a disclosure to clients (Huebner & Huberty, 1984; Shank, et al., 2010). Burnout is a very real possibility in rural settings and is commonly manifest in rural caregivers resulting from inadequate self-care, isolation in the community and through the nature of work role, heavy caseloads, and lack of community supports. However, if there is adaptation and growth as a result of lessons learned about how to live and work in an isolated community, the caregiver can be quite satisfied (Chipp, et al., 2010; Cummings, Massey, & Jones, 2007). Hence, resilience can be developed.

Considering the small community of a school network, the school caregivers (social workers, psychologists, or teachers) have a tremendous role in responding to suicide-related ideation and communication. The smaller the community, the more the caregiver is sought out for help and support. As a professional, a caregiver is identified as the *mental health help* if their profile is that of school psychologist or counsellor. This professional role in small rural communities is amplified as a result of: role conflict, financial restrictions, lack of resources, limited supervisor support, inadequate job preparation and professional isolation (Huebner & Huberty, 1984).

Conversely, benefits in close caregiver-community involvement and visibility can create trust and respect, normalizing the caregiver role in the community (Barbopoulos & Clark, 2003; Shank, et al., 2010). Monitoring and resourcing for suicide-ideated clients, using local people and paraprofessionals, can be more readily set up in a rural setting than in an urban setting providing permission is established with the client (Barbopoulos & Clark, 2003; Shank, et al., 2010). Local elders, cultural or
spiritual leaders with connection to the rural caregiver may seek services on behalf of potential clients (Chip, et al., 2010). Adequate resourcing when working with adolescents at risk of suicide may dictate advocacy across the community including school, family, various community resources, or legal systems (Daniel & Goldston, 2009). Similarly, working with adults may require advocacy extended to employers, landlords, or financial institutions.

**Public or Private Practice**

To be responsive to suicide, a caregiver needs to be able to hear the client without distraction. Workloads can be oppressive in public practice (Norcross & Guy, 2007) and work pressures causing distraction in the caregiver reduce the ability to be genuinely present and open to the needs of the client (Baker, 2002; Norcross & Guy, 2007; Skovholt, 2001; Stamm, 2010). Private mental health practitioners may be more *customer-oriented* due to income differences noted when compared to public practice caregivers (Bjorngaard, Garratt, Grawe, Bjertnaes, & Ruud, 2008). More time and energy may be delivered when the private caregiver has choice over caseload volume and client presentation. Caregivers in public practice tend to be more heterogeneous, while private practitioners tend to specialize – the spread in skills and training may influence effective work with specific client presentations (Bjorngaard, et al., 2008). Suicide risk is a specific client presentation, which requires focused skills in order to respond (Niemeyer, 2000; Niemeyer, Fortner, & Melby, 2001). Adequate assessment of suicide risk and appropriate intervention response has been found wanting in emergency settings (Hurry & Storey, 2000).
Managed care mandates are limiting - private insurers indicate specific limits on mental health sessions, as well, in some public mental health care diagnostic treatment pathways, limited sessions are identified - there can be issues about adequate care being provided for individual client needs (Daniels, 2001). Ethically and legally, the caregiver, regardless of sector, is responsible for adequate mental health care regardless of resources and being attentive to suicide is essential (CPA, 2000). However if a system is not supporting payment for services or there are negative consequences in extra time spent with clients, caregivers may compromise care provision by overtaxing themselves or not delivering ethical work (Skovholt, 2001). In addition to adequate time required to identify client suicide risk, managing suicide risk requires collaboration of resources, professionally and informally (Chiles & Stroshal, 1995). Clients describe the importance of their caregivers providing adequate “listening, sensitivity, and respect” and emphasize that continued connections are beneficial to their increased functioning (Griswold, Zayas, Pastore, Smith, Wagner, & Servoss, 2008). However, collaboration suffers with too many cases and too little time available - the need for an increase in professionals’ communication to engage collaborative practices are necessary between medical practitioners, private and public psychiatrists, and mental health specialists in order to better serve client needs and manage severe cases (Younes, Hardy-Bayle, Falissard, Kovess, Chaillet, & Gasquet, 2005).
Training, Balanced Workload and Supervision

Mental health, primary health and emergency health care providers should be recognized as key gatekeepers in the prevention, assessment, intervention, and treatment of suicide risk (WHO, 2012). Monitoring best practices and adequate training, supervision opportunities and workload/caseload structure may differ between public or private mental health caregiver practices.

Graduate programs, the preparation place for professional caregivers, are thought to be where suicide interventionist training should be well-developed so that the professionals coming out of the program are well prepared to deal with suicide ideation, communication and behaviours. Bongar and Harmatz (1991) found 40% of psychology graduate programs offered formal training in suicide and of this training it was unclear what percentage was skill-based, experiential, practice. Curriculum materials were related to suicide prevention (attitudes, knowledge, awareness, and risk factors), categorization, and diagnostics but there was inadequate interpersonal skill practice specific to suicide intervention (Bongar & Harmatz, 1991; Hazell, Hazell, Waring, & Sly, 1999; Liebling-Boccio & Jennings, 2013; Neimeyer, 2000; Schmitz, et al., 2012). Inadequate ‘how to’ training results in “defensive, distancing, advice-giving, and authoritarian [responses]… dismiss[ing] client complaints with simplistic reassurance… [and] excessive passivity” (Neimeyer, 2000, p. 556) – there was failure to adequately assess, respond appropriately and intervene with suicide risk. Adequate skill-based training increases responsiveness and intervention skills (White, 2003).

Appropriate supervision facilitates growth in the caregiver, promotes understanding of clients and increased caregiver’s sense of accomplishment (Azar,
2000; Linley & Joseph, 2007; Schultz, 2004; Talbot, et al., 1992). Supervision that debriefs operationally or has a legal-focus decreases feelings of accomplishment (Schulz, 2004). Compassion satisfaction increases and burnout decreases when caregivers feel they are reinforced for accomplishing good work, are validated, and valued by their direct supervisor (Maltzman, 2011; Stamm, 2010). Growth oriented supervision protects against traumatization through exposure to client trauma or the challenges of working with traumatized clients (Toren, 2008).

Lack of appropriate training, inadequate peer or supervisory support, along with pressurized work environments, create deteriorative attitudinal influence toward clients demonstrating suicide-related behaviours (Friedman, Newton, Coggan, Hooley, Patel, Pickard, & Mitchell, 2006; McAllister, Creedy, Moyle, & Farrugia, 2002). Clients with challenging personality presentations and/or borderline personality traits presenting with suicide ideation increase potential for burnout in counsellor trainees without adequate support and supervision (Miller, Iverson, Kemmelmeier, MacLane, Pistorello, Fruzzetti, Watkins, Oser, Katrichak, Erikson, & Crenshaw, 2011). Occupational stress increases as a result of inadequate work balance, too many difficult cases, severity of trauma in cases, isolation and lack of peer support and poor boundaries (Maltzman, 2011). Positive regard and understanding of suicide-related behaviour diminish because of inadequate training, support, supervision, or oppressive workloads - angry responses can be given patients, missing suicide ideation and communication in self-harming clients entirely (McAllister, et al., 2002; Wilstrand, Lindgren, Gilje, & Olofsson, 2007).
Psychologists’ Personal Experiences Influence Responsiveness

Occupational stress is increased by the personal elements active in caregivers’ personal lives such as dealing with stressful events, experiencing transitions or losses, having young children, taking on overly-responsible parenting roles (Case & McMinn, 2001; DeAngelis, 2002), and adverse childhood experiences, such as victimization, abuse, or trauma (Elliott & Guy, 1993). Without ensuring personal and professional self-care, balance and boundaries, caregivers are exposed to compassion fatigue and/or burnout. Personal or work distress decreases caregivers’ abilities for listening, understanding, compassionately caring, working collaboratively to best find treatment and resources for the client and meeting therapeutic needs of clients (Smith & Burton-Moss, 2009). Listening and responding to suicide ideation is by caregivers’ abilities to understand and compassionately care (Neimeyer, 2000).

Healer, Heal Thy Self. There is Stigma.

Mental health caregivers acknowledge childhood histories of abuse, dysfunction, traumatization, alcoholism in family homes, parents struggling with mental health, and neglect – in higher proportion than other caregivers (Elliot & Guy, 1993; Murphy & Halgin, 1995; Pope & Feldman-Summer, 1992). Adverse childhood experiences (ACE) studies support that such experiences lead to higher risk for various health issues, including suicide ideation (Anda, 1998; Feletti, et al., 1998). Such vulnerabilities can predispose caregivers to increased distress and subsequent risk of developing burnout or compassion fatigue if there is not resolution to the childhood issues or if the issues are reactivated through client trauma (Elliot & Guy, 1993; Miller, 1998). Perfectionist patterns noted in caregivers interfere with work-life balance and create increased risk
for stress and burnout (D’Souza, et al., 2012). If health and stress are not adequately
managed, stress related illness can be activated such as “heart disease, depression,
cancer, arthritis, and gastrointestinal system disorders” (Skovholt, 2001, p. 158).

Despite receiving counselling, mental health caregivers with moderate to severe
histories of trauma are still at greater risk to develop secondary or vicarious
traumatization (Toren, 2008). Caregivers who had personally experienced suicide
ideation presented less effective responding to clients’ suicide-ideation and
communication even after training – this finding indicates further need for screening
and adequate therapy for the caregiver to be concrete about their values clarification to
be effective in responding in suicide intervention (Neimeyer, 2000). Greater pressure is
on caregivers to be well, have it together and not admit there is need to improve their
health - caregivers are expected to have the answers and be models of balanced mental
health (Baker, 2002; Good, Khairallah, & Mintz, 2009; Skorina, Bissell, & DeSoto,
1990; Smith & Burton-Moss, 2009). So there is a barrier of perceived failure - a
stigma, which does not allow caregivers to admit they need support or help (Baker,

Caregivers may also be exposed to other traumatic experiences such as violence
enacted upon them by clients (Miller, 1998) or client suicide (Valente, 1994). Client
suicide is traumatic for caregivers who may feel stigmatized by colleagues (or
themselves), overwhelmed by their emotions, and unable to gain resolution (Hendrin,
Pollinger, Hass, Maltsberger, Szanto, & Rabinowicz, 2004; Kleepsies & Dettmer, 2000;
Schultz, 2004; Valente, 1994; Wurst, Mueller, Petitjean, Euler, Thon, Wiesbeck, &
Wolfersdorf, 2010). Severe distress, similar to that in bereaved patients, was noted in
caregivers following client suicide (Valente, 1994; Wurst, Kunz, Skipper, Wolfersdorf, Beine, & Thom, 2011). Intrusive thoughts of the client suicide and personal suicide ideation were reported following a client suicide (Thomyangkoon & Leenaars, 2008). Fear of professional repercussions, such as litigation or being seen as professionally inadequate, increase isolation (Hendin, et al., 2004; Kleepsies & Dettmar, 2000). Unrealistic expectations as caregiver specific to suicide-related work can set a caregiver up for failure and undue stress (Kleepsies & Dettmer, 2000; Neimeyer, et al., 2001; Schultz, 2004).

In addition to dealing with trauma, traumatic events, or client suicide, mental health practitioners maintain that ongoing self-care, professional growth, prevention of impairment, and increased satisfaction occur in the work of therapists if they maintain personal therapy as an ongoing resource (Daw & Joseph, 2007; Digiuni, 2011; Figley, 2002; Linley & Joseph, 2007; Rake & Paley, 2009; Schultz, 2004; Sherman, 1996). Therapy for the caregiver is necessary when traumatization occurs and therapy can be preventative in maintaining good insight, balanced emotional and psychological health, as an effective self-care to offset illness and maintain appropriate responsiveness to clients (Norcross & Guy, 2007; Mahoney, 1997; Weiss, 2004).

When trauma has been dealt with through spirituality, counselling, work supports, appropriate supervision, or connection with family and friends, there is potential for growth and resiliency, where individuals report increased wisdom, strengthening and improvement in professional work (Case & McMinn, 2001; Linley & Joseph, 2007; Munson, 2009).
Stigma-Based Barriers Related to Suicide Responsiveness

“When meaning is co-created or shared in therapy, the interaction is experienced as an intimate one…this is therapeutic. Conversely, when meaning is rejected, provided, imposed, or misunderstood, the interaction is … nontherapeutic” (Weingarten, 1992, p. 46). Responding positively to the client’s invitation to talk about suicide rather than rejecting or minimizing the seriousness is an opportunity to provide understanding at a deeply meaningful level, where the individual is validated, knowing their life matters (Chiles & Strosahl, 1995; Lang, et al., 2014). Attitudes related to suicide can diminish taking suicide ideation as serious. Suicide behaviour that has created hospital admission has been overlooked as not serious or as a means of attention seeking rather than an intentional attempt to end one’s life – attitudes can prevent positive treatment of such persons (Anderson, 1997).

Language and Stigma of Suicide

Many world religions still condemn suicide ideation and behaviour as sinful and, although society is becoming increasingly secular, there is still influence of such paradigms (Wertheimer, 2001). Historically, legislation around suicide, demonstrated criminalization, where those who attempted suicide were punished equal to those who attempted homicide (Wertheimer, 2001). In the Middle Ages, in the event of a suicide attempt, properties were confiscated from the survivor and upon a death by suicide surviving family forfeited properties willed them (Bell, 2012; Pritchard, 1995). Absolution to hell was deemed to befall those who died by suicide (Pritchard, 1995, p. 11). In most instances individuals who suicided were disallowed church funeral rites, and graves were set outside church grounds, left unmarked (Bell, 2012; Silverman,
Property, rights and identity are not to be acknowledged for those that died by suicide. Families were punished for the suicide of their loved one. Society or the church did not permit talking about suicide.

Although times and paradigms change, past attitudes about suicide do not immediately disappear; there is a continuing affect in today’s attitudes (Pritchard, 1995). Language specific to suicide resonates with past paradigms. Considering words used in description of suicide, ‘committing suicide’ or becoming a ‘victim of suicide’ aligns with criminal action (Wertheimer, 2001). Language around ‘failed’ or ‘unsuccessful’ suicide has a connotation of judgment and creates a negative implication for those who survive suicide behaviour (Ball, 2012; Silverman, 2006; Wertheimer, 2001). A ‘completed’ or ‘successful’ suicide gives a misappropriated sense of ‘success’ (Ball, 2012; Silverman, 2006).

A nomenclature of words specific to suicidology is important for professionals, caregivers, educators, family and clients so inappropriate meaning is not attached in description, discussion, or notes (Silverman, et al., 2007a). For professional clarity, direct communication without incorrect implications or negative connotations allows for staff communication to support the client and be clear about suicide ideation, communication, and behaviours, and intention toward death (O’Carroll, et al., 1996; Lester & Fleck, 2010; Silverman, et al, 2007a; Silverman, et al., 2007b).

Power in words and attitudes conveyed therein can resonate with a client if the caregiver is not mindful of such influence. Subjectivity in labeling suicide-related behaviours can become problematic, as there can be misunderstanding and assumption (O’Carroll, et al., 1996; Silverman, 2006). Unless the ‘sinful-religious’, ‘criminal-
illegal’ or ‘successful’ paradigms are self-examined in the caregiver, it may be that condemnation or damnation messaging may unwittingly seep in to the conversation between the caregiver and the client.

Stigmatized suicide beliefs, whether cultural or religious, create an unwillingness to speak about suicide ideation (Jacobs, Baldessarini, Yeates, Fawcett, Horton, Meltzer, Pfeffer, & Simon, 2003). A fear that the caregiver will not respect cultural or faith-based beliefs also creates unwillingness to talk about suicide (Goldston, et al., 2008). Caregivers demonstrate discomfort in talking directly about suicide, informed by myths and past stigmas, using metaphor rather than direct responses, leaving room for confusion and lack of permission to talk directly about suicide (Reeves, Bowl, Wheeler, & Guthrie, 2006). Caregiver-client discussions need to clarify meanings so judgments and misinterpretations can be minimized specific to suicide talk.

**Shame, Isolation and Fear**

Survivors of suicide report isolating, feeling shamed and talking little about the suicide and their feelings – some lie about the cause of their loved one’s death – they set themselves apart to avoid further judgment and stigmatization (Wertheimer, 2001). Caregivers, as survivors of client-suicide, have expressed similar responses. Caregivers describe avoiding talk of client suicide, blaming the suicide on family or system failures, experiencing doubt, guilt and shame implying they did not provide adequate treatment or intervention, feeling inadequacy in their professional practice, and experiencing grief that shakes both profession and personal interactions and belief-systems (Grad & Michel, 2004; Grad, Zavasnik, & Groleger, 1997; Hendin, et al., 2004;

Death attitudes and death anxiety can shape the caregiver’s ability to communicate and intervene with suicide, preventing responding to suicide communication clues (Neimeyer & Neimeyer, 1984). Situations involving suicide risk have been found to be more uncomfortable for beginning caregivers to confront over most other crises (Neimeyer, Wittkowski, & Moser, 2004). Fear avoidance, fear of talking about suicide risk, noted in both caregiver and client reinforces not speaking about suicide and risk of death (Chiles & Strosahl, 1995; Lang, et al., 2014; McKenzie-Deighton, Gurris, & Traue, 2007). In effect, caregivers rejecting talk of suicide is, in part, internalized as a rejection to the client who is attempting to engage help. Conversely, caregivers develop increased comfort related to death after working on their attitudes and feelings related to suicide and death, these caregivers are less likely to create protective distance— they engage direct talk related to suicide more effectively (Neimeyer, et al., 2001).

**Culture - Connections Influence Responsiveness**

Every client has a unique experience. Diversity considerations are many: “i) age, culture, ethnicity, gender, language, physical disability, race, sexual orientation, and social class; ii) educational background, geographic location, income, marital status, religion, work experience, citizenship status, military experience, and hobbies/recreation interests; and iii) historical moments or eras” (Weinrach & Thomas, 2002, p. 25). Contributing racial, ethnic and cultural factors for suicide risk and views of suicide and death are helpful for caregivers in being able to identify and respond to
suicide communication (Alegria, Atkins, Farmer, Staton, & Stelk, 2010; American Psychiatric Association, 2003). Understanding norms in a culture can demonstrate how symptoms of mental illness may manifest but the indicators related to suicidal communication may also be unique culturally (Hart, Jorm, Kanowski, Kelly, & Langlands, 2009).

The majority of caregivers are not from ethnic or racial minorities and as a result they may not be aware that their attitudes and values may come across as oppressive or privileged to their clients (Grus, 2009; Israel, 2012). Underutilization of mental health resources and lack of connecting culturally stems from distrust resulting from: stigma related to seeking help; historical abuses from the majority culture; discomfort with mental health systems; and poor experiences with culturally incompetent or insensitive mental health caregivers (Downs & Eisenberg, 2012; Goldston, et al., 2008). Assessment measures or stylized interviewing that match the majority may not be adequate for a minority, aboriginal, or rural population (Choi, et al., 2009; Goldston, et al., 2008; Judd, et al., 2006; Hirsch, 2006; Pedersen & Marsella, 1982). Interventions are more effective when cultural and spiritual beliefs and community resources are involved (Gone, 2011; Whitley, 2012).

Mental health caregivers or resources that share a culturally similar identity are recommended as there may be a better fit therapeutically for being responsive to the client (Hart, et al., 2009; Hass, Eliason, Mays, Mathy, Cochran, D’Augelli, Silverman, Fisher, Hughes, Rosario, Russell, Malley, Reed, Litts, Haller, Sell, Remafedi, Bradford, Beutrais, Brown, Diamond, Friedman, Garofalo, Turner, Hollibaugh, & Clayton, 2010) but when such a caregiver is unavailable, the onus is ethically on the caregiver to make
One size does not fit all - there is “difficulty in formulating a global approach to counselling suicidal individuals that encompasses all cultures. Each culture has its own particular stresses that influence either a person’s suicidality or the manner in which it needs to be addressed” (Westefeld, Range, Rogers, Maples, Bromley, & Alcorn, 2000, p. 457). Specificity of rapport must be developed for the individual needs and distresses of the client to be unravelled so the caregiver can suitably intervene - not only is this essential for the therapeutic nature of the caregiver-client relationship but also to develop the best outcome for safety from suicide (Chiles & Strosahl, 1995; Lang et al., 2014).

**Biopsychosocial Responsiveness**

The biopsychosocial health of an individual must be elaborately reviewed to understand how a client may have context to struggle with the idea of suicide (Ellis & Goldston, 2012; Hoffman, 2000; Pritchard, 1995; World Health Organization, 2012). Overall client health status specific to suicide is influenced by psychosocial contributors - cognitions, attitudes, moods, affect, behaviours, social supports (interpersonal and institutional), interpersonal and functional roles, coping styles; biosocial contributors – race, ethnicity, culture, social economic status, gender, sexual orientation, environment; and biomedical factors - biological processes, disease symptoms and characteristics, and genetics (Hoffman, 2000)

Consideration must be given to the whole picture of a client, the individual, and the dynamics, the context, surrounding the individual to understand their situation,
problems and subsequent needs. Unless the psychologist explores all contextual pieces and client meanings, there may only be a partial or an assumed understanding (Fischer, 1972; Weingarten, 1992). An incomplete understanding prevents psychologists from helping clients to reach an improved understanding of their own problem, additionally, psychologists may be offering guidance about a matter that is not considered problematic by clients (Chiles & Strosahl, 1995).

Most importantly, how individuals define themselves is paramount to the work (Weinrach & Thomas, 2002). Reality is defined by lived experience and so, too, suicide ideation develops from the lived experience:

An individual’s experiential bond with their own world defines their reality, their reality cannot be prescribed or readily seen through the eye of science nor the psychologist’s own paradigm – the client’s experience is what has been lived to create whatever challenges are in their perspective and, as a result, the client’s reality must be investigated adequately to understand the difficulties and needs. (Fischer, 1972, p. 369)

**Communication, Shared and Developed**

Communication that is respectful of the client and the clients’ needs is part of being ethical as a psychologist. Psychologists need to engage in language that is culturally appropriate and respectful, developing a rapport that is meaningful to client needs and balanced so that clients feel that the treatment they are receiving and the understanding that psychologists have is based on the relationship with the clients (CPA, 2000). Responsiveness to client suicide communication is required to be
appropriate and encouraging of continued discussion. Hearing what is being said may be nuanced in meanings and can be understood through a desire to establish rapport.

Finding shared meanings that are developed through conversation and match client’s needs and experiences are essential – the meanings cannot be expert-driven ideas or agendas (Strong & Sutherland, 2007). Intervention must match the client needs, abilities, available resources, and environment (Jacobs, et al., 2003; Schmitz, et al., 2012; U. S. Department of Health and Human Services, 2012).

Cutcliffe (2003) identified “…healthcare practitioners have several “windows of opportunity” in which they might be able to intervene and prevent [suicide]…” (p.98). Caregivers have to tune to seeing or hearing the presentation of these ‘windows of opportunity’, as identified through suicide-related communication. That window may be closed if caregiver burnout, compassion fatigue, vicarious traumatization, lack of training, negative attitudes about suicide, death anxiety, or cultural disconnection prevents appropriate responsiveness.

**Summary**

Saskatchewan’s diversity includes urban, rural and frontier populations, along with varied cultures. There are challenges to offer appropriate psychology services when the profile of the province is so diverse. Provision of suicide work can be more challenging as a result of the heightened stigma observed in certain populations and cultures. Rates of suicide in Saskatchewan are high in comparison to other provinces in Canada. A provincial suicide prevention strategy is not clearly defined and it is unclear how best practice guidelines are being implemented to support persons at risk of suicide or suicide interventionists.
Psychologists are key professionals in providing suicide intervention. Psychologists’ practices vary, as do employers who provide psychology services. Psychologists have been tasked with the professional responsibility of ensuring they are ethically fit and competent in practice. Self-care, personal experiences, and work-life balance contribute to the health and wellbeing of the psychologist. Further, quality of life in the professional setting is influenced by manageable workloads, support in the workplace, access to positive specific supervision, and structures that allow time for best practices. Quality of professional life contributes to psychologists’ health, wellbeing, and capacity to provide ethical and competent responses to client needs.

Psychologists are identified as professionals that deal with vulnerable populations and working with risk of suicide, at least at an initial interventionist level, is almost a certainty. Appropriate responsiveness in suicide intervention or in ongoing suicide work develops as a result of: awareness of and working through stigma-based personal and professional attitudes toward suicide and suicide work; experiential suicide-specific training; adequate suicide-specific supervision; and adherence to best practices when dealing with suicide risk. Psychology programs provide knowledge and discussion around suicide but education specific to experiential suicide-specific training, examination of personal and practitioner attitudes around suicide, and study of best practices related to management of suicide risk varies in graduate psychology programs.

Considering the literature, a link that is unclear is the relationship between the quality of psychologists’ professional life as an influencing factor in how appropriately their responsiveness is when engaging suicide intervention or ongoing suicide work.
Saskatchewan literature was not found to support this curiosity. The impact of suicide work on psychologists is noted in some literature but there is a paucity of understanding of how Saskatchewan psychologists are experiencing the impact of their work related to suicide. Additionally, in literature searches, studies that considered the appropriateness in suicide intervention responsiveness in Saskatchewan psychologists are not found. The manner in which Saskatchewan employers are organized to offer support related to psychologists’ ongoing suicide work is not clearly understood. The quality of professional life of the psychologists in the province was not found in the literature. This study provides opportunity to explore some of these areas and contribute to building knowledge around how the quality of psychologists’ professional lives may be an influencing factor in psychologists’ responsiveness to suicide-ideated clients.
CHAPTER 4 - METHODOLOGY

Mixed Methods Research

There is not a singular approach to the world rather there are many approaches - mixed methods research offers the researcher a vehicle to consider different viewpoints (Johnson, et al., 2007). The intent in mixing quantitative and qualitative knowledge together appeals to different ways of knowing and offers variety for those intending to research and learn. Two ways of interpreting provide more depth:

Mixed methods research is, generally speaking, an approach to knowledge (theory and practice) that attempts to consider multiple viewpoints, perspectives, positions, and standpoints (always including the standpoints of qualitative and quantitative research). (Johnson, et al., 2007, p. 113)

The reason for mixing is to supplement the knowledge, offer details or deepen the understanding of a phenomena and to substantiate or strengthen one method of research with another (Creswell, 2003). Triangulation, as brought forward by Campbell and Fiske in 1959, supports that validation of data comes with putting two data sets together and taking time to create an examination of both the qualitative and quantitative (Johnson, et al., 2007). Triangulation has weakness as well as strengths. Weaknesses can be identified in: the additional time necessary to conduct the different research activities; the burden of interpreting large amounts of data; conflict between the methods used to collect the data; challenges in converging data into an interpretation that can be readily understood; the risk of over or under use of triangulation of data sources; and, users of research not being familiar with the use of triangulation in their understanding and appreciation of application of such research (UNAIDS, 2010).
Additionally, triangulation of qualitative and quantitative data has been debated as pushing two different onto-epistemological paradigms however when combined there is the potential to strengthen the research and increase a study’s credibility and accuracy (Hussein, 2009). The potential to strengthen the research has been carefully considered and triangulation has been the selection for analysis of findings in this study.

Triangulation can be separated into four types using: various data sources compared and contrasted; different researchers in the study for different view points; multiple theories and perspectives to interpret results; and multiple methods to study the research problem (Johnson, et al., 2007; UNAIDS, 2010). Triangulation allows for either, convergence and richness of data, or inconsistencies and contradictions of data - converging of qualitative and quantitative sets of data allows richness of understanding and can increase the confidence in the results, and comprehensiveness of the discussion (Johnson, et al., 2007). The intention with cross-examination is to confirm or corroborate findings (Creswell, 2003) and to enhance the completeness of the research with more in-depth understanding particularly when considering “less explored or unexplored research problems” thereby offering a more rich understanding of the phenomenon (Hussein, 2009, p. 8).

Mixed methods research may have different ways in which weight or dominance is placed on the quantitative data or on qualitative data (Johnson, et al., 2007; Creswell & Plano Clark, 2007). There can be different ordering of how the mix takes place, quantitative and qualitative methods can occur concurrently, sequentially, and/or with different research elements (quantitative or qualitative) embedded within one of the methods (Creswell & Plano Clark, 2007). Additionally, multiple methods and multiple
theoretical frameworks can be used within the quantitative or qualitative approaches (Creswell, 2003).

**Mixed Methods Purpose**

The purpose of this primarily concurrent mixed methods study is to better understand the manner in which the quality of Saskatchewan psychologists’ professional lives, including reflection upon workplace structures and supports, and factors that have influence over professional functioning related to quality professional life, act as a determinant in competent responsiveness, when providing suicide work, intervention and/or ongoing focus on safety from suicide behaviours. The approaches selected for the study are comparison and contrast of three data sources (i.e., i) closed survey with measurement instruments for a quantitative perspective, ii) open-ended survey questions for one qualitative aspect, and iii) interviewing to develop the other qualitative perspective) through multiple study methods (i.e., statistical comparison, thematic qualitative analysis, and a qualitative narrative deriving essences of meanings).

The intention was to provide equal weighting and consideration for quantitative and qualitative results. The instruments used for quantitative measures, the ProQOL-5 and SIRI2, allow explanation through a numerical, positivist, description of how the quality of professional life and responsiveness to client suicide ideation/communication can be observed. Correlational indications and mean comparisons from these two instruments, along with participant demographics and practice information, generate understanding of factors that either correlate or demonstrate differences in regard to reported experiences. A qualitative perspective, set within the survey, asked open-ended but focused questions that elicited responses from the participants related to descriptions
of their experiences or understanding of professional quality of life and suicide intervention work responsiveness. The content of the open-ended responses was organized, and themed so that understanding of essences, meanings, could be connected to professional quality of life as a determining factor in responsiveness to suicide work.

A second qualitative portion, running concurrently, was based on interviews with five participants. The interviews utilized a semi-structured open-ended question guide that provided a framework to develop conversation and discussion with focus on the research topic to develop a connection to the participants’ contextual experiences. Development of a descriptive, and somewhat interpretative, narrative reflected how professional quality of life impacts responsiveness in suicide work. Results were derived separately and at point of interpretation the quantitative and two sets of qualitative results are converged to reach a richer understanding (Creswell, 2003).

The Internet survey with both qualitative and quantitative methods is a nested, or embedded, strategy (Creswell, 2003). Although demographics informed qualitative findings, there was not a specific emphasis on quantitative measure of the ProQOL5 and SIRI-2 being contrasted specifically against only the qualitative open-ended responses. Arguably, there is a hope to consider different levels of meanings and address different ways of understanding by deriving meaning from quantitative and both qualitative strategies as three sources of data were analyzed separately (Creswell, 2003). Literature suggests that a strategy of nesting implies weighting is intended on one or the other of the methods from the outset (Creswell, 2003) however, this was not an intended focus, to create weighting of one or the other methods. Rather, the data was considered for overall interpretation with triangulation of the three sets.
In the following methods section a description of participant recruitment and an overview of the procedural process will be outlined. Quantitative methods, procedures and hypothesis will be separate from the qualitative methods and analysis. Within the qualitative section, because there are two distinctly different methods to collect data, there will be two parts to the qualitative section. Part A of the qualitative section will reflect how the survey response text data were analyzed and understood. Part B will describe the interview approach and the subsequent development of narrative stories.

The results section for the quantitative and qualitative sections will also be separated for ease of reading and understanding. Within each section, the research methods, outcomes and results will be described separately for clarity, notably the processes are very different from one another in both method and the research paradigm (Griswold, et al., 2008; Creswell & Plano-Clark, 2007). An interpretation discussion will triangulate findings, developing knowledge through the mix of quantitative and qualitative meanings thus, a larger understanding can be developed resulting from convergence (Creswell & Plano Clark, 2007). Recommendations will be developed from the whole picture rather than the sum of the parts.

The following diagram (Figure 3) offers a visual representation of the mixed methods design. Red demarcates the quantitative methods. Blue, with two different tonal qualities, represents the two qualitative methods. Violet demonstrates a blending of red and blue, in the convergence of data during interpretation. The use of color will be utilized in each section in tables or figures to demonstrate the connection to the method being engaged.
Figure 3. Mixed Methods Concurrent Design

(Framework based on Creswell, 2003; Hesse-Biber, 2010)

Mixed Methods Design

Overview: Participant Recruitment, Survey and Interview Strategy

Ethical approval was obtained from the University of Regina Research Ethics Board (Appendix A). Approval for email access to the membership of Saskatchewan registered psychologists was obtained through the Executive Director-Registrar and Executive Council of the Saskatchewan College of Psychologists. The Assistant to the Registrar of the Saskatchewan College of Psychologists forwarded the research survey
letter of invitation (Appendix B) to Saskatchewan psychologists inviting them to participate in the online survey. The link to the Internet survey was at the end of the invitation letter. Upon activating the link, a consent form to participate in the on-line survey popped up in their Internet browser (Appendix C). To begin the survey the participant would indicate that they had read and acknowledged what the research was intended for and that they consented to the use of their responses which included: demographics, closed survey responses (ProQOL5 and SIRI-2) and open-ended questions with regard to their experiences and professional practices related to suicide work. Upon agreement, by clicking on “Yes”, the on-line survey began (Appendices D, E and F).

Upon completion of the last page of the on-line survey, an additional and separate Internet survey link was activated which was an expression of appreciation for the psychologists’ participation through a letter of gratitude and an offer for the participant to enter a draw for spa services (Appendix G). In the letter of gratitude there was an additional invitation for psychologists to contact the researcher to participate in a personal interview if they chose to (Appendix G). Psychologists who chose to participate in the additional interview process independently contacted the researcher, by email and/or telephone, to advise of their desire to participate in a personal interview.

Upon individual contact with the interviewees, the purpose and style of the interview were described, explaining the semi-structured format, audiotaping, transcription and analysis. The date, time and location were set for the convenience and comfort of each interview participant. The interviewees chose the environment in
which they wished to be interviewed and they self-determined the time of day for their individual interviews. Interviews were conducted separately. Consent for each interview was obtained upon meeting each participant (Appendix H). A semi-structured interview guide, questions that were intended for discussion during the interview, was provided to each participant, at the time of completing the consent form, so that consent was adequately informed specific to interview content (Appendix I).
Phase I - Quantitative Method Section

Survey Data Collection

Upon activating the link to the online research survey, as provided in the invitation email, participant psychologists were asked to read the consent form embedded in the start of the survey (Appendix C). Participants upon indicating their consent began the survey (Appendix D). Psychologists were in control of their on-line participation (i.e., when, where and if they chose to participate or discontinue). Participants were advised that they could discontinue the survey at any time by closing their Internet browser.

Surveys were collected through Survey Monkey, an Internet tool. All surveys were anonymous, no names or IP addresses were collected – participants were advised of this in their consent forms. Spa services entries, although identifying names of draw entrants, were not linked back to the previous survey as administration of the entry was on a separate link. This was made known to participants for reassurance of anonymity.

Survey Participants

Survey participants were drawn from the registered members of the Saskatchewan College of Psychologists. During the period of time the survey was conducted on-line, April 4-July 4, 2013, there were 529 (426 Full Practice, 67 Provisional Practice, and 36 Non-Practice) psychologists registered in Saskatchewan (Saskatchewan College of Psychologists, 2014).
Survey Participant Demographics

Participant demographics include information specific to gender, age, marital status, professional licensure, areas of competence, level of education, years of work in psychology practice and psychology-related work, suicide-specific training, client geographic location, domains of practice, psychologists’ focus of work, primary client populations, caseload numbers, self-care activities, work with suicide, and resource utilization specific to suicide work.

Various demographics are considered not only for their descriptive value but to fulfill comparison and correlation with the hypotheses developed with use of the survey instruments. The hypotheses identified later in the methods section will indicate the comparisons between demographics and instruments.

Instruments Within Survey

The Professional Quality of Life, Revised – ProQOL5 (Stamm, 2010) measures levels of compassion satisfaction and compassion fatigue, with secondary trauma, and burnout as subsets of compassion fatigue. “Professional quality of life is the quality one feels in relation to their work as a helper” (Stamm, 2010, p. 8). Initially, Figley developed the Compassion Fatigue test (CFST or CSF) a 66-item scale (Figley & Stamm, 1996). Then, Figley, along with Stamm, continued assessment and testing improving reliability and validity measures. Eventually, Stamm took over the CFST instrument with further development into the ProQOL – with a more positive frame of reference to also including the satisfaction scale (Stamm, 2002; Stamm, 2010). Please refer to Appendix E, to review the instrument.
The following diagram provides a visual representation of Professional Quality of Life (Stamm, 2010) and will offer reference to the manner in which the scales of the ProQOL5 are developed.

![Diagram of Professional Quality of Life](image)

**Figure 4. Professional Quality of Life, sub-scale divisions (Stamm, 2010, p. 8)**

The SIRI-2 – Suicide Intervention Response Inventory-Revised 2nd edition (Neimeyer & Pfeiffer, 1994) measures most effective suicide-interventionist responsiveness to client expression of suicide-related ideation and communication as rated against expert suicidologists who collectively identified the most effective responses. Refer to Appendix F to review the SIRI-2.

**The Professional Quality of Life Scale, Revised – ProQOL5**

The ProQOL5 developed by Beth Stamm (2010) is a 30-item self-report, 5-point Likert-scale rating measure, that is administered to ascertain levels of compassion satisfaction and compassion fatigue - burnout and secondary traumatic stress fall under subscales of compassion fatigue (Figure 4). Scale ratings of compassion satisfaction, burnout and secondary traumatic stress (with 10-questions for each scale) are used for research and categorization but not for diagnostic purposes. The ProQOL5 is used in
caregiver populations - helpers, including suicide-interventionists, such as therapists or counsellors and commonly used to measure positive and negative effects of people who have experienced a stressful event (Stamm, 2010).

Stamm’s (2010, p. 12-13) scale construct definitions are identified as follows: *compassion satisfaction* refers to pleasure from doing one’s helping work well and feeling positively about colleagues and contributions to society; *compassion fatigue* is made up of two parts – *burnout* (with “exhaustion, frustration, anger, depression…associated with feelings of hopelessness and difficulty in dealing with work or in doing your job effectively…usually hav[ing] a gradual onset…reflect[ing] that your efforts make no difference…[and] can be associated with a very high workload or non-supportive work environment”) and *secondary traumatic stress* (with “negative feelings driven by fear and work-related trauma…primary and secondary…[that] may include fear, sleep difficulties, intrusive images, and/or avoiding reminders of the person’s traumatic experiences”). Vicarious traumatization overlaps with secondary traumatic stress in the literature and this construct is not additionally identified as a separate construct scale in the ProQOL5 but is captured under the scale for secondary traumatic stress (Figure 4).

Compassion fatigue, secondary traumatic stress/vicarious traumatization, burnout, and compassion satisfaction, as defined and reflected in the ProQOL5 measures, are consistent with the conceptual and operational definitions in over 200 published papers and over 100,000 internet articles (Stamm, 2010). The original scale CFST is no longer recommended for use, as there were psychometric problems, however, the current ProQOL5 has been indicated to be much more valid and reliable –
much of literature is more specific to the CFST (Elwood, Mott, Lohr, & Galovski, 2011). The three scales for burnout, secondary traumatic stress and compassion satisfaction, measure the three separate constructs, for construct validity, both convergent and discriminant, the definitions match what is being measured with diagnostic consideration and descriptions (Bride, Robinson, Yegidis, & Figley, 2003; Figley & Stamm, 1996; Jenkins & Baird, 2002; Stamm, 2002; Stamm, 2010).

There is some criticism of the rigour of earlier versions of the compassion fatigue scales (Elwood, et al., 2011). Burnout scale variance is observed against secondary traumatic stress as noted in the work by Jenkins and Baird (2002) where validity testing examined the construct validity rigour of the Compassion Fatigue Self-Test, for psychotherapists (the originating scale developed by Charles Figley that Stamm maintained in the ProQOL for measures of burnout and secondary traumatic stress), when compared to the Trauma Symptom Inventory (TSI-BSL), Maslach Burnout Inventory (MBI), and Symptom Checklist-90 Global Severity Index (SCL-90-R GSI). It was demonstrated that there was moderate concurrent validity with the compassion fatigue scale and the TSI-BSL at \( r = .58 \), strong concurrence of compassion fatigue scale with the SCL-90-R GSI at \( r = .61 \), and low-moderate concurrence of the burnout scale with the MBI total scale at \( r = .38 \) (Jenkins & Baird, 2002). In a study by Deighton, Gurris and Traue dated 2007, comparing the MBI, the ProQOL and diagnostic criteria for post-traumatic stress disorder, when working with German speaking therapists treating torture victims, it was identified that the constructs less clearly matched the diagnostics for PTSD (notably this was a more subjective
assessment of a tool not yet validated), but did match the scoring for burnout on the MBI (Elwood, et al., 2011).

In support of the instrument, Sprang, Clark, and Whitt-Woolsey in 2007, considered behavioural health providers, some already diagnosed with PTSD and those not diagnosed, were compared with the ProQOL determining that the subscales were a better indicator of the prediction of compassion fatigue, compassion satisfaction and burnout (Elwood, et al., 2011). Again with Racanelli’s study in 2005 of mental health professionals from New York City and Israel, the ProQOL was measured for internal consistency and reliability demonstrating that those exposed to work with trauma victims against those who did not have similar exposure demonstrated significant scores on compassion fatigue (Elwood, et al., 2011). Further, within the same study, higher burnout scale scores were observed in those with fewer years in practice, positing that resilience had not grown (Elwood, et al., 2011). Construct validity testing demonstrated that the Compassion Fatigue scale is distinct, and inter-scale correlations show 2% variance with Secondary Traumatic stress and 5% shared variance with Burnout – Burnout and Secondary Traumatic Stress scales will have some overlap as there is distress common to both conditions, fear is the defining factor for Secondary Traumatic Stress, subsequently, the shared variance between the two scales is 34% (Stamm, 2010).

In test-retest application, the overall internal consistency, the reliability, of the ProQOL5 with regard to the specific scales is as follows: for compassion satisfaction the alpha scale reliability is .88; for burnout the alpha scale reliability is .75; and for compassion fatigue/secondary traumatic stress the alpha scale reliability is .81 (Stamm, 2010).
Although the ProQOL5 is not used as a diagnostic tool, it was compared to the Depression Anxiety Stress Scales (DASS) as a tool to determine relationship – the compassion satisfaction scales and secondary traumatic stress scales were not significantly related, medium negative correlation was noted in the burnout and compassion satisfaction scales, and there was a large and significant correlation between burnout and secondary traumatic stress scales (Hegney, Craigie, Hemsworth, Osseiran-Moisson, Aoun, Francis, & Drury, 2013). Their study determined that the DASS and the ProQOL5 scales showed significant correlation between compassion fatigue constructs, of burnout and secondary traumatic stress, and higher levels of anxiety, stress and depression (Hegney, et al., 2013). It was also observed that lower compassion satisfaction scores, although not necessarily a causal pathway for compassion fatigue, did infer a potential causal hypothesis (Hegney, et al., 2013). Additionally, younger professionals were observed to demonstrate higher anxiety on the DASS and higher scores on the compassion fatigue on the ProQOL (Hegney, et al., 2013).

Across multiple tests of varied demographics from 1,289 caregiver cases, no statistical differences were observed across gender, age group, race, income groups, years at current employer, or years in the field of work (Stamm, 2010). The instrument is able to reliably reflect caregivers’ compassions satisfaction, compassion fatigue-secondary traumatic stress or burnout scores without influence of particular demographics changing the outcome of scale measures.
The Suicide Intervention Response Inventory, 2nd Edition – SIRI-2

The Suicide Intervention Response Inventory, SIRI developed by Neimeyer and MacInnes (1981) is used to assess paraprofessional counsellors’ ability to respond appropriately to clients demonstrating suicide-related ideation and communication. Although construct and discriminant validity were demonstrated in the SIRI, a ceiling effect was observed with more skilled counsellors (Neimeyer & MacInnes, 1981; Cotton & Range, 1992; Neimeyer & Bonnelle, 1997).

The revised SIRI-2 incorporated a Likert-scale, seven point format rating, rather than the original dichotomous, two option, scoring format and the criterion for appropriate responding was assessed by expert suicidologists. As a result of this change the ceiling effect was removed and the SIRI-2 is applicable to assessment of clinical skills of professionals and paraprofessionals who work with clients anticipated to be at risk of suicide (Moulin-Brown & Range, 2005; Neimeyer & Bonnelle, 1997; Palmieri, Forghieri, Ferrari, Pingani, Coppola, Colombini, Rigatelli, & Neimeyer, 2008; Pasco, Wallack, Sartin, & Dayton, 2012).

Construct validity was confirmed through comparing individuals with groups of respondents demonstrating different levels of suicide counselling skills (Neimeyer & MacInnes, 1981; Cotton & Range, 1992), medical students prior to and following intensive rotation in psychiatry (Neimeyer & Diamond, 1983), and comparing scores before and after crisis counselling training (Neimeyer & MacInnes, 1981; Cotton & Range, 1992; Abbey, Madsen, & Polland, 1989). The SIRI “distinguishes among groups varying in their suicide counselling skills, as well as to detect improvement in
such skills over the course of more and less intensive training in crisis counselling” (Neimeyer & Bonnelle, 1997, p. 62).

With the criterion scoring sensitivity added to the SIRI-2, in the Likert Scale, improvements from training effects were significantly demonstrated pre-training, Mean=54.66; Standard Deviation=17.86; post-training Mean=41.02; Standard Deviation = 9.95, F91, 310=30.65, p< 0.001 suggesting greater sensitivity in the new scoring resulting from suicide intervention training (Neimeyer & Bonnelle, 1997).

Convergent validity was determined by comparison of the SIRI to the Counselling Skills Evaluation (CSE - a validated test of counselling ability), and it was found that the two instruments, the CSE and the SIRI, correlated moderately across two tests of both measures, Time 1, r=.58, p<.01; Time 2, r=.66, p<.002, (Neimeyer & MacInnes, 1981). The SIRI compared to the CSE at a crisis hotline found that r=.60, p<.0001, hence a reflection of strong convergent validity (Neimeyer & Oppenheimer, 1983).

Reliability was demonstrated with different populations using the SIRI. Internal consistency was demonstrated using coefficient alphas Kuder-Richardson method where .83 was observed when comparing undergraduate education majors and crisis line trainees (Cotton & Range, 1992). Internal consistency with coefficient alphas was .84 where the SIRI was taken between crisis intervention paraprofessionals, alcohol counsellor trainees and students from adult education classes (Neimeyer & MacInnes, 1981). Test-retest reliability was r=.86 as reported by Neimeyer and MacInnes (1981) over a 3-month interval where control subjects were not involved in suicide intervention training.
In comparing the SIRI to the SIRI-2, internal consistency improved in the SIRI-2. In the SIRI coefficient alphas of .78 were noted pre-test and .85 at post-test while in the SIRI-2, with new criterion-based scoring, internal consistency was coefficient alphas of pre-test .90 and post-test .93 (Neimeyer & Bonnelle, 1997). Test-retest reliability was also demonstrated using Pearson correlations using the SIRI and SIRI-2 on two occasions over a two-week period. The Test-Retest reliability coefficient of r=.79, p<.001 was noted on the SIRI and the SIRI-2 showed a higher reliability coefficient of r=.92, p<.001 (Neimeyer & Bonnelle, 1997).

Age, medical specialty, marital status, and religion were not related to SIRI scores but females scored higher than males (Neimeyer & Diamond, 1983). Females demonstrated they had received training or had more experience in suicide intervention than males when responses were measured using SIRI-2 (Neimeyer & Bonnelle, 1997). There are numerous other studies with the SIRI and SIRI-2 demonstrating applicability to numerous helping professionals that work with suicide risk.

**Correlation Analysis**

A series of Spearman’s rank correlation coefficient ($r$) rank-order correlations were conducted to determine the strength of relationship between the two sets of ranked ordinal variables, those from the ProQOL5 and the SIRI-2, rather than the actual data values. Excel was used to run the calculations. The data was collected, entered by the researcher on Excel and ranked in order to run the Spearman’s Rank correlation.

$$Rho = \frac{1 - \frac{6 \sum (d_i)^2}{n(n^2 - 1)}}{\sqrt{\frac{1}{2(n^2 - 1)}}}$$

is Spearman’s rank correlation coefficient equation where

$Rho=1$ is representative of perfect agreement between two sets of ranks and where
*Rho*= -1 is representative of complete disagreement between the two sets of ranks (McDonald, 2009 p. 221-223)

**t-Test Analysis**

The t-Test is a statistical test that is used to determine if there is a significant difference between the mean or average scores of two groups. The t-Test determines if the means are sufficiently different from each other to confirm that there are two distinct groups (McDonald, 2009). By using the average score from the SIRI-2 from the group of educational psychologists and the other group being the clinical psychologists, the difference of the two means is calculated and then the variability in scores of the two groups is considered the standard error (McDonald, 2009). The difference between means, with the standard error taken into account, gives the T-Value. The T-Value is the basis for determining if the difference is enough to conclude that one group scored better than the other group, eliminating the possibility that it was a chance occurrence.

A t-test was only run in the comparison of the SIRI-2 means from the educational psychologists versus clinical psychologists as noted in the quantitative findings section.

**Quantitative Hypotheses**

**Two Questions**

Initial conceptualization of the research considered two research questions:

1) What is the experience of Saskatchewan psychologists with regard to their professional quality of life?

2) According to the Saskatchewan psychologists themselves, how do their professional experiences and professional quality of life, influence ethical competent responsiveness to suicide-ideated clients?
The first question examines how caseloads, years in practice, self-care, and satisfaction are demonstrated and measured with the regard to the ProQOL5. The second question focuses on the measure of the satisfaction (burnout and secondary traumatic stress) with the ProQOL5 demonstrating if there is a correlation or a connection in how psychologists select appropriate ways in which to respond to suicide-ideated clients (SIRI-2). Professional quality of life can be influenced by factors such as caseload, self-care, and the number of years working as a psychologist (Baker, 2002; Elwood, et al., 2011; Hegney, et al., 2013; Skovholt, 2001; Figley, 1995, 2002, 2007; Stamm, 2010), hence effort is made to determine if these factors correlate with the ProQOL5. Literature would indicate that appropriate responsiveness to suicide-ideated clients is influenced by factors such as: practice-based experiential suicide-specific training, psychology training discipline (i.e., Clinical rather than Educational), level of education (i.e., Doctorate over Masters), and how well the psychologist has cared for her/himself (Figley, 1995, 2002, 2007; Lang, et al., 2014; Neimeyer, 2000; Neimeyer, Fortner, & Melby, 2001; Smith & Burton-Moss, 2009; Schmitz, et al., 2012).

**Hypotheses**

1. **ProQOL5 correlation with SIRI-2**

   Specific to correlation of the ProQOL5 – Compassion Satisfaction, Burnout, and the Secondary Traumatic Stress scales, and the SIRI-2, a null hypothesis (Ho) is offered. It is not anticipated that compassion satisfaction, burnout or secondary traumatic stress ratings will positively correlate with psychologists’ selections of responsiveness to client statements related to suicide-related ideation and communication.
II. Self-care, caseloads or years in practice correlation to ProQOL5

A null hypothesis (Ho) would indicate no correlation would be observed between frequency of self-care, caseload numbers or years practicing psychology and the scores for compassion satisfaction scale, burnout scale or secondary traumatic stress scale.

III. Psychology discipline, education-level or suicide-specific training correlation to SIRI-2

Again, a null hypothesis (Ho) indicates that specific training discipline, psychologist education level, and suicide-specific training would not correlate with ratings of responsiveness to suicide-ideated clients.
Participant Survey

Twelve open-ended questions were asked of participants participating in the online survey (Appendix D). The intention behind open-ended questions is to glean rich open-ended responses, that provide understanding about the experiences and ways that psychologists have come to understand their work regarding how professional quality of life determines connection to responsiveness in suicide work. As observed by Kvale (1988) even with good intention to not lead by selecting open-ended questions, some leading still occurs because a posed question draws from knowledge or contextual reference of the researcher hence it begs a particular manner of answering. Nonetheless, questions were asked in hopes of hearing larger meanings.

Four questions were designed to engage all psychologists who participated in the survey. The four questions focused on developing understanding in the following areas: effects of self-care; benefits to psychologists when accessing resources for suicide-ideated clients; outcomes of accessing professional supports to continue suicide work; and barriers that may exist that prevent psychologists from accessing help when they need support.

Eight questions were designed to be contingent upon psychologists’ having experiences of client suicide. The eight constructs that were dependent on the psychologist experiencing client suicide were: impact of client suicide on the psychologist; value of supports following client suicide; work environment supports already in place to help psychologists deal with client suicide; needs identified by
psychologists post client-suicide; changes in psychologists’ practices as a result of
client suicide; learned strategies to improve and continue suicide work; self-identified
changes observed in psychologists resulting from client suicide; and changes needed
from workplaces so that psychologists’ are supported in suicide work to create growth
in their practices.

All questions were drawn from the literature to consider contributing factors to
quality of professional life and competence related to suicide work. Areas of focus
were:

i) factors that contribute to fitness and competence in practice;

ii) the importance of resources being developed for suicide-ideated clients
    beyond the caregiver;

iii) the importance of resources being engaged to help the psychologist in
    quality of life;

iv) the importance of support in suicide work;

v) the impact of suicide on the psychologist;

vi) the need for a caregivers to process cognitively and emotionally after a
    client suicide;

vii) lessons learned from client suicide that change interventions or practices;

viii) attitude shaping, resiliency, growth and/or change that results from
    suicide; and

ix) situations, events, or organizational set up that may prevent or encourage
    psychologist help-seeking to offset stress or distress.

Strategy of Analysis

Analyzing text data, in this case open-ended written response data, is an inductive, simultaneous, iterative, eclectic process that is based on the researcher’s perspective (Creswell, 2012; Hesse-Biber, 2010). The process of analysis takes time, processing, creativity, and reflection (Borkan, 1999; Miller & Crabtree, 1999). Several cycles of the process described below can occur in some instances where meanings are more challenging to develop. The text data, open-ended responses, were put into an ordered text format to read through responses to each question individually. Each set of responses was read several times. The cases were then read across questions, taking in meanings from one participant at a time, ensuring clarity of overall meanings from each participant. The text was then broken down into ideas that hung together based on similarity of content (Saldana, 2013; Tesch, 1987; Creswell, 2012). Visually colorizing the text that had similarities in meaning was helpful to appreciate which could be connected.

Following the colorization and grouping of ideas, an essence-capturing short phrase was assigned to segments that seemed to connect or be related in idea or essence, effectively, this was an initial code (Saldana, 2013; Creswell, 2007). More focused coding occurred to become increasingly conscious of capturing conceptual or thematic similarities (Creswell, 2007; Saldana, 2013). Codes for each question were reduced to
eliminate excessive overlap or redundancy per question (Creswell, 2003). Developing together into more thematically based ideas, a larger meaning was pushed forward (Saldana, 2103; Tesch, 1987). Thorough immersion in the text data, following thinking, rereading, and reprocessing, allows for crystallization of larger ideas (Borkan, 1999).

These larger meanings, the emerging themes, were then recorded for each question as a means to capture responses in a more concise manner from the varied initial text data (Creswell, 2003; Saldana, 2013, Smith, 2008; Tesch, 1987). Emerging themes were subsequently grouped, based on overlap and similarity of conceptual meaning, and then tabulated; also demonstrating the frequency of initially coded perceptions to support the emerging theme – these data can be referenced in Appendix J (Creswell, 2003; Giorgi, 2000; Saldana, 2013; Smith, 2008; Tesch, 1987).

Reading across texts again and through each question summarizing and pulling together a larger set of themes to metatheme the data, occurred last in order to establish learning and meanings from the overall text (Tesch, 1987). The term master theme intends to capture a coherent narrative or a metasummary of the collected data, participant experiences and the learning their responses could impart (Saldana, 2013; Smith, 2008; Giorgi, 2000; Tesch, 1987). Master themes were formed from meanings that surfaced and demonstrated overlap from the emerging themes. Tables 8 and 9 represent emerging themes developed from the coding of participant perceptions. Table 10 represents the master themes developed from the entirety of survey content after reflection on participant perceptions and emerging themes.

A visual model demonstrates the elaborative analytic process to develop emerging themes and master themes from the survey text data in Figure 5.
The number of occasions in which a theme has been captured or reinforced through participant perceptions is identified to demonstrate frequency of the idea. This counting of codes or occurrences could be a means to quantize the coded qualitative data into a quantitative data set (Driscoll, Appiah-Yeboah, Salib, & Rupert, 2007; Hesse-Biber, 2010), however in this study the intent in counting frequencies of perceptions (focused and emerging themes) was not to then run analytic transformation of the qualitative data to quantitative data (Creswell, 2003). Rather the frequency of perception was to reinforce that the ideas were expressed on numerous occasions. It should be noted that all perceptions of participants were included in the coding and at no time were any ideas discounted because of a low frequency of expression. All responses were valued even if expressed by only one participant and subsequently were included in coding (Saldana, 2013; Tesch, 1987).
Part B: Interviews - Sharing Lived Experiences and Stories

Narrative Research

Narrative is framed upon human experiences being shared through story (Moen, 2006). Story is our communication that primarily opens potential for understanding another person from the unique perspective that is theirs. The moment a story is shared there is an effort of the listener to begin to interpret what is being shared (Moen, 2006). In our own experiences we exist and understand, making meaning as we progress from moment to moment, through action and interaction. Hence context and how a person has learned to be in the world differ from one individual to the next. When a story is shared, new learning begins. There is engagement by the listener with the story such that thinking and processing is activated with effort to grasp the others’ paradigm. An individual is reshaping themselves and their context each time they receive a new story. The meaning of the stories can only be interpretations and are unlikely to be exact truths because a story is, firsthand understood by another within their own experience, and we can understand from within our context and constructions (Moen, 2006; Denzin, 2004).

The development of narrative is described by Creswell (2007) as: organizing the data, in this case audio recording to text data; reading through text data to develop initial notes and/or codes; describing the story or experiences framed in a sequence; classifying the contextual meanings or stories; interpreting larger meanings from the stories; and presenting the unique features, meanings or knowledge developed. There is more than this seemingly clear process. There is an intimacy - a relationship development with the participants and the researcher as they gave freely of themselves to enhance learning through a personal exposure of their lives (Josselson, 2007). The
ethical weight of finding a respectful and accurate delivery of their stories is much larger than may been seen from the outside, there is a duty to be accurate, authentic and provide interpretation without disservice or misrepresentation of their stories (Josselson, 2007).

**Participant Interview Data Collection**

Participant psychologists self-selected to interview and set up interview times, after contact with the researcher following awareness of the online survey (as outlined in Quantitative Methods-Survey Data Collection heading). Participants identified the location and time that they chose to be interviewed. Their comfort was paramount.

At the outset of the interview participants were provided with the consent form (Appendix G) along with a copy of the semi-structured interview question guide (Appendix H) to inform preparation and consent for the general content of the interview. The participants were informed in the consent form that they could discontinue the interview at any time without any data collection being analyzed. It was identified to the participants that interviews were only intended to understand lived professional practice and personal experiences of psychologists. The researcher clearly stated every effort would be made to ensure no identifiers would be released and their anonymity protected.

**Interview Structure**

Interviews were arranged with the 5 participant psychologists. The intention of a semi-structured interview is to target areas for guidance of the experience sharing. See Appendix H for the specific questions that initiated movement in the interviews. Open-ended questions were designed with the intention of gaining insight through
engagement in descriptive conversation, prompting and clarifying as necessary (King & Horrocks, 2010; Hesse-Biber, 2010; Smith, Flowers, & Larkin, 2009). Flexibility in interaction in the interviews was highly valued to appreciate the direction the participants wished to share their lived experience with interviewer guidance but, yet, without rigidity (Josselson, 2013; Smith, 2008). It is clear that a discussion, with response from the researcher, including facial and vocal expression and inflection will influence the discussion (Kvale, 1988). Efforts were made to prompt, reflect, and empathize with the participant rather than judge or attempt to overlay ideas of the researcher – the effort was made to listen to the participants’ viewpoints with empathic responsiveness (Josselson, 2013).

In the initial contact it was suggested that participants might wish to access a quiet or private room away from the informant’s place of work if they required additional privacy – ultimately, effort was made for the participants to have control over the environment, choosing where they wished to interview (King & Horrocks, 2010). Interviews were tentatively scheduled for a block of 90 minutes however, the interviews ran for the duration that the participant wished to interview, based on their pacing and interactions. All interviews were audiotaped. The end of the interview was a time for summary and consideration. A debriefing process allowed closure, where the interview experience could be shared with regard to how it was experienced and if there were particular comments or feelings or learning to be shared from the interaction – the end sharing allows a respectful denouement and release for closure as meaningful discussion was had and was respected (Josselson, 2007).
Analytic Approach

An overall strategy to prepare for each interview included making adequate time pre-interview to be settled and focused, this included meditative thoughts and quieting of my mind. As noted, interviews were requested by the participants to be in their preferred location and so extra time was taken to arrive in a timely manner ahead of the scheduled appointment to settle and ready. The semi-structured interview guide, the questions to be part of the interview, were read by the participant prior to the consent form being signed as a means to ensure that consent was truly informed about what the topics and focus might be (Appendices H and I). It was also noted that other conversation was welcomed and that there was not necessarily only room for the semi-structured interview guide questions (King & Horrocks, 2010). The pre-reading was a tool to allow not only preparation for consent but also for a starting point in accessing experiences and thoughts from the participants, I think of this as a focused priming. Rapport with the participants was built around initial questions about education, work, suicide-specific training, and what made the participant choose to interview.

During each interview, notes were jotted relevant to particular emotions or reaction observed in either the participant or in myself. These field notes were an effort to capture some essences or moments that were particular to the interview and a note would have been made with respect to the timing of the emotion or reaction so that the note could be matched with transcripts produced afterward (King & Horrocks, 2010). Pacing of reactions and particular immediate personal reflections were noted as the interview unravelled. This is not to suggest that I wrote or took notes the entire time
there was conversation. Conversation was paramount. I tuned in, as much as I could, to the content, tone, emotion and meaning. I strove to be close to the participants’ experiences to feel the understanding. The electronic audio recording was very useful to allow freedom to be attentive and connected in the moment. Primarily, the focus in interviewing was on connecting with the participant - discussing and being in the moment to gain as much clarity in understanding through intent listening and probing for more elaboration and clarification of meanings. Active and reflective listening was utilized in order to maintain connection in the interaction. Questions, from the semi-structured guide were used in a conversational rather than rigid delivery. At no time, did I fall into a strict Question-Answer format, that might feel like an interrogation or a prescription for content as there is a danger in overuse of semi-structured questions that can subsequently offset potential for real conversation (Roulston, 2010). Interpretation begins the moment a discussion is engaged (Moen, 2006). So there was need for conversation and discussion. When I believed I was in the process of understanding, I would reflect back to the participant my thought and asked if it was accurate to their idea or meaning (Denzin, 2004). This generally resulted in agreement about meaning or it allowed for elaboration and clarification. As the interview questions were satisfied it was left open to the participant to decide if they had further information, reactions or thoughts they wished to offer.

After the interview I reviewed any thoughts that occurred during the interview and took time to reflect upon discussion and record further reactions in journal writing. Transcription of the taped interviews was put into verbatim text.
The following are steps that occurred post-transcription:

- Any field notes, specific to the interview, matching specific phrases or particular reaction were matched in the text margin to ensure they were connected to the time marker or discussion point that was relevant.

- Each transcript was read through several times separately. New notes and comments were then written into the margin of the transcripts specific to the reading and rereading process. The new notes were a reflection of ideas, reactions, recollections, or emotions felt during read through. Time was taken between re-reads of the same transcripts.

- Identification and labeling of story lines, emerging themes, factors, and/or meanings in each transcript occurred. Indications of how the phenomena were understood and experienced by the participant were considered based on the cultural and environmental contexts described by the participant. Themes, factors, and/or meanings were related back to each transcript text, one transcript at a time.

- Visual charts were used to cluster emerging themes and later master themes, or larger meanings in the transcripts were developed. There was effort to be flexible and creative without losing the intent from the participant with a constant awareness to situate personal and professional ways that the researcher has lived and experienced.

- For the purposes of post-interview collaboration, direct quotations were connected to particular ideas or meanings and each participant (specific to their own quotations) were asked if their quotations did reflect back to
the themes pulled from their words. Upon receiving the okay from
participants that their meanings were sensible to them or were clarified
for me, the production of a multi-voiced story, threading all the
participants’ meanings together ensued.

(Creswell, 2007; Giorgi, 2000; Hesse-Biber, 2010; King & Horrocks, 2010 ; Larkin, et
al., 2008; Lester, 1999; Moen, 2006; Pringle, et al., 2011a; Saldana, 2013; Smith, et al.,
2009; Tesch, 1987).

**Reflexivity**

Self-awareness and being conscious of my own position with respect to the
experiences of the participants required consideration before, during and after
interviewing. Consciously avoiding judgment during interviews and self-managing
reactions was essential to the reflexive process during interaction (Josselson, 2007).
Being conscious and aware of my own assumptions, preconceptions, personal views,
and interpretations specific to my worldview, was necessarily considered so that my
ideas would not taint the description or story of the participants (Groenewald, 2004;
Lester, 1999; Smith, 2008; Smith, et al., 2009). Initial awareness, for transparency of
this study was initiated earlier with reference to my epistemological position, context
and positioning of some experiences that brought me to this research. Bracketing is an
effort to expose the writer, allow for self-examination, and deepen the exploration from
participants’ perspectives and make effort to balance researcher apart from the
participants - it is clear that a writer cannot strip themselves from the work they produce
but situating themselves allows understanding of their position (Larkin, Eatough, &
Osborn, 2011; Moen, 2006).
During the interviews, a reflective and reflexive journal was used to help situate myself with notes when I was: a) preparing prior to each individual interview, b) reflecting following each interview, c) tracking any insights or learning that occurred through the interviews and transcript readings, d) developing themes, and, sorting through larger meanings (Hesse-Biber & Leavy, 2004; Wall, et al., 2004). A decision was made to write myself into the work, so that there was more clarity about how I was reflexive about the meanings developed through the participants’ stories. My intention was to be very clear about who I am with regard to the experiences of the stories and meanings shared by the participants (Moen, 2006).

Figure 6 represents the qualitative process for development of the narrative.
This visual representation of the narrative strategy utilized is developed from several sources but is primarily informed by Creswell’s organization of narrative research (Creswell, 2007; Giorgi, 2000; Hesse-Biber, 2010; Hesse-Biber & Leavy, 2004; King & Horrocks, 2010; Larkin, et al., 2008; Lester, 1999; Moen, 2006; Pringle, et al., 2011a; Saldana, 2013; Smith, et al., 2009; Tesch, 1987).
CHAPTER 5 – ANALYSIS

Phase I - Quantitative Results

Survey Participants

Of the 529 (426 Full Practice, 67 Provisional Practice, and 36 Non-Practice) psychologists registered in Saskatchewan during the period the survey was offered from April 4 – July 4, 2013 (SCP, 2014, Annual Newsletter), 82 psychologists answered the online survey. Of the 82 psychologists that answered the survey, 61 completed the survey. Twenty-one surveys were not complete with discontinuation of the survey at various points throughout the body of the survey. Only the completed results are included for analysis. The sample size of Saskatchewan psychologists participant group was \( n=61 \). Which is equivalent to 11.5% of the population of psychologists registered with the Saskatchewan College of Psychologists.

Survey Participant Demographics

Age and marital status

Sixty-one psychologist participants responded in full to the Internet survey. The participant psychologists were 14 males and 47 females. Participant ages ranged as follows: 1 was 20-29 years of age; 22 were 30-39 years of age; 16 were 40-49 years of age; 13 were 50-59 years of age; and 9 were 60-69 years of age. Personal partnership status-marital status, was identified as: 47 were married or common-law; 9 single; 4 separated/divorced; and 1 widowed/widower.
Licensure, education and competencies

Fully licensed/fully registered Full-Practice psychologists in the Saskatchewan College of Psychologists numbered 52, one of whom was also licensed in another jurisdiction besides Saskatchewan. Provisionally registered psychologists numbered 9 persons. The levels of education identified in the psychologist participant group were 30 persons with a masters degree, 30 with a doctoral degree, and 1 with a post-doctoral degree. Formal declaration of competencies identified by the psychologists were: 38 Clinical; 19 Educational; 15 Counselling; 2 Forensic; 2 Research Psychologists; 1 Assessment; 1 Neuroscience; and 1 Rehabilitation.

Years as psychologist

The length of time participants had worked as psychologists was identified as follows: 17 had worked for 0-5 years as a psychologist; 14 had worked from 6-10 years; 12 had worked form 11-15 years; 8 had worked from 15-20 years; 5 had worked from 21-15 years; 3 had worked from 26-30 years; and 2 had worked over 30 years.

Prior related work

Twenty-five of the psychologists identified working in other fields closely related to psychology prior to their work as a psychologist. The closely related work areas identified prior to work as a psychologist were: 8 Educators; 5 Youth Workers (in residential treatment); 4 Guidance Counsellors/Therapists; 2 Social Worker; 2 Community Mental Health Worker; 1 Telephone Crisis Counsellor; 1 Victim Services Worker; 1 Psychiatric Nurse; 1 Health Policy Analyst; 1 Administration; and 1 Psychometrician.

Table 1 represents the demographics of the survey participants.
Table 1. Survey-participant demographics

<table>
<thead>
<tr>
<th></th>
<th>Participant Numbers</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>14</td>
<td>23%</td>
</tr>
<tr>
<td>Female</td>
<td>47</td>
<td>77%</td>
</tr>
<tr>
<td><strong>Age (in years):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20-29</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>30-39</td>
<td>22</td>
<td>36.1%</td>
</tr>
<tr>
<td>40-49</td>
<td>16</td>
<td>26.2%</td>
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<tr>
<td>50-59</td>
<td>13</td>
<td>21.3%</td>
</tr>
<tr>
<td>60-69</td>
<td>9</td>
<td>14.8%</td>
</tr>
<tr>
<td><strong>Marital Status:</strong></td>
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<td></td>
</tr>
<tr>
<td>Married/Common Law</td>
<td>47</td>
<td>77.0%</td>
</tr>
<tr>
<td>Single</td>
<td>9</td>
<td>14.8%</td>
</tr>
<tr>
<td>Separated/Divorced</td>
<td>4</td>
<td>6.6%</td>
</tr>
<tr>
<td>Widowed/Widower</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td><strong>Licensure:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fully Registered</td>
<td>52</td>
<td>85.2%</td>
</tr>
<tr>
<td>Provisionally Registered</td>
<td>9</td>
<td>14.8%</td>
</tr>
<tr>
<td><strong>Education:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Master</td>
<td>30</td>
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<tr>
<td>Doctorate</td>
<td>30</td>
<td>49.2%</td>
</tr>
<tr>
<td>Post-Doctorate</td>
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<tr>
<td><strong>Competencies:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Clinical</td>
<td>38</td>
<td>62.3%</td>
</tr>
<tr>
<td>Educational</td>
<td>19</td>
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</tr>
<tr>
<td>Counselling</td>
<td>15</td>
<td>24.6%</td>
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<tr>
<td>Forensic</td>
<td>2</td>
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</tr>
<tr>
<td>Research</td>
<td>2</td>
<td>3.3%</td>
</tr>
<tr>
<td>Assessment</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Neuroscience</td>
<td>1</td>
<td>1.6%</td>
</tr>
<tr>
<td>Rehabilitation</td>
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<td>1.6%</td>
</tr>
<tr>
<td><strong>Years of Psychology Practice:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>0-5</td>
<td>17</td>
<td>27.9%</td>
</tr>
<tr>
<td>6-10</td>
<td>14</td>
<td>22.9%</td>
</tr>
<tr>
<td>11-15</td>
<td>12</td>
<td>19.7%</td>
</tr>
<tr>
<td>16-20</td>
<td>8</td>
<td>13.1%</td>
</tr>
<tr>
<td>21-25</td>
<td>5</td>
<td>8.2%</td>
</tr>
<tr>
<td>26-30</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>&gt;30</td>
<td>2</td>
<td>3.3%</td>
</tr>
<tr>
<td><strong>Closely related field of work prior to being a psychologist (n=25):</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Educator</td>
<td>8</td>
<td>30.8%</td>
</tr>
<tr>
<td>Youth Facility Worker</td>
<td>5</td>
<td>19.2%</td>
</tr>
<tr>
<td>Guidance Counsellor/Therapist</td>
<td>4</td>
<td>15.4%</td>
</tr>
<tr>
<td>Social Worker</td>
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<td>7.7%</td>
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<td>Victim Services Worker</td>
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</tr>
<tr>
<td>Psychiatric Nurse</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Health Policy Analyst</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Telephone Crisis Worker</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Administrator</td>
<td>1</td>
<td>3.8%</td>
</tr>
<tr>
<td>Psychometrician</td>
<td>1</td>
<td>3.8%</td>
</tr>
</tbody>
</table>
Psychologists’ Workload and Work Demographics

**Caseload**

Average caseload per psychologist was determined as follows: 7 psychologists had a caseload of 1-10 client cases; 8 had 11-20 client cases; 13 had 21-30 client cases; 3 had 41-50 client cases; 4 had 51-60 client cases; 5 had 61-70 client cases; 1 had 71-80 client cases; and 5 had over 100 cases to manage.

**Client geographic location**

Psychologist survey participants identified their primary geographic client population groups served were: 48 identified urban; 8 identified rural, which included First Nations reserves; 4 served both urban and rural populations; and 1 served residents residing in an institutional setting.

**Primary client population**

Psychologists identified their primary client populations with whom they worked: 45 worked with adults; 34 with adolescents; 20 with families; 20 with children; 14 with couples; 4 with organizations/communities; and 1 with educators.

**Focus of work**

Primary focus of psychologists’ work were identified as: 51 in counselling/treatment/therapy; 37 in assessment; 8 in education; 4 in research; 3 in consultation; and 1 in assessment/treatment and consultation.
Domains of practice

Domains of psychologist practice were identified as: 27 were in private practice or third party payer; 24 were in mental health; 10 were in schools; 6 were in training and consultation; 5 were providing in-patient hospital; 5 served out-patient hospital, rehabilitation or youth residential treatment; 5 were in corrections; 2 were in university or postsecondary settings; 1 was in addictions; and 1 in a non-governmental organization.

Table 2 reflects the data related to psychologists’ workload and work demographics.
### Table 2. Psychologists’ workload and work demographics

<table>
<thead>
<tr>
<th>Caseload (on average):</th>
<th>Participant Numbers</th>
<th>Percentage</th>
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<tr>
<td>1-10</td>
<td>7</td>
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<td>11-20</td>
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<td>13.1%</td>
</tr>
<tr>
<td>21-30</td>
<td>13</td>
<td>21.3%</td>
</tr>
<tr>
<td>31-40</td>
<td>13</td>
<td>21.3%</td>
</tr>
<tr>
<td>41-50</td>
<td>5</td>
<td>8.2%</td>
</tr>
<tr>
<td>51-60</td>
<td>4</td>
<td>6.6%</td>
</tr>
<tr>
<td>61-70</td>
<td>4</td>
<td>6.6%</td>
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<td>71-80</td>
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<td>81-90</td>
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<td>91-100</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>&gt;100</td>
<td>5</td>
<td>8.2%</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Client work in geographic location:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
</tr>
<tr>
<td>Rural (including First Nation reserves)</td>
</tr>
<tr>
<td>Urban and Rural</td>
</tr>
<tr>
<td>Institutional</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Client population:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adults</td>
</tr>
<tr>
<td>Adolescents</td>
</tr>
<tr>
<td>Families</td>
</tr>
<tr>
<td>Children</td>
</tr>
<tr>
<td>Couples</td>
</tr>
<tr>
<td>Organizations/Communities</td>
</tr>
<tr>
<td>Educators</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Focus of work:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Counselling/treatment/therapy</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
<tr>
<td>Education</td>
</tr>
<tr>
<td>Research</td>
</tr>
<tr>
<td>Consultation</td>
</tr>
<tr>
<td>Assessment</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Domains of practice:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private practice/3\textsuperscript{rd} party payer</td>
</tr>
<tr>
<td>Mental health clinic</td>
</tr>
<tr>
<td>School</td>
</tr>
<tr>
<td>Training/consultation</td>
</tr>
<tr>
<td>Inpatient-hospital</td>
</tr>
<tr>
<td>Outpatient-hospital, rehabilitation, youth residential treatment</td>
</tr>
<tr>
<td>Corrections</td>
</tr>
<tr>
<td>University/Postsecondary</td>
</tr>
<tr>
<td>Addictions</td>
</tr>
<tr>
<td>Non-government organization</td>
</tr>
</tbody>
</table>
Self-Care Practices

Frequency of self-care

All psychologists surveyed acknowledged participation in intentional self-care activities. Frequency of self-care was identified as: 27 indicated that they participated in self-care several times throughout their day; 10 identified once-daily self-care; 23 identified that they participated in self-care several times each week; 3 identified that several times in the course of a month they would participate in a self-care activity; and 5 psychologists reported inconsistent or sporadic self-care activities.

Self-care connected to professional development

Self-care activities were sub-divided into numerous categories. Professional competence building and work-related activities were also listed in self-care. Work-related or professional competence building activities that were identified as self-care were listed as: 48 participants listed debriefing work activities with colleagues; 36 listed attending workshops; 31 listed debriefing feelings that originated at work with spouse/family/friends; 30 indicated reading for advancing work skills; 29 talked informally with colleagues between sessions; 29 listed receiving consultation or supervision; 23 listed limiting case load; and 17 indicated diversification of therapy strategies.

Personally oriented self-care

Personally oriented self-care listed that: 55 participants indicated exercise as the most commonly pursued self-care activity; 49 engaged interactions with friends; 47 indicated family connections; 45 identified taking time alone; 44 listed connecting with their spouse; 40 participants listed watching movies/television; 38 listed vacationing; 37
read for pleasure; 35 took time with their pets; 32 pursued hobbies/arts/crafts/cooking/music; 29 enjoyed traveling; 21 listed participation in a spiritual practice or service; 17 engaged in prayer; 12 identified massage; 12 followed sports; 12 took spa treatments/hot baths; 10 pursued writing/journaling; 9 took counselling from a professional or pastor; 2 listed alcohol; 2 took on outdoor chores; 1 engaged good sleep hygiene; and 1 listed community service.

Table 3 reflects psychologists’ self-care practices.
Table 3. Psychologists’ self-care practices

<table>
<thead>
<tr>
<th>Frequency of self-care practice:</th>
<th>Participant Numbers</th>
<th>Percentages</th>
</tr>
</thead>
<tbody>
<tr>
<td>Several times during a day</td>
<td>27</td>
<td>44.3%</td>
</tr>
<tr>
<td>Once daily</td>
<td>10</td>
<td>16.4%</td>
</tr>
<tr>
<td>Several times each week</td>
<td>23</td>
<td>37.7%</td>
</tr>
<tr>
<td>Once weekly</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Several times throughout the month</td>
<td>3</td>
<td>4.9%</td>
</tr>
<tr>
<td>Once monthly</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Sporadically/inconsistently</td>
<td>5</td>
<td>8.2%</td>
</tr>
</tbody>
</table>

| Professionally connected self-care:                                                            |                     |             |
| Debriefing work activities with colleagues                                                    | 48                  | 78.7%       |
| Attend workshops                                                                               | 36                  | 59.0%       |
| Debrief work feelings with spouse/family/friends                                              | 31                  | 50.8%       |
| Reading for advancing work skills                                                             | 30                  | 49.2%       |
| Informal discussions at work with colleagues                                                  | 29                  | 47.5%       |
| Formal consultation/supervision                                                              | 29                  | 47.5%       |
| Limiting caseload                                                                             | 23                  | 37.7%       |
| Diversification of therapy strategies                                                        | 17                  | 27.9%       |

| Personally oriented self-care:                                                                 |                     |             |
| Exercise                                                                                      | 55                  | 90.2%       |
| Interaction with friends                                                                      | 49                  | 80.3%       |
| Family connection                                                                             | 47                  | 77.0%       |
| Time alone                                                                                    | 45                  | 73.8%       |
| Spouse Connection                                                                             | 44                  | 72.1%       |
| Movies/TV                                                                                    | 40                  | 65.6%       |
| Vacations                                                                                    | 38                  | 62.3%       |
| Reading for pleasure                                                                          | 37                  | 60.7%       |
| Time with pet                                                                                 | 35                  | 57.4%       |
| Hobbies/arts/crafts/cooking/music                                                             | 32                  | 52.5%       |
| Travel                                                                                       | 29                  | 47.5%       |
| Spiritual practice/services                                                                    | 21                  | 34.4%       |
| Prayer                                                                                       | 17                  | 27.9%       |
| Massage                                                                                      | 12                  | 19.7%       |
| Following sporting events                                                                     | 12                  | 19.7%       |
| Spa treatments/hot bath                                                                       | 12                  | 19.7%       |
| Writing/journaling                                                                            | 10                  | 16.4%       |
| Counselling (professional or pastoral)                                                        | 9                   | 14.8%       |
| Outdoor chores                                                                                | 2                   | 3.3%        |
| Alcohol                                                                                      | 2                   | 3.3%        |
| Community service                                                                             | 1                   | 1.6%        |
| Good sleep hygiene                                                                           | 1                   | 1.6%        |
Suicide-Specific Training, Suicide Work, Supports, and Client Suicide

Twenty psychologists had experienced client suicide while forty-one had not. All psychologists identified their work included making some connection with suicide-ideated clients.

Suicide-specific training

Suicide specific training, in the psychologist participant survey group, is identified, as either not practical-experientially based training or practical-experiential training. In the non-practical training: 49 participated in university class discussions and/or university text readings; 32 wrote a paper, or, did self-directed readings; 24 attended a 1-day session; 9 attended a ½ day session; 3 participated in a 3 ½ hour session, specifically safeTALK (which has a very limited practice component); and 3 participated in on-line training. Those that identified participation in experiential-based training were: 36 participated in the 2-day workshop ASIST (Applied Suicide Intervention Skills Training); 3 participated in doctoral internship with closely supervised suicide work; 2 participated in Dialectical Behaviour Therapy which was also highly supervised around suicide work; and 2 participated in suicideCARE (a one day workshop which also requires ASIST as prerequisite). Seven individuals indicated a training that was ambiguous with regard to content or practice specificity.
Suicide work

All sixty-one psychologists identified that they worked with suicide-ideated clients. Fifty psychologists identified their suicide work is longer term or ongoing. Eleven psychologists identified that they provide only initial assessment for their clients and then provide a next-step referral for treatment/therapy for those persons in whom suicide ideation was assessed.

Client suicide work related to repetitive suicide-ideation

Participants were asked to identify how many clients on their caseload would be in a position of repetitively experiencing suicide ideation. Five psychologists out of sixty-one did not work with this population. Forty-eight psychologists identified that 1-5 of the clients on their caseload would be in a position of being in a repetitive pattern of thinking about suicide. Six psychologists indicated that they would have between 6-10 clients who would be considering suicide in an ongoing manner, while 2 psychologists indicated that they would have 11-15 clients on their caseload that repetitively think about suicide.

Psychologists organized external supports for suicide-ideated clients

Psychologists were asked if they initiated and engaged external or other resources other than themselves as helpers to support their clients who had suicide ideation. Thirty-five psychologists acknowledged that they always engaged other resources to support the client. Twenty-six psychologists indicated that it was mostly true that they engaged supportive resources, other them themselves, for client support.
Psychologists who engage self-supports during work with suicide-ideated clients

Psychologists were asked if they engage resources to support themselves as they work with suicide-ideated clients. Thirty-three psychologists indicated that it was mostly true that they engaged supports for themselves as they worked with suicide-ideated clients. Twenty-three psychologists indicated that it was always true that they engaged resources for self-support when working with suicide-ideated clients. Three indicated that they did not engage resources for self-support when working with suicide-ideated clients. Two did not work with suicide-ideated clients.

Primary therapeutic approach in suicide work

Therapy strategies that psychologist survey participants identified as using to work with suicide-ideated clients were identified as: 46 engaged Cognitive Behaviour Therapy; 33 utilized Client-Centered Therapy; 30 used Solution-Focused Therapy; twenty used Interpersonal Therapy; 19 used Dialectic Behaviour Therapy; 17 used Cognitive Therapy; 15 used Behavioural Therapy; 9 used Family Systems Therapy; seven used Rational Emotive Therapy; 3 indicated they do not provide therapy but upon identification of suicide ideation refer on to a therapist who will provide therapy; 2 used a multi-theoretical approach; 2 used crisis intervention and risk management; 2 used Narrative Therapy; 1 used Psychodynamic; 1 used Acceptance and Commitment Therapy; 1 used Choice Theory-Reality Therapy; 1 used Emotion-Focused Therapy; 1 used a holistic approach; 1 used an Adlerian approach; 1 used Memetic Self-mapping; and 1 used Eye Movement Desensitization and Reprocessing.
Table 4 reflects data specific to psychologists’ work related to suicide-specific training and suicide work with clients.

<table>
<thead>
<tr>
<th>Table 4. Suicide-specific training, suicide work, and client suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Participants</strong></td>
</tr>
<tr>
<td><strong>Suicide-Specific Training:</strong></td>
</tr>
<tr>
<td>Non-practical/non-experiential:</td>
</tr>
<tr>
<td>University class/text reading(s)</td>
</tr>
<tr>
<td>Self-directed reading(s)</td>
</tr>
<tr>
<td>1-day session</td>
</tr>
<tr>
<td>½-day session (lecture)</td>
</tr>
<tr>
<td>3½-hour session safeTALK</td>
</tr>
<tr>
<td>On-line training</td>
</tr>
<tr>
<td>Practical/experiential:</td>
</tr>
<tr>
<td>ASIST 2-day workshop</td>
</tr>
<tr>
<td>Doctoral Internship with suicide work supervision</td>
</tr>
<tr>
<td>Dialectic Behaviour Therapy with suicide work supervision</td>
</tr>
<tr>
<td>suicideCARE</td>
</tr>
<tr>
<td>Unspecified content and experiential components:</td>
</tr>
<tr>
<td>Corrections Services Canada Module/consultation</td>
</tr>
<tr>
<td><strong>Suicide Work:</strong></td>
</tr>
<tr>
<td>Working with suicide ideated clients</td>
</tr>
<tr>
<td>Suicide work is ongoing and longer term</td>
</tr>
<tr>
<td>Initial assessment and referral</td>
</tr>
<tr>
<td>Client suicide work related to repetitive suicide-ideation:</td>
</tr>
<tr>
<td>Do not work in ongoing manner with suicide ideated clients</td>
</tr>
<tr>
<td>1-5 clients</td>
</tr>
<tr>
<td>6-10 clients</td>
</tr>
<tr>
<td>11-15 clients</td>
</tr>
<tr>
<td>Psychologists organized external supports for suicide-ideated clients:</td>
</tr>
<tr>
<td>Always true</td>
</tr>
<tr>
<td>Mostly true</td>
</tr>
<tr>
<td>Psychologists who engage self-support during work with suicide-ideated clients:</td>
</tr>
<tr>
<td>Always</td>
</tr>
<tr>
<td>Mostly</td>
</tr>
<tr>
<td>Do not engage self-support resources</td>
</tr>
<tr>
<td>Do not work with suicide-ideated clients</td>
</tr>
<tr>
<td>Primary therapeutic approach in suicide work:</td>
</tr>
<tr>
<td>Cognitive Behaviour Therapy</td>
</tr>
<tr>
<td>Client-Centered Therapy</td>
</tr>
<tr>
<td>Solution-Focused Therapy</td>
</tr>
<tr>
<td>Interpersonal Therapy</td>
</tr>
<tr>
<td>Dialectic Behaviour Therapy</td>
</tr>
<tr>
<td>Cognitive Therapy</td>
</tr>
<tr>
<td>Behavioural Therapy</td>
</tr>
<tr>
<td>Family Systems Therapy</td>
</tr>
<tr>
<td>Rational Emotive Therapy</td>
</tr>
<tr>
<td>Multi-Theoretical Approach</td>
</tr>
<tr>
<td>Crisis Intervention and Risk Management</td>
</tr>
<tr>
<td>Narrative Therapy</td>
</tr>
<tr>
<td>Psychodynamic Therapy</td>
</tr>
<tr>
<td>Acceptance and Commitment Therapy</td>
</tr>
<tr>
<td>Holistic Approach</td>
</tr>
<tr>
<td>Adlerian</td>
</tr>
<tr>
<td>Memetic Self-Mapping</td>
</tr>
<tr>
<td>Eye Movement Desensitization and Reprocessing</td>
</tr>
<tr>
<td>Psychologists who experienced client suicide:</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
**ProQOL5 Data Analysis**

On the Compassions Satisfaction Scale, Burnout Scale, and Secondary Traumatic Stress Scale a score of 50 is considered to be in the average range, scores less than 43 are considered to be low level scoring, and scoring above 57 is high level scoring (Stamm, 2010).

On the Compassion Satisfaction Scale 43 of the 61 participants surveyed responded such that they were in the low level of compassion satisfaction with a mean score of $\mu=37.91$. In the average level of compassion satisfaction 18 of 61 participants were scored with a mean score, $\mu=46.67$. No participants scored in the high level rating for compassion satisfaction.

On the Burnout Scale all 61 participants surveyed responded in the low level of the Burnout Scale, with a mean scoring of $\mu=21.62$.

On the Secondary Traumatic Stress Scale 46 out of 61 participants scored in the low level rating for Secondary Traumatic Stress, with a mean score of $\mu=17.89$. 15 participants out of 61 scored in the average range with a mean score of $\mu=26.87$.

The following Table 5 describes participant scoring for ProQOL5, for scales of Compassion Satisfaction, Burnout, and Secondary Traumatic Stress.
Table 5

*ProQOL5 scale scores*

<table>
<thead>
<tr>
<th></th>
<th>Low level Individual score compared to norms in typical caregiver population is &lt;43</th>
<th>Average level Individual score compared to norms in typical caregiver population is &gt;43 and &lt;57</th>
<th>High level Individual score compared to norms in typical caregiver population is &gt;57</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Compassion Satisfaction</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants</td>
<td>43</td>
<td>18</td>
<td>0</td>
</tr>
<tr>
<td>n=61</td>
<td>70.5%</td>
<td>29.5%</td>
<td></td>
</tr>
<tr>
<td>Mean score CS</td>
<td>$\mu = 37.91$</td>
<td>$\mu = 46.67$</td>
<td>0</td>
</tr>
<tr>
<td><strong>Burnout</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants</td>
<td>61</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>n=61</td>
<td>100%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mean score BO</td>
<td>$\mu = 21.62$</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td><strong>Secondary Trauma Stress</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of participants</td>
<td>46</td>
<td>15</td>
<td>0</td>
</tr>
<tr>
<td>n=61</td>
<td>75.4%</td>
<td>24.6%</td>
<td></td>
</tr>
<tr>
<td>Mean Score STS</td>
<td>$\mu = 17.89$</td>
<td>$\mu = 26.87$</td>
<td>0</td>
</tr>
</tbody>
</table>
SIRI-2 Data Analysis

Participants’ responses from each SIRI-2 question were compared to the responses of the expert panel of suicidologists. The expert suicidologists’ ratings are derived from scoring and instrument validation where best possible outcome ratings for the SIRI-2 responses were developed (Neimeyer & Bonelle, 1997). The participants’ discrepancy responses were summed and squared to provide the totals for Table 6 that follows. Higher scores are demonstrative of more discrepancy from the ideal ratings demonstrated by expert suicidologists, while lower discrepancy ratings are demonstrative of participant responses lining up closer to the expert responses for ideal interventionist responses. Hence higher scoring represents less competence in identifying the more facilitative responses to a suicide-ideated individual.

A score of 0 would demonstrate a perfect score with no discrepancy and would be a reflection of an ideal rating when compared to the expert panel of suicidologists. For example, a discrepancy sum totalled and squared for participant 10, whose discrepancy score is the lowest in the group (of 61 participants) totalled 84.22, which would be representative of 47 points off the ideal score of 0. The discernment on the Likert scale ranged across 7 possible responses, specifically: Highly Appropriate, Appropriate, Marginally Appropriate, Neither Appropriate nor Inappropriate, Marginally Inappropriate, Inappropriate, and Highly Inappropriate. Two caregiver response styles were demonstrated, Option A and Option B – of which, one response was highly appropriate and the other highly inappropriate.

61 participants responses are recorded. The discrepancy responses are averaged, $\mu = 173.84$. 
To give some sense of comparison to $\mu = 173.84$, participant 18 had a discrepancy sum total of 172.18 (the closest score under $\mu = 173.84$). A discrepancy sum of 172.18 demonstrates inaccuracy in discerning the most facilitative responses to a suicide-ideated individual – this participant scored 59 points off an ideal score of 0.

Table 6 shows SIRI-2 participant responses with discrepancy comparisons as compared to the expert panel of suicidologists.
Table 6

*SIRI-2 discrepancy comparisons.*

Discrepancy sums totalled and squared:

| 140.10, 180.74, 131.52, 132.44, 194.46, 165.06, 187.18, 197.56, 123.90, 84.22, 183.84, 189.96, 321.04, 235.74, 144.66, 169.10, 142.58, 172.18, 186.40, 163.84, 205.30, 157.16, 156.32, 117.08, 146.86, 91.96, 110.42, 149.82, 139.82, 190.28, 181.64, 199.58, 238.72, 179.68, 199.04, 160.64, 215.00, 155.80, 177.94, 135.62, 133.34, 211.06, 111.32, 144.96, 174.96, 184.20, 140.40, 203.70, 139.24, 189.02, 171.84, 163.64, 227.32, 179.26, 187.58, 146.90, 206.40, 169.78, 274.60, 173.94, 315.62 |

Total all squared discrepancy sums = 10604.28

\[ n = 61 \text{ (14 males, 47 females)} \]

\[ \mu = 173.84 \]

*Note: Individual participant responses are recorded as total errors summed and squared. The discrepancy is determined based on comparison to scoring from an expert panel of suicidologists who scored with best possible outcomes on the SIRI-2. The table scores represent ability to determine most facilitative responses to suicide-ideated persons. Scores are summed and squared for use in analysis.*
Quantitative Hypotheses – Findings

Results of Analysis

**ProQOL5 correlation with SIRI-2**

The ProQOL5 was run against the SIRI-2 using the Spearman’s Rank Correlation coefficient. When calculating the specific scale for compassion satisfaction with the SIRI-2 it was demonstrated that the $p-value = .17$, $rho = -.12$, *therefore, $p > .10$ non-significant*. No correlation was found between compassion satisfaction scale ratings and SIRI-2; therefore more appropriate responsiveness did not correlate with higher compassion satisfaction ratings.

The burnout scale was run with the SIRI-2 demonstrating $p-value = .36$, $rho = .05$, *therefore, $p > .10$ non-significant*. Therefore increased ratings on the burnout scale scores did not correlate with inappropriate responses on the SIRI-2.

The secondary traumatic stress scale was run with the results of the SIRI-2 demonstrating a $p-value = .16$, $rho = .13$, *therefore, $p > .10$ non-significant*. Higher secondary traumatic stress scale scores did not correlate with inappropriate responsiveness on the SIRI-2.

**Frequency of self-care correlation with SIRI-2**

The frequency of participants’ self-care activities was run through Spearman’s Rank Correlation coefficient with the ratings of the SIRI-2 to demonstrate a $p-value = .13$, $rho = .15$, *$p > .10$ non-significant*. Increased frequency of reported self-care did not correlate with more appropriate SIRI-2 responsiveness.
**Frequency of self-care correlation with ProQOL5**

Frequencies of participants’ self-care activities were measured with Spearman’s Rank Correlation coefficient with the ProQOL5. Self-care activities when run with the compassion satisfaction scale demonstrated a $p-value = .07, \rho = -.19, p < .10$ significant. Increased frequency of self-care did correlate with increased ratings of compassion satisfaction.

The frequency of self-care activities when run against the burnout scale demonstrated a $p-value = .007, \rho = 0.31, p < .10$, significant. Reduced frequency of self-care activities correlated with increased ratings of burnout scale scores.

The frequency of self-care activities when run against the secondary trauma scale demonstrated a $p-value = .04, \rho = 0.23, p < .10$, significant. Reduced frequency of self-care activities correlated with increased ratings on the secondary traumatic scale scores.

**Training discipline means comparison with SIRI-2**

Participants’ SIRI-2 scoring was separated for those psychologists who identified their University Psychology training as either Educational Psychology or Clinical Psychology. A one-tailed T-Test was run on the two training groupings SIRI-2 scores which demonstrated a $p-value = .02, T-value = 2.11, p < .10$, significant. Clinically trained psychologists did demonstrate increased appropriate responsiveness over psychologists trained in educational psychology programs.
Suicide-specific training correlation with SIRI-2

Suicide-specific training was considered based on 3 gradations: i) those with 1 day or less of training (included were university readings or brief classroom focus); ii) those with the ASIST workshop (suicideCARE was included here as ASIST-training is a prerequisite); and, iii) those participants who identified a doctoral program internship with supervised focus on suicide work (DBT training was included because of the intensity of the training and supervision). The suicide-specific training gradations were then run with Spearman’s Rank Correlation Coefficient with the participant results of the SIRI-2. Outcome demonstrated was \( p-value=0.06, \rho=-0.20, p < .10, \text{significant}. \) This demonstrated that those with more training demonstrated more appropriate responsiveness on the SIRI-2.

Level of university education correlation with SIRI-2

Master level education and doctoral level education were rank-ordered and then the Spearman’s Rank Correlation coefficient was run against the participant’s results of the SIRI-2 to demonstrate \( p-value=.19, \rho=.12, p > .10, \text{non-significant}. \) There was no correlation with level of education demonstrating more appropriate responsiveness on the SIRI-2.

Caseload correlation with ProQOL5

Caseload numbers were ranked and the Spearman’s Rank Correlation coefficient was run against the participants’ results of the ProQOL5 – compassion satisfaction scale to demonstrate \( p-value=.08, \rho=-.18, p < .10, \text{significant}. \) Lower caseload volume demonstrated increased compassion satisfaction scores. In comparison when caseloads were run against the burnout scale it was demonstrated that the \( p-value=.05, \rho=.22, \text{significant}. \)
\( p < .10, \text{significant} \). Hence, higher caseload numbers correlated with higher burnout scale scores. Caseload numbers run with the secondary traumatic stress scale demonstrated \( p-value=.05, \rho=.21, p < .10, \text{significant} \). Higher caseload numbers did correlate with higher scores on the secondary traumatic stress scale.

**Licensure and SIRI-2**

Full practice and provisionally licensed psychologists were ranked and the Spearman’s Rank Correlation coefficient was run against the participants’ results of the SIRI-2 to demonstrate \( p-value=.50, \rho=0, p > .10, \text{non-significant} \). No correlation was found to demonstrate that full practice or provisionally licensed psychologists scored better on SIRI-2 responsiveness ratings.

**Years of psychology practice correlation with ProQOL5**

Years of psychology practice were ranked and the Spearman’s Rank Correlation coefficient was run against the participants’ results of the ProQOL5. With regard to years in practice and the compassion satisfaction scale scores correlation was demonstrated with a \( p-value=.07, \rho=.19, p < .10, \text{significant} \). Hence, the more years in practice demonstrated correlations with higher compassion satisfaction scores. Conversely, years in practice as a psychologist ran against the burnout scale scores demonstrated a \( p-value=.05, \rho=-.21, p < .10, \text{significant} \). Psychologists practicing for fewer years demonstrated correlations with higher scale scores of burnout. Similarly, years in practice as psychologist as run against the secondary traumatic stress scores demonstrated a \( p-value=.04, \rho=-.22, p < .10, \text{significant} \). This indicates that the fewer years practicing as a psychologist showed correlation with higher secondary traumatic stress scoring.
Outcomes of Hypotheses

I. ProQOL5 correlation with SIRI-2

No correlation was demonstrated between the scale scores of the ProQOL5 and the SIRI-2. Based on the use of these instruments, there is no indication that compassion satisfaction or compassion fatigue (burnout or secondary traumatic stress) had any influence over the ability for psychologists to more appropriately or less appropriately respond to suicide-ideated client statements.

II. Self-care, caseloads or years in practice correlation to ProQOL5

Demonstrated separately, increased frequency of self-care, lower caseload number, and the longer a psychologist was in practice correlated with higher compassion satisfaction scale scores. Burnout and secondary traumatic stress scores were both correlated with fewer years practicing psychology and with higher caseloads.

III. Psychology discipline, education-level or suicide-specific correlation to SIRI-2

Clinical-trained psychologists demonstrated correlation with more appropriate responsiveness to suicide-ideated client statements over psychologists with university training in educational psychology. Being a doctoral or master level psychologist had no correlation with responsiveness on the SIRI-2. More experientially oriented suicide work correlated with higher adaptive responsiveness ratings on the SIRI-2. Suicide-specific training workshops (ASIST) and supervised doctoral-training internships with suicide-work correlate with more appropriate responsiveness to suicide-ideated client statements, internships correlated more strongly. Those with one-day workshops and
university readings or class focused on suicide demonstrated least appropriate responsiveness to suicide-ideated client statements.

Table 7, on the following page, demonstrates the outcomes of correlational analysis utilizing Spearman’s Correlation Coefficient and a T-Test. The interpretation of the hypotheses, significant and non-significant findings will be addressed in detail in Chapter 6, where the quantitative and qualitative findings will converge for more clarity or the larger meaning of the work.
### Table 7. Quantitative analysis, correlations and T-Test

**Spearman’s Correlation Coefficient**

<table>
<thead>
<tr>
<th></th>
<th>SIRI-2</th>
<th>Practice Years</th>
<th>Caseload</th>
<th>Self-care</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ProQOL5 Compassion Satisfaction</strong></td>
<td></td>
<td>(more years)</td>
<td>(lower caseload)</td>
<td>(higher frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>p-value: .17,</td>
<td>p-value: .07, rho=.19,</td>
<td>p-value: .08, rho=.18,</td>
<td>p-value: .07, rho=.19, p &lt; .10,</td>
</tr>
<tr>
<td></td>
<td>rho=-.12, p&gt;.10</td>
<td>p &lt; .10, significant</td>
<td>p &lt; .10, significant</td>
<td>(more years)</td>
</tr>
<tr>
<td></td>
<td>non-significant</td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td><strong>ProQOL5 Burnout Scale</strong></td>
<td></td>
<td>(less years)</td>
<td>(higher caseload)</td>
<td>(less frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>p-value: .36,</td>
<td>p-value: .05, rho=.21,</td>
<td>p-value: .05, rho=.22,</td>
<td>p-value: .007, rho=.31, p &lt; .10,</td>
</tr>
<tr>
<td></td>
<td>rho=.05, p&gt;.10</td>
<td>p &lt; .10, significant</td>
<td>rho=.22, p &lt; .10,</td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>non-significant</td>
<td></td>
<td>significant</td>
<td>(less frequency self-care)</td>
</tr>
<tr>
<td><strong>ProQOL5 Secondary Traumatic Stress Scale</strong></td>
<td></td>
<td>(less years)</td>
<td>(higher caseload)</td>
<td>(less frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>p-value: .16,</td>
<td>p-value: .04, rho=.22,</td>
<td>p-value: .05, rho=.21,</td>
<td>p-value: .04, rho=.23, p &lt; .10,</td>
</tr>
<tr>
<td></td>
<td>rho=.13, p&gt;.10</td>
<td>p &lt; .10, significant</td>
<td>rho=.21, p &lt; .10,</td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>non-significant</td>
<td></td>
<td>significant</td>
<td>(less frequency self-care)</td>
</tr>
<tr>
<td><strong>Self-care</strong></td>
<td></td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>p-value: .13,</td>
<td></td>
<td></td>
<td>(lower frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>rho=.15, p&gt;.10</td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>non-significant</td>
<td></td>
<td></td>
<td>p-value: .007, rho=.31, p &lt; .10,</td>
</tr>
<tr>
<td><strong>Masters or Doctorate</strong></td>
<td></td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>p-value: .19,</td>
<td></td>
<td></td>
<td>(lower frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>rho=.12, p&gt;.10</td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>non-significant</td>
<td></td>
<td></td>
<td>p-value: .04, rho=.23, p &lt; .10,</td>
</tr>
<tr>
<td><strong>Licensure</strong></td>
<td></td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>p-value: .50,</td>
<td></td>
<td></td>
<td>(lower frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>rho= 0, p&gt;.10</td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>non-significant</td>
<td></td>
<td></td>
<td>p-value: .007, rho=.31, p &lt; .10,</td>
</tr>
<tr>
<td><strong>Suicide-specific training</strong></td>
<td></td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>p-value=0.06,</td>
<td></td>
<td></td>
<td>(lower frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>rho=-0.20, p &lt; .10,</td>
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<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>non-significant</td>
<td></td>
<td></td>
<td>p-value: .04, rho=.23, p &lt; .10,</td>
</tr>
<tr>
<td><strong>t-Test</strong></td>
<td></td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
<tr>
<td><strong>Clinical vs. Educational Psychology</strong></td>
<td>p-value = .02,</td>
<td></td>
<td></td>
<td>(lower frequency self-care)</td>
</tr>
<tr>
<td></td>
<td>T-value = 2.11,</td>
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<td>(higher caseload)</td>
</tr>
<tr>
<td></td>
<td>p &lt; .10,</td>
<td></td>
<td></td>
<td>p-value: .007, rho=.31, p &lt; .10,</td>
</tr>
<tr>
<td></td>
<td>significant</td>
<td></td>
<td></td>
<td>(higher caseload)</td>
</tr>
</tbody>
</table>
Phase II – Qualitative Findings

Part A: Survey Open-Ended Responses Theme Development

Survey Emerging Themes

Themes collected from text data were developed based on 12 questions as noted in the Phase II-Qualitative Methods section. First colorized groupings of text, initial coding, and focused coding are not included in the following outlines of emerging thematic content. Emerging themes are meanings that will capture more refined perceptions nuanced in text data (Tesch, 1987).

In the outline of emerging themes, the first four heading titles are a reflection of all 61 survey participant responses. The eight titles following summarize emerging themes from the questions that were answered by 20 survey participants. The twenty participants were individuals who responded that they had experienced client suicide(s).

The frequency of emergent themes is noted in the write up as a frame of reference. Frequency recordings will be noted in parentheses following the identification of the emerging theme. Reference to focused coding, where perceptions of participants were more elaborative and not yet formed into the larger meaning of an emerging theme, can be located in Appendix J.

**Psychologists’ self-care affects the impact of work stress**

All survey participants (n=61) were asked, in an open-ended question, to describe the influence of self-care activities in improving their reaction to work stress (Question 21, Appendix D).

Participants identified that psychologists are more emotionally stable as a result of self-care (49). Self-care allowed psychologists to feel and be more present and
competent in their professional work (47). Increased self-awareness supported psychologists to be more self-reflective, have clearer perspective, feel improved spirituality and establish appropriate healthier boundaries (26). Increased health benefits were observed, including less stress, increased calmness, and more ability to focus (19). Another direct result of self-care was that personal relationships were identified as being improved (11).

**Benefits to psychologists when accessing supports for suicide-ideated clients**

All psychologists (n=61) were asked how they benefitted when additional external supports were organized around their clients who were at risk of suicide (Question 29, Appendix D). A majority of responses identified that there was increased satisfaction within their work because the psychologists’ were aware that they had provided better clinical or therapeutic suicide work with their clients because they instilled the safety of external support(s) (35). Increasing client safety created a sense of relief for psychologists (34). Psychologists experienced a reduction in stress and a sense of release from the burden of excessive responsibility because external supports were engaged to support suicide-ideated clients (28). Self-care activity increased because more time was available to psychologists when external resources were supporting clients (16). Accessing external supports produced relief for the psychologists, specifically because legal and ethical concerns were allayed (12).

**Supports engaged in workplaces help to continue suicide work**

All participants (n=61) were asked what professional supports they created or engaged in to continue their suicide work (Question 30, Appendix D). Two categories developed in response to the perceptions: one category of perceptions related to the
strengthening of psychologists and a second category of perceptions related to isolation of psychologists.

Related to strengthening of psychologists, participants’ indicated that colleagues are their biggest supports (46). Supervisors who provide supportive discussion, understanding and debriefing were identified as helpful (22). Consultation with a mentor, who has experience around suicide work proved supportive (14). Ongoing training specific to suicide was needed to strengthen psychologists’ suicide work (13). Personal counselling was identified as helpful in continuing suicide work (6). Self-care was identified as strengthening the psychologists’ abilities so that they could continue suicide work (6).

With regard to the idea of being isolated and not particularly helped, it was stated that organizations do not offer adequate help and support to the psychologists providing suicide work (13). Colleagues and managers stigmatized psychologists who made effort to access mental health services (5).

**Barriers preventing psychologist help-seeking**

All survey psychologists (n=61) were asked to identify barriers that prevent their seeking or accessing help when there is extreme work stress or pressure (Question 40, Appendix D). Seventeen respondents indicated that they did not identify external barriers to accessing help as a psychologist, however, their summary perceptions identified that, in fact, a barrier did exist because the psychologists stopped themselves from accessing help or did not recognize they needed help. Forty-four respondents identified that there were barriers to psychologists accessing support.
Psychologists identified that excessive work place demands created inadequate time to seek necessary help (24). Lack of support from the organization/employer was identified as a barrier (17). Concerns related to the size of the psychology community created interference with help seeking because confidentiality and non-biased support was questionable (17). Stigma and judgment placed on psychologists who seek help created a barrier as well (17). Fears that other professionals would identify the psychologist as incompetent prevented activation of support (8). An unwillingness to forfeit family time to was identified as problematic (4). An identified lack of resources was noted, specifically, with regard to rural isolation (4). The personality composition of the psychologist was identified as a factor that would interfere in seeking help (3). Being in private practice was an identified limitation as collegial support would be more difficult to access (2).

Table 8 reflects the survey responses emerging themes specific to perceptions of self-care, supports in suicide work, and barriers for psychologist help-seeking. All 61 participants are reflected in these emerging themes. Appendix J demonstrates participant perceptions that were coded and formed into emerging themes, where frequency is also accounted for.
### Table 8

Survey emerging themes: perceptions of self-care, supports in suicide work, and barriers for psychologist help-seeking  \( n=61 \)

#### Effects of Self-care
- Psychologists are more emotionally stable when self-care is engaged.
- Psychologists are more present and competent professionally as a result of adequate self-care.
- Increased self-awareness grows from self-care.
- Health benefits come from self-care.
- Improved personal relationships are a result of self-care.

#### Benefits to psychologists when accessing supports for suicide-ideated clients
- Satisfaction increased because better clinical/therapeutic work was done for suicide-ideated clients through accessing supports.
- Increased client safety through accessing supports created relief in the psychologists.
- Psychologists’ stress and sense of responsibility were less burdensome with supports being accessed.
- With supports involved, self-care for psychologist increases.
- Legal and ethical concerns are allayed when external supports are accessed.

#### Professional supports accessed to continue suicide work

**Strengthening**
- Colleagues are the biggest support.
- A supervisor providing supportive discussion and debriefing is essential.
- Consultation with a mentor is helpful.
- Suicide-specific training strengthens psychologists’ suicide work.
- Personal counselling helps psychologists stay balanced.
- Self-care is important to continue suicide work.

**Isolating**
- Organization/employers do not offer adequate help.
- Accessing mental health services or supports is stigmatized.

#### Barriers prevent psychologists from accessing help
- Internal barriers within the psychologist would block help seeking.
- Excessive work place demands create inadequate time to seek necessary help.
- Lack of support from organizations and/or employers is problematic.
- Confidentiality and non-biased support is a concern in a small psychological community.
- Stigma and judgment is placed on psychologists’ help seeking.
- Help seeking creates fears related to being seen as incompetent in practice.
- There is unwillingness to forfeit family time to pursue help seeking.
- Lack of (awareness) of resources.
- Personality composition interferes with help seeking.
- Private practice limits collegial support.
Impact of client suicide on caregiving psychologist

The 20 survey participants who identified that they had experienced client suicide (n=20) were asked what help they accessed or what supports were provided to them following client suicide (Question 32, Appendix D). There were two parts in this question. The first asked for responses about how the news of the client suicide was shared with the psychologist. Secondly, psychologists were asked to describe the impact of finding out about the client suicide. Nineteen participants responded with clarity around how the client suicide was shared with them. Sixteen identified specific impacts upon them.

Professional self-doubts (14) and experiencing grief, that required lengthy processing, (14) were described by participants. Others described that they experienced shock, disbelief and a good deal of distress (13). Being hurt by the demonstration of lack of compassion by their manager was noted (5). Feeling helpless and frustrated was observed as well (4).

News of client suicides were received by psychologists through: personal connections of the client or community members shared (11); the workplace employer advised the psychologists (5); media coverage (4); coroner contact (3); and through another agency in the professional community (2).
Supports, for psychologists, activated following client suicide

The 20 survey participant psychologists who had experienced client suicide (n=20) were asked what follow up was accessed or support provided to them following a client suicide (Question 33, Appendix D).

Three participants identified that no support was activated following learning of client suicide. Seventeen indicated that they received or sought out support following clients’ suicides (six of whom noted that there was a work-related support mechanism).

Professional doubts were identified that sparked a need to improve suicide work and so there was effort to focus on better practice strategies (13). Connections with colleagues and healing with self-care were identified as valued to gain release (15). Operational debriefs alone were identified as not offering adequate support (8). Supervisors can be helpful and offer improved perspective (1).

Work environment supports post client-suicide were helpful

Participants who experienced client suicide (n=20) were asked what work environment supports, from colleagues, managers or the employer/organization, were most helpful following client suicide (Questions 34, Appendix D). Eight psychologists identified that no organizational or work supports were offered to them, they reported that their managers were not particularly helpful and they felt that their organization expends little investment in employees.

One emerging theme highlighted that colleagues offered themselves as a support to psychologists who experienced a client suicide - elements of cultural understanding and personal experiences were helpful (7). Unconditional support and listening allowed for the development of perspective related to the suicide and professional growth.
developed improving future suicide work (5). Time off to attend the funeral of the client allowed for grief to be processed - it was helpful to share feelings with other colleagues, family or Elders (5). Releasing feelings with colleagues, where no judgment was levied, felt safe and helpful (4). Recognizing that loss to suicide in mental health work is inevitable provided some level of comfort (2). Support offered from a supervisor helped to provide perspective on the suicide work done with the client and growth developed for future suicide work (1).

**Supports needed post client-suicide**

Participants who experienced client suicide (n=20) were asked to comment on what would have been helpful to them, that was not offered when a client suicided. They also commented on what was lacking and not helpful, these points were restated as needs (Question 35, Appendix D). Five participants indicated that they did not know what would have been helpful or needed. Three participants indicated that nothing would have proved helpful to them.

Emotional support was identified as being necessary, particularly from managers or psychologists who had experienced client suicide (6). Others identified that a supportive debriefing process would have been useful (4). Recognition and validation of efforts made with the client was necessary and helpful (4). Recovery time, away from work and demands, was highlighted as important (4). Responses highlighted that it was necessary for direct talk in the community about suicide helped to reduce how much the psychologist was required to respond to the community (focused on increased risk of suicide resulting from addictions, mental illness, First Nations adversity, and coping strategies that are helpful) (3).
Further, following a suicide, workplace support needs to focus on the wellbeing of the psychologist (8). Time away from work, post client-suicide, would have allowed them to reduce emotional reactions activated by a stressful work environment (4). Training, supervision, and freedom to ask for assistance with client cases were highlighted as necessary (4).

**Change in practice resulting from learning through client suicide**

Participants who experienced a client suicide (n=20) were asked how they changed their practice, worked differently or had grown in their practice as a result of the experience of client suicide (Questions 36, Appendix D). Two respondents indicated they did not experience any change in their practice. Eighteen identified that they did experience change in their practice.

Participants observed that there was an increased seriousness in the responsiveness in suicide work (14). Ensuring that clients had established resources outside of the psychologist-client relationship was focused on (13). Increased direct and specific talk about suicide was noted to change (13). Participants observed an increased attentiveness to their own emotional and physical health that allowed for improved focus on client suicide work (9). Resilience, as a psychologist, increased in addition to the belief that professional competence improved (7). Suicide-specific training was identified as necessary to engage clients for improved response in future suicide work (5). Consultation work with colleagues or supervisors was necessary to receive adequate support for the psychologist who, in turn, could be more helpful to the client (5). Developing an increased acceptance that clients having choice around suicide was helpful to psychologists (4).
Strategies learned to improve and continue suicide work

Participants who experienced client suicide (n=20) were asked what was needed for themselves or to ask of their support systems, personally or professionally, to continue suicide work in a positive manner (Question 37, Appendix D). One participant indicated that no change was needed. All other participants indicated that they learned strategies to improve so they could continue better suicide work.

Reflective self-monitoring would ensure that ethical practice could be maintained (12). Activation of self-care is important because suicide work is intense and can be fatiguing (11). Collaboration is safer and more protective for the client and the psychologist (9). Being mindful while doing suicide work allowed for increased focus and presence with the client so the psychologist could better hear and respond to their needs (7). Grieving activities after a suicide were helpful to establish human responses and develop closure around the suicide (6). It was identified as important to establish external resources to connect the client with (6). Suicide-specific training for psychologists is necessary to know best practices and increase professional responsiveness – this included helping students recognize that there is increased risk of experiencing a client suicide when you are engaged in ongoing suicide work (5). Caseloads, when high or have many suicide-ideated client presentations are intense, lowering the caseloads or the number of suicide-ideated clients on a caseload would be helpful to support ongoing suicide work (5). Community suicide alertness and awareness training would be supportive to youth (1).
Self-identified changes within psychologists who experienced client suicide

Participants who had experienced a client suicide (n=20) were asked what ways self-care, health management and/or personal outlooks changed as a result of working through a client suicide (Question 38, Appendix D). Six participants identified no changes were observed.

Psychologists’ self-care increased (11). There was increased awareness that clients must be valued (7). Becoming more real in suicide work was identified as a change (6). Balancing work time was necessary in order to provide suicide work (4). More open and direct talk about suicide was a change in psychologists (4). Consultation was sought out as a result of experiencing client suicide (4). Psychologists were more able to seek their own help recognizing that they were not getting help from their organization or manager (3). External resources were more likely to be utilized (3). Therapy was embraced as useful as a result of seeing the impact of client suicide and providing suicide work (3).

Changes needed in workplaces to support suicide work and create growth in psychologists’ practice

Participants who experienced a client suicide (n=20) were asked what changes should be encouraged in workplaces or within a therapist so adequate support and potential for growth occurs when psychologists work with clients who experience suicide ideation (Question 39, Appendix D).

Recognition, by psychologists, supervisors, and organizations, that suicide work is stressful is a necessary change (18). Organizations need to implement supportive mechanisms for psychologists related to suicide work (17). Collaboration of colleagues
around suicide-related cases was seen as significant (17). Supervisory support and advocacy for suicide work was identified as needing to be enhanced (14). Balancing work and caseloads was identified as a necessary change specific to suicide work (8). Suicide-specific training was identified as being necessary (6). Self-care must be considered important when providing suicide work (4). Lean initiatives are not considerate of the psychologists’ needs to provide ethical suicide work when trying to balance client needs (4). Lean initiatives were referred to the system-wide changes that are occurring within Saskatchewan health regions, based on the Kaizen model of streamlining to create efficiencies that promote reduced waste in health-care providers’ time and roles. The intention is to create consistency in health care.

Table 9 presents a summary of the survey emerging themes with regard to the impact of suicide.
Table 9. Survey emerging themes: Impact of client suicide n=20

<table>
<thead>
<tr>
<th>Impact of client suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Professional self-doubt occurred.</td>
</tr>
<tr>
<td>• Grief and long processing occurred.</td>
</tr>
<tr>
<td>• Shock, disbelief, and distress occurred.</td>
</tr>
<tr>
<td>• Hurt resulted from manager’s lack of compassion.</td>
</tr>
<tr>
<td>• Helplessness and frustration were experienced.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Value of supports following client suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Professional doubts came up.</td>
</tr>
<tr>
<td>• Improving practice was a focus.</td>
</tr>
<tr>
<td>• Connections with colleagues, taking time to heal and engage self-care provided release</td>
</tr>
<tr>
<td>• Operational debriefings alone do not offer support.</td>
</tr>
<tr>
<td>• Supervisors can be helpful and offer improved perspective.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Work environment supports post client-suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Organizations offered no support.</td>
</tr>
<tr>
<td>• Colleagues offered themselves for support.</td>
</tr>
<tr>
<td>• Unconditional support and listening allows perspective and growth.</td>
</tr>
<tr>
<td>• Time off to attend the funeral allowed processing of grief.</td>
</tr>
<tr>
<td>• Releasing feelings with colleagues without judgment was safe.</td>
</tr>
<tr>
<td>• Loss to suicide in mental health work is inevitable and comforting knowledge.</td>
</tr>
<tr>
<td>• Supervisor support allows perspective and growth.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Needs identified by psychologists post client-suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Supportive debriefing was a need.</td>
</tr>
<tr>
<td>• Emotional support was necessary.</td>
</tr>
<tr>
<td>• Recognition and validation of efforts was needed.</td>
</tr>
<tr>
<td>• Recovery time was needed.</td>
</tr>
<tr>
<td>• Direct talk with the community about suicide was needed.</td>
</tr>
<tr>
<td>• It is necessary to be focused on the psychologists’ needs and wellbeing.</td>
</tr>
<tr>
<td>• Time off would have alleviated distress of the workplace.</td>
</tr>
<tr>
<td>• Supports are required through training, supervision, and freedom to ask for assistance</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Changes in psychologists’ practice as a result of client suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Increased seriousness in responsiveness.</td>
</tr>
<tr>
<td>• Ensuring client resources are established.</td>
</tr>
<tr>
<td>• Increased direct and specific suicide talk.</td>
</tr>
<tr>
<td>• Self-monitoring of psychologists’ emotional and physical health to maintain improved focus in client suicide work.</td>
</tr>
<tr>
<td>• Psychologist resilience and competence increased.</td>
</tr>
<tr>
<td>• Suicide specific training was recognized as necessary.</td>
</tr>
<tr>
<td>• Consultation with work colleagues or supervisors was engaged more frequently.</td>
</tr>
<tr>
<td>• There was an increased awareness that clients have choices.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Learned strategies to improve and continue suicide work</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reflective self-monitoring maintains ethical practice.</td>
</tr>
<tr>
<td>• Suicide work is intense and the onus for self-care is on the psychologist.</td>
</tr>
<tr>
<td>• Collaboration with external resources is safer and protective for client and psychologist.</td>
</tr>
<tr>
<td>• Be mindful during client suicide work.</td>
</tr>
<tr>
<td>• Take time to grieve client suicide.</td>
</tr>
<tr>
<td>• Establish and connect with external client resources.</td>
</tr>
<tr>
<td>• Suicide specific training for psychologists is necessary to know best practice and increase professional responsiveness.</td>
</tr>
<tr>
<td>• Avoid overwork of too many cases with high intensity work, specifically, suicide work.</td>
</tr>
<tr>
<td>• Community suicide alertness and awareness training will support youth.</td>
</tr>
</tbody>
</table>
Self-identified changes observed in psychologists resulting from client suicide

- Self-care increased.
- Clients must be valued.
- Psychologists became more real in suicide work.
- Balancing time is necessary at work when providing suicide work.
- More open talk about suicide occurred.
- Consultation is sought out.
- Psychologists seek their own help.
- External resources are more utilized.
- Therapy is useful.

Changes needed for workplaces and psychologists’ to support suicide work and create growth in psychologists’ practice

- Recognition of the stress of suicide work is needed.
- Organizational implementation of support mechanisms related to suicide work is needed.
- Collaboration of colleagues around suicide-related casework is needed.
- Supervisory support and advocacy for the suicide work provided by psychologists is needed.
- Balanced work and caseloads are necessary around suicide work.
- Suicide-specific training is needed.
- Self-care must be considered when providing suicide work.
- Lean initiatives are not considerate of the psychologists’ needs around ethical suicide work and balancing client needs.
Master Themes Taken from Survey Emerging Themes

Reviewing the text data allowed for more clear meanings to be understood and identified as focussed codes. Considering meanings in the focused codes, emerging themes were identified and subsequently named. Similarly upon reviewing and processing the emerging themes, larger meanings that encompassed the emerging themes become more and more clear after periods of time reviewing the participants comments about their experiences. The process of examination and re-examination of focussed coding and emerging themes, along with reviewing initial data occurred across time with a self-reflection loop - this process is lengthy and iterative (Miller & Crabtree, 1999). The larger meanings in the text data begin to form patterns that flow into a metasummary – an essence in the phenomenon (Tesch, 1987). The metasummary, likened to a hierarchy of larger meanings summed from the emerging themes, moving from a primary to a secondary level, will be referred to as master themes reflecting the text data responses (Fereday & Muir-Cochrane, 2006; Smith, 2008; Giorgi, 2000; Tesch, 1987). Master themes provide a larger picture of clarity formed from smaller emerging themes. To offer additional clarity and collaboration in demonstration of the master themes, the following direct verbatim quotations derived from the participants’ text data will offer support.

The master themes will be numbered off in the following pages to facilitate organization. The italicized quotations are excerpts of participant quotations from the twelve open-ended questions originally set up to derive text data.
Master Themes Supported

Six master themes have been identified upon considerable examination of emerging themes and perceptions noted in the text data responses. The master themes represent larger meanings and will be powerfully spoken best through several quotations derived from the survey participants.

Theme 1: Suicide work has a high intensity and impact on psychologists and requires increased balancing efforts in how many cases are managed - consideration must be given to the formulation of client needs and demands on the psychologist.

High intensity and impact on psychologists are highlighted in the following quotations:

“It is helpful in that I don’t have to carry the full weight of responsibility.”

“[They are] Very complex cases. I alone do not want to be responsible for making a decision that results in someone taking their own life.”

“Post-suicide of a client, I increased my acuteness in assessments and the seriousness with which I interact and treat.”

“I have learned not to minimize any sort of signs or red flags I might have about a client…”

“I used to get panicky when someone expressed suicidal ideation.”

“Yes, suicide is still a topic that generates fear – will I say the wrong thing that will tip the person to suicide? Will I appear not able to handle the suicidal ideation?”

“Suicide in First Nations is complex because I must honour native culture and spirituality. Once the at-risk person is home there is little follow-up with Western services, which they access only in times of imminent danger. There is little understanding and acceptance of depression and anxiety in the communities in which I work.”
The weight of responsibility, complexity of client needs, and the awareness of danger when working with suicide ideation and behaviours are challenging to manage. Fear and uncertainty around safety is heavy for psychologists. There can be limited support because of the stigma of mental illness. The need to be actively engaged and present can push psychologists to a hyper-alert state in order manage risks.

Challenges to professional and personal balance were observed:

“What I need to do is avoid countertransference and check myself... I will lose perspective and become over involved and overly sympathetic... sometimes even depressed. I have learned to be empathic yet maintain clear boundaries.”

“I have found it important to not become over worked and rushed, as this may lead to missing crucial information or to minimize aspects of clients experience.”

“I am always under extreme work stress. It is always a challenge with such a large caseload and so many demands.”

Emotional reactions are normal human reactions. Empathetic or sympathetic reactions to the pain of a client are real and normal. Valuing a client can reflect becoming involved in caring beyond the one dimension of being a professional – the client is much more. Clients are human beings, like a sibling, a child, or a friend. Becoming involved in many lives when risks are present can be challenging. Boundaries and ethics still have to be maintained. Caring professionally with genuine authentic regard takes energy. To be taxed with too many cases creates an overburden on not only managing risks, but the exposure to the emotional connections to pain. Professional and personal balancing can be challenging for the psychologist.
Balancing client needs and demands of the psychologist is challenging, as noted:

“...there is a lot of pressure to see a certain amount of clients per day which creates a lot of stress in and of itself. If it is necessary to consult or take a break to ‘destress’, it is very difficult to do so with limited time.”

“Time to process feelings and to be the helper – listener in a situation of suicidal ideation.”

The needs of the client require full focus and attention to ensure there is ethical safe practices upheld. Being entirely present to hear the needs of the client with suicide ideation requires the psychologist to be attentive. An organizational push to engage a high volume of clients creates stress. Stress and time pressures can reduce psychologists’ attentiveness and potential effectiveness in responsiveness. Adequate time and room to talk through and consult on suicide-ideated client cases is important and difficult to do if there are too many clients to be seen in a day. Having to ready for the next client and process the feelings evoked from providing suicide intervention is burdensome without time and space to process emotions, safety needs of the clients, and ensure that potential threats are ameliorated.

**Theme 2: Psychologists’ help seeking is stigmatized - advocacy to engage supports is necessary.**

Stigma is systemic, as observed in these statements:

“Stigma is tremendous in psychologists to be healthy and not require help. Managers and supervisors get on this train, it would seem, as they pile more and more on caseloads. Organizations create barriers to getting help or accessing help. Gossip and lack of confidentiality have interrupted clinicians seeking care. Judgment is problematic amongst people, and, counsellors/psychologists are people, after all.”

“Barriers around judgement and stigma in asking for help, setting limits, saying no, and taking time off are problems.”
“There seems to be shame put on a professional who has these issues.”

“Not allowing shame to get the best of me.”

Shame prevents accessing support. Judgement, gossip, and stigma occur in mental health organizations just as they occur in any other setting. Psychologists can struggle to get help when it is needed. Their professionalism is called into question for having to set limits or acknowledging the need for support. Healthy boundaries and self-care are not engaged nor supported if stigma pressurizes fears in psychologists.

Advocacy may be helpful to offset stigma, as many are involved from colleague through to the top of the organization:

“Judgment from others in health care. Lack of support from manager.”

“Employers do not offer adequate support and so, one might appear weak if they don’t overproduce or accommodate.”

“Yes, the perception that it is not necessary for professional to need this support; stigma with accessing services is sometimes even greater for professionals than public.”

Psychologists are held to a higher standard. They cannot demonstrate the need for help, least it be interpreted as weakness. Employers and managers have power to offer support providing there is recognition that psychologists require help just as anyone else does. They have the power to make changes – to advocate for psychologists’ needs.

**Theme 3: Responsiveness in suicide work increases when psychologists are present, healthy, cared for, and not overburdened.**

Staying healthy as a psychologist improves how psychologists react and interact with client suicide ideation:

“I am constantly diligent. I need to work on greater balance, variety in life; my practice has grown tremendously, hopefully in competence.”
“I need increased self-care and not an overload of work around that time. Gentleness with my own expectations of me is helpful.”

“I need to limit caseloads. I need to have fewer intense cases. I need to consider working outside of an organization that pushes me into taking on too much.”

“I need to be constantly mindful of self, ensuring no fatigue, or other undue influence that might influence practice in general.”

“They should have access to counselling themselves through something more than an EAP service – perhaps a service that is specialized in working with counsellors who deal with suicidal or high trauma cases regularly.

Psychologists who focus on self-care build their capacity and competence. Being realistic about work expectations, related to caseloads and work volume, is partly the psychologists’ responsibility however the employer has to have healthy limitations on workload as well. Too many cases limits the time necessary for diligent client-focused care. If self-care at the workplace is forfeited, then psychologists are less likely to be as effective with clients. Easy access to support or specialized supports, related to psychologists suicide work, are needed to manage the self-care aspect that allows for adequate processing of suicide work. Adequate self-care and processes support responsiveness in suicide work.

**Theme 4: Supportive supervision, mentorship, collaboration and suicide-specific training increase competency and practice fitness.**

Supervision, mentorship and collaboration increase competence, as noted here:

“Consultation and supervision is a constant in my practice and liaising with the other professional involved in my patient’s care is something that I now do routinely whether there is a threat of suicide or not.”

“Debrief to ensure that I have not missed any risk areas.”
“I believe I need some support and help from colleagues but I need to access this help on my own even though the caseloads are overwhelming and the employer should be more involved. I do not feel particularly supported by my employer.”

“Case conference more.”

“Always be part of a team and never carry it alone... Continue to take training in this area”

“I usually ask to consult with colleagues to help maintain a clear perspective.”

Working in isolation or without suicide-specific supervision increases risk that best practices are not being followed. Having adequate external connection with helpers that are offering support to suicide-ideated clients is important to guard against potential threats to clients’ safety. Teamwork, collaboration, and mentoring offer discussion and reflection that offer a more clean perspective of what a client may need. Working together reduces client risk. Effectively suicide-specific support and training increase competence when working with suicide-ideated clients.

Suicide-specific training increases competence and practice fitness and is highlighted in these passages:

“I have taken a lot of training and I do not ever take anything lightly, always going straight to this issue as soon as possible.”

“Tell my students how I have been affected by it [suicide and suicide work], how I handled it, get them to understand they will be faced with it and will not be prepared no matter how prepared they think they out to feel.”

“Ongoing training and self-care is key.”

“I plan on taking ASIST soon.”

Psychologists are aware that suicide-specific training is necessary to ensure they are matching ethical practice. Adequate training can also be a means of self-care as
preparedness offsets feeling negative emotional responses. Recognizing the value of open and direct talk about the impact of suicide-work and suicides of clients is an important part of readying students to enter psychology practice.

**Theme 5: Recognition of psychologists’ human needs of self-care, recovery time and working through grief processes related to suicide work and client suicide is important for health and practice.**

Psychologists need time to process client suicides:

“The impact of suicide is a heavy one and one that I learned early on needs to be processed carefully with colleagues and in one’s own therapy.”

“The impact upon me was strong: Shock, disbelief, questioning if I could have/should have done anything differently. The impact upon me was severe. I was shocked, disbelieving it at first.”

“The callousness of the manager was shocking. I was quite devastated hearing about the suicide but felt helpless and shocked by grief. My manager never asked if I was affected. The shock of the death was even more impacted by the disengagement of the manager.”

“I felt responsible, irrationality, but, definitely, in that, it is my job to help people and I failed.”

“I took some time to consult with my pastor, my spiritual leader, and a counsellor...I had permission to establish boundaries and not share/talk about anything unless I was ready/wanted to...My work friends were also very helpful.”

“I need to take time to grieve and process the situation.”

“Attending funerals to allow for real human closure.”

Client suicide requires an organizational response that supports psychologists well being and processing of grief. The emotional connections made and the human value experienced in suicide work creates a relationship between client and psychologist. Grief takes time and psychologists require support to acknowledge the loss. Open
recognition and direct supports are necessary to deal with any death. The suicide of a client has complication in the emotional layers involved. After the shock of an intentional self-killing wears off, then the fears of professional and personal self-doubt set in. Support, time and caring from managers are necessary to work through the professional aspects of fears of failure. Personal therapy can be necessary to process the client suicide. Rituals to honour the relationship of psychologist and client, such as attending the funeral are important. Taking time to integrate the humanness of needs around suicide, recognizing and embracing the death of an individual whom a psychologist cared for, is essential for health and subsequent practice.

Theme 6: External resources are necessary to support suicide-ideated clients in safety and this allows for psychologists to be supported in their practice.

Establishing resources for the client is a best practice that is essential for helping both the client and the psychologist, is highlighted clearly in these quotations:

“I have become more cautious and try to involve more external helpers for the client.”

“I am extremely aware and vigilant and have increased those involved more and more to ensure that safety can be reached and that others are more supportive to the client.”

“I am much more diligent and reflective. I speak even more openly and directly about suicide. I feel I take exceptional time and detail in safety planning and ensuring the client is well-resourced.”

“I always enlist a team of helpers also, and never deal with it alone…”

“Make connection with others who know the client.”

“Immediate psychiatry consultation including possible in-patient admission.”

“Always have a plan and resources and always follow ‘best practice guidelines’…”
“I need to work to involve these client with other resources and supports”

Being vigilant and cautious are powerful words that demonstrate importance. The need to involve external resources and supports to offer every opportunity to support to a client is good practice. When life is at risk, it is essential to activate as many life-preserving measures as possible. Besides the very real threat to the life of client, there is an emotional cost involved in dealing in life-threatening situations. Suicide work is a life-threatening situation. A sense of safety and more certainty for both the client and the psychologist is paramount. With client safety intact, psychologists can pay increased attention to other clients or casework.

The six themes offer my interpretation of the content of the survey participants’ cumulative responses. Table 10 provides the summary of the master themes that crystallized over time in order to provide metasummaries.
Table 10

_Master themes developed from open-ended survey questions_

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<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td><strong>1.</strong></td>
<td>Suicide work has a high intensity and impact on psychologists and requires increased balancing efforts in how many cases are managed - consideration must be given to the formulation of client needs and demands on the psychologist.</td>
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<tr>
<td><strong>2.</strong></td>
<td>Psychologists’ help seeking is stigmatized and advocacy to engage supports is necessary.</td>
</tr>
<tr>
<td><strong>3.</strong></td>
<td>Responsiveness in suicide work increases when psychologists are present, healthy, cared for, and not overburdened.</td>
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<td><strong>4.</strong></td>
<td>Supportive supervision, mentorship, collaboration and suicide-specific training increase competency and practice fitness.</td>
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<tr>
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<td>Recognition of psychologists’ human needs of self-care, recovery time and working through grief processes related to suicide work and client suicide is important for health and practice.</td>
</tr>
<tr>
<td><strong>6.</strong></td>
<td>External resources are necessary to support suicide-ideated clients in safety and this allows for psychologists to be supported in their practice.</td>
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Part B: Interviews

Interview Participants’ Demographics

Five fully licensed female psychologists who work in Saskatchewan volunteered to interview. Two selected to interview in their home environments and three selected to interview in their work environments.

All had engaged suicide work in their careers, either in the past or in an ongoing manner. One interview participant had the experience of client suicide and another spoke about significant ambiguity around a client death that resonated with her as a client suicide. All had experience of client suicide behaviours. Two experienced suicide intervention efforts in their personal lives with family members. One interviewee had experienced the suicide of a family member.

Pseudonyms have been assigned for the purposes of confidentiality. Additionally all workplace and location references have been removed.

See Table 11 for a description of the interviewee demographic information.
Table 11

*Interview Participants’ Demographics*

<table>
<thead>
<tr>
<th>Pseudonyms</th>
<th>Veronica</th>
<th>Wilma</th>
<th>Xandra</th>
<th>Yvonne</th>
<th>Zena</th>
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<tr>
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<td>FP</td>
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<td>10-15</td>
<td>20-25</td>
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<td>P/PF</td>
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<td>-</td>
<td>Yes</td>
<td>-</td>
<td>-</td>
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<tr>
<td><strong>Experience with suicide behaviours and suicide in family</strong></td>
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<td>Yes</td>
<td>-</td>
<td>-</td>
<td>-</td>
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<tr>
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<td>Morning</td>
<td>Evening</td>
<td>Afternoon</td>
<td>Afternoon</td>
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</tbody>
</table>

**Key:**
- **F** - Female
- **M** - Married
- **APE** - Authorized Practice Endorsement
- **FP** - Fully Registered Practicing Psychologist
- **A** - Assessment
- **C** - Clinical
- **E** - Educational
- **FO** - Forensic
- **T** - Treatment/therapy
- **M.A.** - Master of Arts (Clinical Psychology)
- **M.Ed.** - Master of Education (Ed. Psychology)
- **Ph.D.** - Doctor of Philosophy (Clinical Psychology)
- **NGO** - Non-government organization/not for profit
- **P** - Private practice
- **PF** - Publicly funded/health
Interview Stories

Interview stories reflecting the experiences of the five participant-psychologists are shared in the following pages. Quotations from each interview are threaded into a narrative, that has descriptive and, at times, interpretative qualities. My own experience, in response to the interviews, is also narratively reflected. The reader will need to be mindful that although the interview-conversations were conducted separately, in my mind’s eye, my context, through the process of reviewing and processing interviews repetitively, I have envisioned all five of the participants in conversation together with me. I have recorded their words, transcribed their words, reread the interview transcripts, and played audio recordings at length in priming development of a ‘restory’ of their sharing (Creswell, 2007). Because of the integration of these conversations in my processing, it became an almost internal conversation with my interjections as part of a six-person dialogue. As a result, the narrative is situated in my context – some of the narrative is dialogic and other parts are more descriptive.

In the interview-conversations, following the initial demographic questions, the ebb and flow of dialogue focused on several questions as generated from the semi-structured interview question guide used as a reference for discussion (Appendix I). The questions were only a guide and not an absolutely rigid tool. Discussion and conversation flowed very naturally and were not stopped or started solely based on the use of the interview questions. The semi-structured interview questions focused on the following areas: satisfaction or fatigue culminating from workplace elements and/or interactions; experiences, learning and impact related to client suicide
ideation, communication and behaviours; supportive mechanisms related to supervision, personal therapy, engaging self-care, or organizational structures; helpful recommendations and considerations for psychologists dealing with suicide-related work and/or client suicide; and barriers observed in accessing supports.

**Organization of the Narrative-Multiply Voiced Stories**

The focus areas of the semi-structured interview questions are set apart with bolded headings to assist in navigating the various elements developed within the narrative. Questions from the semi-structured interview guide, asked in the interview, are pieced into conversation to guide the framework and create context by situating the topic within the discussion. Notably, not every interview flowed in the exact ordering of questions as presented in the semi-structured guide. At times, the conversation flowed into a topic because the participants had read the semi-structured question guide, and/or were self-guided in moving to one of the topic areas.

Within the narrative written text, prior to the tracking of a question, the bolded black heading will alert the reader of a topic shift. Indented headings demonstrate organization of thematic content that was developed during the analysis process. The indented headings are not intended to interrupt the narrative or to force a meaning on the reader but to offer a reference of how post-interview meanings developed from how I understood the narrative to move and show thematic essences. Thematic highlights started to become organized for me as I processed my
understanding of the stories and the essences within stories. The thematic highlights are considered emerging themes.

Quotations taken from the participants during the interviews will allow for pieces of individual stories to be shared as verbatim quotes from their personal interviews. These quotations are the participants’ voices. Linkages, story connection, context orientation, and the development of the repartee of dialogue mesh the interviews together. My thought, reflections and personal experiences are also included in the narrative. Direct extractions from my field notes, journal writings, or theme development jottings are offset in quotations to demonstrate my personal process in developing the narrative storyline. Emotion and reactions were sometimes captured in field notes at moments in the interviews that seemed significant and were inserted to develop context of emotional state, either the participants or my own. Similar to the print style of a play written for theatre, round brackets with italicized print will set apart these emotional context note descriptors, e.g., *(tears flowing, she spoke - she was saddened)*. The italicized content in the round bracket are direct notes from the interviews highlighting emotional states of either the participant or myself.

My own writings reflecting the research process were developed at various stages - prior to or directly following interviews and during periods of immersion and crystallization when themes were becoming more consciously understood after periods of sitting with the material and reading reflexively – with effort to be aware of my own positioning (Borkan, 1999). These field notes were recorded during and directly following interviews. Note taking also occurred during review of transcripts
while processing meanings, issues, coding and, eventually, appreciating thematic highlights and meaning. Personal context and story are used as a means to show and situate myself. I am the narrator.

And, so, begins the weaving of threads from ideas, stories, and themes into a larger story for understanding.

Psychologists’ on Quality of Self, Work, and Suicide Work - The Story of Six

After settling in to talking and getting to know one another over small talk about education, background in work and length of time working, remarkable conversations took off. There was connection that seemed to develop quickly. We were peers, all psychologists - all women. Women whose ages fell within the span of thirty-five to fifty. We had worked with suicide-ideated clients. Some of us had the experience of feeling the loss of a client suicide. There was some common ground.

The loss from client suicide resonated for Veronica, Xandra and me. We each experienced loss in that way. Closeness was in place because of that connected experience. Conversation rose to more emotional heights when Wilma, Veronica and I spoke about personal struggles around suicide, with family and friends. That connection was immediate. These psychologists wanted to talk. There seemed to be a need to talk about what supports made them feel they could create good work. They were clear in talking about what created an impact on their work with the clients who had thought about suicide, tried to suicide and had suicided. They spoke readily, with a genuine willingness and openness. I was moved by their intentions as
they shared pieces of their worlds. I was honoured. Their clients were honoured through their words.

**The Development of Satisfaction or Fatigue in Psychologists’ Professional Lives**

One of the early questions that felt easy to bring up because of the openness that was established, was posed, “Please tell me about your experiences, that have influenced your quality of professional life – feeling satisfaction or feeling fatigue within your work?”

**Client progress creates satisfaction**

Zena spoke first, easily and clearly, “Just knowing that I am helping people reach their goal and so that is real and what drives me at work”.

Similarly articulating the personal importance of client progress, Veronica articulated, “I also really appreciate knowing that there is improvement in clients, that is helpful to continue to do this work.”

Yvonne chimed in, *(...beaming as she spoke...)*, “Also feeling like you are doing good work for families is helpful. When you see kids reach a goal or you get access to a service and you have been a part of making sure that happens”.

Yvonne, *(...quietly...)*, went on sharing, more intimately, “When you feel like you've done good service or you get kids the services they need, when you get them connected, when a diagnoses leads to something positive, not just a label, when you make connections with families.”
Considering Zena’s comment, I noted, “I know this is why I work and am driven in my own work. Personal belief, power and strength grow in folks when they reach a goal.” Thinking about Veronica’s comment on ‘progress’, I was moved and felt so appreciative, jotting, “Improvement is enough to be satisfied. It is not always that an entire goal must be met for success.” Yvonne demonstrated enthusiasm, I penned during transcription, “Sharing assessment and diagnosis cements a relationship…” Opportunity to share assessment and diagnosis is a “…deep intimacy - an understanding.”

While focusing on connection and understanding in the client relationship, Wilma related, “I feel somewhat honoured that they are entrusting me with the things that are going on in their life and allow me to be a part of their journey (…tears in her eyes…) and so I think for me that plays into it - just all on its own, just the work that we do. I do it because I enjoy what we do. I think when I see people make positive change that definitely reaffirms for me that I am where I am supposed to be and it's just fantastic.”

Reflecting on Wilma’s comments about feeling honoured while being entrusted with lives, it struck me, “The intimacy of sharing a life and revealing painful feelings…is a gift…to be cherished.” I feel this way so often, blessed that individuals choose to share with me.

Xandra’s developed a similar awareness of a blessing, she identified a satisfaction, “…when you are getting good feedback from clients, expressing appreciation, expressing they felt understood.”
Speaking about the intrinsic pull to client work, Xandra continued, “I do it because I think I am called to do it. And I think we talk about rewards and that can be a reward after. That’s interesting that I feel good after doing that.”

When speaking specifically about suicide intervention, Xandra went on to highlight satisfaction comes, “If you talk about suicide, I don't know - did you keep them alive in the time you were with them?”

A visceral reaction hit me as Xandra’s statement left her lips. She paused and was thoughtful, sipping her tea. I, aware of my own self-judgment, noted, “My heart and stomach drop…success means, not suicide…” I felt shaken – my thoughts swelled, “I have tried, as have so have many other caregivers, yet suicide cannot always be stopped”.

And, then, Xandra went on, “Hopefully that is success right there. It is a daily thing for some people if you manage to treat them with dignity and respect and maybe you gave him some tools to think about it a little bit differently - about their lives, their potential for the brief period of time, your life connected with theirs…”

Her words, really, her perspective, was so powerful. Sitting under a dimly lit street lamp that night, after meeting with Xandra, I took time to think. I noted, “Treating clients with respect and with dignity, when their identity, self-respect and dignity has been robbed, is a gift. A gift of life…”

Weeks later, I processed, “I think of a couple of clients who have suicided…I pray I offered them dignity and respect. I worked with hopes of their being successful – safe from suicide. They chose suicide. I pray that at least they felt
cared for in those moments with me.” It is hard sometimes, I noted, “I still grieve.”
I wonder, for them, was it really a choice.

Thoughts of my own practice came into focus upon reflecting on these quotations. Trust, connection, and intimacy are successes. Moment to moment, being mindful of small steps in movement forward is important for satisfaction. Providing choice, dignity and caring for clients are gifts connecting to life. The choice to care is mine. The choice to care is ours. Perhaps, we can change how we engage caring so that more folks choose life.

**Collaborative work creates satisfaction**

After more conversation, Zena began unravelling additional understanding about how satisfaction manifests for her through working together, she stated, “Learning from other professionals. I have always worked on an inter-collaborative professional teams so that is really satisfying from learning from other people and learning from other clients, too.” Zena went on to further stress how satisfaction is dependant upon, “…other people or working inter-personally and professionally.”

Xandra backed this observation up, stressing the importance of supportive collaboration, “Well even that…*(Xandra was soft-spoken here...)* in that situation where it wasn’t just myself. It was a colleague and myself, and, at the hospital the psychiatrist tends to be more of a colleague to me, we were both there and it was unspoken support, it was indirect. We both sort of had to acknowledge that.”

Yvonne was more forward here, highlighting that collaboration comes from colleagues, friends, who really understand the work and its challenges, “Having
friends/colleagues at work that you can talk to is very important and is often very helpful. So people who either would share the same clients or understand the struggles…”

Wilma noted how working together with colleagues is also key for her, “I'm just enjoying where I am and the people that I work alongside and just collaborating together. Working together is just…huge…right?”

It can be truly enjoyable working with colleagues as Veronica observed, “I really like working with teams - so having a really positive close team that I connect with, sort of like-minded and, or, at least, we can have a good time, we can challenge each other, I really enjoy that…I do like to have a team around me. I find it makes it really fun.”

When Zena had spoken about the importance of an inter-collaborative professional team, I had penned, “A dream…?” I thought of a variety of teams through my twenty years of work. In some of those environments, missed opportunities for collaborative work seemed to light up like a glare from a blinding light. It would be a dream situation to have collaboration in all teams - all the time. As I jotted my reactions after Zena and I had met, I noted, “There is powerful learning from others when given opportunity…if only all workplaces could create this.”

A remembrance of working independently, almost in isolation, came up for me upon reflection on Xandra’s words, I noted, “So often I have worked alone…wishing for support. Seeking connection after a painful day or meeting –
support would have been helpful afterward.” Further processing Veronica’s comments, I realized, “I’m worried that many do not feel that positive team dynamic – there are teams that are not healthy nor helpful.”

Friends and colleagues at work, as Yvonne spoke of, can be so helpful. I recollected friendships developed through work and noted, “Sharing is comfort. Being understood is safety. This parallels suicide intervention.” To really be understood supports a feeling of safety. Sharing concerns and needs with colleagues creates safety in the work environment. A client at risk, sharing with the psychologist, creates safety through understanding the threats to life. I noted, “Understanding is a collaborative discovery.” One does not do better in isolation – collaboration breaks through barriers. No one does well in isolation neither client or psychologist.

It also became evident in my journaling after Wilma’s interview, after we talked of collaboration with colleagues, that, “Private practice is not always collaborative.” We often work in isolation unless mentorship and collegial conversations are intentionally sought out. I went on to write with regard to work, as well as academic pursuits, that, “Collaboration without egos, without restrictions, freedom to learn, freedom to give knowledge, without guarding it or setting [negative] boundaries – learning and collegiality support personal and professional well-being.”
Control over workload affects satisfaction

The conversation evolved from how connecting professionally was important to how essential it was to have a sense of control over one’s work. Lack of control removes freedom. Yvonne reported her worry when too many demands interfere with direct client work, she stated, “It feels a lot beyond your control, like it’s a lot of staffing and administrative issues at the end of the day”

Zena pulled on this thread and went on, “Again it goes back to they [management/organization] decide how many clients you get and if the support isn’t there, in terms, of your own immediate supervisor to set those boundaries, which can be difficult.”

Veronica continued, “Like I said it’s a lack of resources. I find that frustrating, and, again where I feel dissatisfied that, I’m not doing as good as I can be (Veronica express[ing] self-doubts...appeared angry).”

Not doing as well in the work, because of having too much to do, seemed to be a concern for Wilma as well, she stated, “I set standards for myself and I think that when I'm not getting as much as I want to get done in a day that definitely plays into the fatigue because I have a standard that I need to reach and if I'm not reaching it then I know that I will work more and that will cut into family time.”

Additional effects of being overloaded resonated through Yvonne’s words, “Workload would be a big one. (Yvonne...honest, showing real frustration...) I’ve been here at least 10 years and I have never once worked here without a wait list so
there is pressure always to see kids - to try and provide service in a quicker - timelier way.”

Wilma (warned) to be vigilant in keeping balance, “…be careful if your workload has suddenly gotten bigger…”

Zena, concurring with the changeability of caseloads, said, “Yeah there is all those externals, not controlling, not being able to control my cases. Not having control of who comes in the door, who I will be seeing…”

On a similar note regarding pressure and timing, Xandra acknowledged how much energy is needed to manage to get through demands of a full day:

I notice that in particular if I know that I am going to be working all day, that I am working during the day, then I have a client booked in the evening, I know I am going to be going from one job to another. But if I get a call, cancellation, that night, I notice how much more energy I have so I think subconsciously I am monitoring that internally, how much energy I have to give up, so that I know that I will have enough to last the day.

Reading through these quotations, I identified with the professional pressures that pushed at these psychologists, I wrote, “This is distressing for me!” I thought about Yvonne’s frustration - it was palpable as she spoke, I wrote, “I feel it. Taste it, too…I remember workloads that I thought would break me in half. The weight of so many stories and so much pain was hard.” Never mind having to deal with my own family or life issues, there was so little time. It was a whirlwind!
Upon reflecting on Veronica’s statement about her organization pushing her to do more and her becoming fearful that she may not do the work as well as she would like to I noted, “How terrifying – no control.” Zena spoke about not knowing what client presentation she would have from time to time or how many clients she might see in a day and I penned, “I am so thankful I control how many clients I see in a day.” I recalled a time where I overworked just as Veronica was speaking of. I mused after her interview, “Her ethical capacity changes, because of the employer pressuring how much she is working, and then she is not getting done what she needs to do for client safety.” I recalled fears over this very dilemma, overworking…and, the risk of doing a poor job, not serving clients well or possibly getting run down. I remember feeling fear in those days. Fear that I could not keep up. Fear that a client could slip through the cracks. Fear that I might miss a step in safety for a client. Fear made me work harder. I worked harder to keep up. I pushed myself, probably, too hard.

Control over diversity of work is satisfying

Zena zeroed in on the idea of lack of control over the volume of work. She then wove into the importance of having control by maintaining some variety. Zena noted, that small controls, even in the work diversity really mattered by allowing her the sense of mastery over what she was doing, “Even balance at work. So balancing of lots of different things. Balance between counselling and assessments. Balance between even, in a day, report writing and how much contact there is. Then type of clients and services I am offering, in terms, of having a balance of them, so it is not -
I try not to only see anxiety, or, only see depression I try to balance a range of clients.”

Veronica explained from her perspective, with more detail:

I like to have a good balance of different kinds of clients. I like to have a balance of clinical work seeing people and where I also get to do writing in reports, do assessing, but, also, doing a variety of activities. For me, I like to do groups. I like to do individual work. I like a variety of things. When I'm doing one thing, one type of clinical problem over and over again I find I get burned out or I get bored...It's too repetitive, too much of the same thing for me because maybe overall I start thinking, “I'm feeling not satisfied”.

Xandra elaborated further how challenges increase her satisfaction, she stated:

…[writing] report[s] and I quite enjoy using that other side of my brain and thinking and putting information together and processing it and putting it together to form my hypothesis whereas when you are in counselling, it is much more instantaneous. You have to do that and I like both…Lots of things to manage all at once but I enjoy the challenge of that, thinking on my feet.

In addition to the variety of tasks within the work, workload diversity was also highlighted as coming from differences in client’s ages and abilities as Xandra outlined, “…[it is] easier to get a sense of satisfaction working with adult clients as to adolescents (Xandra appeared so relaxed and easy at the prospect of managing difference and varied work projects-she seemed joyous to have challenge).”
Variety was also highlighted as important to Wilma but she went on to elaborate that she had to monitor her balance:

So, I put myself in a really tricky spot, but I love both of them. I don't think I can do straight assessment because I miss that face-to-face client contact and seeing growth and that work done. But I just love assessments. I don't think I could just let that go because it's so fascinating, right? So I just think it's the best of both worlds if I can figure out how to manage it properly.

The ability to have the flexibility to self-manage caseload and determine her service delivery was also important to Yvonne, she outlined, “We have a very clear mandate from [the employer] in terms of who we see, what services we offer…” Yvonne pause here for a moment or two (Yvonne looked angry when she spoke...shaking her head, furrowing her eyebrows. Trying to make sense.):

… and this will probably come up later so when you do have issues around mental health or a significant depression, what we are told to do and need to do, is move them to a mental health agent. So, well, there is some flexibility in how you manage your caseload, it’s very clear of what services are within our mandate and what are outside. So sometimes that's frustrating and I would say would affect the quality of life.

These ideas of diversity of work, treatment approaches, client problems, and age or development of clients really struck a chord in me. I wrote, after talking with Zena, “I love balance and choice. I remember days when not in private practice
where I had no choice and felt assaulted by the demands of the day. To have control is so helpful and empowering – almost refreshing and energizing.”

From my perspective, when Yvonne spoke about mandates being imposed, I began to think through times, when in previous work, I was limited by a mandate, I noted, “This feels strangulating – as though choice and flexibility are removed. I would be frustrated too.”

What Veronica had said about balance of different clients made sense to me and I noted, “I agree…variety is so important. What’s that saying, ‘A change is as good as a rest’?” I could not help but recognize that, “It sounds wonderful to have this freedom – but do all [psychologists] experience this variety?” Not all psychologists have freedom or self-determination in their practice.

The balancing act of participating in variety seems attractive but not always easy to navigate as Wilma had noted that she struggled to ‘figure out’ how to manage, I wrote, “Walking a tightrope…keep balance or fall.”

**Training improves work quality and satisfaction**

As the women reflected about balance and quality at work, it was increasingly obvious that balance is maintained in many ways. An additional method to finding quality in work comes through training. Zena observed that she improves through ongoing learning:

The opportunity to learn new things…Also the opportunity to go to different conferences, so I try to go to about four conferences a year and even though I
usually, for the most part, pay for those myself. Finding things that are related to my work and I find that helps the satisfaction and also revitalizes me a bit.

As much as training was important to Veronica, she highlighted that at times junior employees do not have required training around suicide and senior staff have to provide training to the junior staff. She stated, “…we have very novice staff. Even the ones that are here, they have no experience at all in this particular area.” Veronica emphasized that teaching new staff, related to suicide work, can take effort but went on to indicate that she enjoyed guiding new staff:

    Right, you have to basically do a lot of it. Initially until they can really get a handle on it so it's not really a break, for a while, which is okay. I understand that it's my role. I think it's great. I'm happy doing it. I like teaching students and all of that, but just the whole complement of it has been challenging over the last few years.

    These quotations allowed reflection on past workplaces where training opportunities were limited or prescribed. In one workplace, I recalled, one mandatory training session set up, per year. This training was to serve all employees in an agency, regardless of the differences in teams or individual needs. The diversity of new learning was limited within the organization. If I wished to grow professionally, by attending training not on the agency agenda, even if it was directly connected to and supportive of my work, then it was necessary to take off work time, use vacation time, and pay my own tuition. Just as I had taken my development upon myself, Zena was creating her own growth, investing in herself
when the workplace was limiting. I had noted after our interview, “If budgets allow training this is great! I have experienced with workplaces, that purse strings are tight and senior workers go before juniors, preventing the needed growth in the junior employees.” Extra consultation, teaching and mentoring need to be extended to junior employees to balance training needs, despite costs.

**Lean initiatives are stressful**

With cost measures being implemented the conversation shifted. Zena, Veronica and Yvonne described that lean initiatives were concerning to psychology practice - they were passionate when they spoke.

Zena stated, “…the organization that I am working for is making big changes, lean changes, that everyone has to go along with but are not having a positive impact.” She went on, “Again, it goes back to they [supervisors] decide how many clients you get and if the support isn’t there, in terms, of your own immediate supervisor to set those boundaries, which can be difficult *(Anger seemed to be an undercurrent when Zena acknowledged that client needs were not being adequately considered)*. If the support is there, then you leave at 5:00 or work a set number of hours a day but if there is pressure, or, a push to do more, work longer hours, offer after hour service.” *(Zena appeared frustrated when she spoke about having to work longer hours.)*

Veronica also acknowledged that demands are hard for her to manage, “There's just a heavy, heavy workload and lots of paperwork demands and lots of new lean initiatives and demands placed on you without losing things *(Veronica look so sad*
when she talked about being tired. There was a sense of defeat...). It is making me very tired. So I find that those particular areas, there are a lot of new things coming on but I don’t find that things are being taken away.”

With the push to do more having lean efficiencies in place, Zena talked of how collegial collaboration was not supported due to the constraints created:

It’s colleagues, yes - but it is frowned upon - but I don’t think people are even aware of what’s going on and it’s not measured when organizations do their time measure, Lean stuff, you know. You know how much time you are spending with your clients- that [collegial collaboration] is not considered an important part.

The need to collaborate was being lost in lean structure as emphasized by Zena. Yvonne elaborated even further and noted that the complexities of being human are erased:

…the Kaizen efficiency. That whole philosophy – (Yvonne demonstrated frustration here, she shook her head, sighed, furrowed her brow, pursed her lips...) that whole approach, is very much looking at data…how many clients you see in a day…what your wait list is… (Yvonne sigh[ing] and shak[ing] her head). Managers are much more interested in your wait list, in your numbers of clients you see, the number of visits you have and so when you are perceived as having work that is out of the mandated program, there is a very strong encouragement to move that on…the philosophy is built in an assembly
line. It's not for human beings with more complex needs. Anyways, that, to me, is frustrating.

I recalled my various social work, counselling and psychology jobs through the years. Long hours with utmost flexibility to accommodate clients were expectations to offer best services. In some ways, even now, in private practice accessibility for clients means being extremely flexible, now by my own choosing. However, when there is no choice, and hours to work are mandated, frustration grows. After talking with Zena and writing summary notes, I penned, “I recall working longer hours and being pushed into doing so. My life became consumed by work – balance was needed.” Based on Zena’s impression it struck me, “There seems to be very little control. Being told what to do sounds ‘cookie cutter’ and not individualized, this certainly is not considerate of individuals’ ever-changing needs.” After Yvonne and I talked about how the lean initiatives were influencing her, I reflected, “Man or mechanism…how can this be a useful framework when it was focused on industry and assembly lines? I feel frustrated listening to this. People’s situations are very complex. They can’t be represented by numbers.”

**Personal losses affect work**

In conversation it was clear, clients have complex needs and psychologists have to navigate those needs. The women also related that as psychologists, they also have real lives that are informed by layers of experiences, professional and personal. Professional quality of life was highlighted as being impacted by experiences related to suicide. Zena observed that she had not had a personal loss to suicide and she
remarked, “I almost see that as a protective factor…There is nothing to kind of bring me back into thoughts…”

“If you are not aware, will it take you there?”, I wondered.

Xandra did acknowledge the impact of loss, “I had gone through a personal loss and I didn’t realize or fully acknowledge the extent that it had fatigued me. So I was working, and continued to work at the same pace and, to be honest, the pace and just the timing of it, it increased for different reasons.”

Complexities in personal lives was highlighted by Veronica as she talked about the vulnerability of working with suicide ideation and behaviour within her family, “So someone in my family who has attempted and goes through bouts in time where he is suicidal…I feel much less helpful. *(Veronica looked pained here – overwhelmed…) I feel that I am not actually nearly doing the right thing or as helpful as I am in my professional life and that's probably because of the relationship and what I can offer and can't offer…”

Yvonne noted as well that there is a balancing act with personal stress running into professional impact, but there is not always clear support offered:

Yeah, I mean I think there is a perception that you can do some things to manage your personal care but we don't want you to be too overwhelmed because if you are too overwhelmed you clearly don't know how to manage things. There is… it's a really fine line between everyone with that. Yeah of course you need to take this time, you need this time but…I don't know *(Yvonne looked genuinely confounded here).*
Wilma was clear to acknowledge that a family member’s suicide was a guiding influence in the work she has chosen:

I don’t know. I was thinking about that [the suicide of my family member] after I sat down to do this. Because I don’t generally…it isn’t something that comes up. It generally does not get put where it needs to be. I think I would have to say that it guides me to where I am at though. I’d had to have at least indicated the decision to go into the type of work I've done…I think so.

Elaborating (Wilma seemed so humorous here – normalizing it all so beautifully), “Who doesn’t go into this type of work not wanting to figure their self out a little bit…In a situation that I couldn't help essentially, and, now ultimately, I have made it like my life goal to help other people in that situation.”

Veronica went on to observe, “People don't always come into this profession because they are healthy. I think we have to have an acknowledgment of that and I would like to see more support around.” Concordantly, Wilma went on to identify that because of her loss to suicide she was more attuned to the possibility of suicide, “Sure maybe because of the personal experience that I did have I understood the seriousness of it to begin with…”

My psychology practice and personal influences were circling my mind after talking with Zena, I wrote, “I feel having a personal loss attunes one to possibilities, increasing awareness. This idea of a protective factor [not having a suicide experience] feels stigmatizing.” The thoughts of suicide I experienced allowed deeper understanding, not necessarily deeper vulnerability in working with client
suicide ideation. I strengthened and learned about myself and about helping others. “Advantageous”, is the word that struck me. It is advantageous to have understanding of suicide, it may still be subjective but there is more advantage in experience rather than having no real understanding.

Yvonne had lived and really understood how judgment prevents talking about personal experiences. I jotted, after our interview, “It is so frustrating to think that there is such a stigmatization of therapist’s needing help – we are only human. We all need help sometimes.” Needing help should be accepted as part of the human condition, not an exception if you are a psychologist.

When Xandra had talked about not necessarily recognizing her own fatigue, I wrote, “This resonates for me. Losses carve away energy. It is much harder at work after a client suicide. Anything personal activates intensity and more effort is necessary to be present for clients.” Knowing that losses are expenditures, it is even more important to insert self-care to generate healing and support.

One of the reasons I chose this work was to help others. There is reciprocity in helping – somewhere it is given and then later, through whatever methods, it is received. When Wilma talked about her choice to become a caregiver, I recalled why I chose this work. The loss and helplessness I felt when a dear friend suicided keyed me to wanting to help prevent the pain for others.

“Helping around suicide because her family member suicided – this is not an accident”, I wrote, after Wilma spoke of her loss. The loss of her family member to suicide made me reflect also on my loss of a loved one, “Feeling a loss makes you
work harder and more carefully to prevent another loss…experiences of suicides
make it personal and now I am sensitized to carefully examine risk- individuals are
someone’s family.” Caring for others demands that we care for ourselves.

**Supportive Mechanisms for Psychologists**

“What are your perceptions of supportive mechanisms for psychologists – such
as supervision, personal therapy, engaging self-care, or organizational structures?” I
queried.

**Self-care is essential for good physical and mental health and work quality**

It was noted in the women’s conversations that in psychology work it is not
always easy to maintain self-care even though the benefits of self-care are helpful to
quality of work, mental health and physical health. Wilma pointed out:

I think that, I think, there definitely needs to be supportive mechanisms for
psychologists whether it is supervision or engaging in self-care, I think it’s
huge and I think, generally, I don't think enough self-care takes
place…right…Self-care keeps your work and your mind fresh and healthy,
right?

Agreeing with Wilma about self-care supporting health and good work, Yvonne
noted that, “…movement toward self-care and knowing that it’s better to be healthy
is important in order to do good work.”

Building further, Veronica noted that self-care could be overlooked:
I think when we do a suicide review or retraining, there is a reminder about self-care but that hasn't happened for years so I think one barrier is you just get really busy and I think you forget until you think you are needing therapy or wanting that, you are already at a point where you probably could have six months ago got some kind of support or something needed to change.

Zena also reflected that her work is compromised and she is more fatigued without self-care efforts, “If I don't take care of myself and exercise and I get fatigued more and then I have less work quality and satisfaction.” Xandra (... so serious and certain) was aware to maintain her basic needs so that she could be energized for her important work with clients, “I know the importance of rest and sleep in my life too, because I highly value the work that I do.”

As I reflected upon the points made about having time and support for self-care, I recognized that only on a few occasions through the years was I encouraged by managers to take time to invest in my own self-care. There can be talk in the workplace about balance but demanding workloads do little to allow it, I wrote after my interview with Veronica, “Reminders do little unless there is planning. Self-care and support need activation. Wouldn’t colleagues and managers be more helpful to encourage and not judge?”

As Zena noted, self-care makes for a better employee – I thought to myself as she spoke, “I was always better in my work when I carved out more time [for myself], or when I asked for support for high intensity cases.” After meeting with Zena I journaled, “Self-care strengthens us and makes us burn brighter and better.”
Wilma when speaking about needing supportive mechanisms for self-care to be engaged, supported my reflection, “I agree. I have seen so little emphasis placed on breaks, or balance.”

Ethically there is emphasis on the psychologist to be healthy and well and if there are few breaks to offer balance at work, there is the likelihood that self-care cannot be easily managed. I thought of numerous days where there was not time to fit in a break or a walk. I realized the shortened lunch breaks, or, no lunch breaks were a demonstration of lack of self-care. At the time, I thought of it as commitment. Did I value the work place demands more than myself in those moments?

**Self-care is self-sought**

Self-care was highlighted during the discussion as being important and it was noted that it was up to the psychologist to ensure that self-care was in place. Zena (...so articulate and clear) stressed, “Staying healthy and making sure that I just set boundaries for myself and time at work and time to exercise and healthy eating and doing things that I should.”

Conversely, Xandra remarked on the importance of supports in the workplace, “My perceptions are that they [supports] are only there if you are making them and you make them through your own personal relationships forged with other colleagues.”
Similarly Yvonne indicated, “…so with colleagues but that's kind of self-created, that kind of stolen moments or an evening phone call…So, if you need to do that, you create it. You are finding it all yourself, I would say”.

Veronica identified that supports are available if chosen, “Those things are there if you want them and you have to access them. Nobody is checking in on you to do that. If you don't recognize that you need to access them or talk about them… (long drawn out pause – it felt like words unspoken).” I sadly thought, “No one is helping to get their colleague well? Ethically, there is an obligation to your colleagues’ fitness in practice?” And, then, Veronica resumed, “…they [supports] are there, if you use them.”

Wilma stated, “I think that, individually, people have to take some ownership of that…” She went on, “You have to engage your own self-care, that has to happen to be well.”

There was a lot to digest after these conversation bits. Realizing that my boundaries were not always respected by managers through the years, I wrote with regard to Zena’s comment, “I hope her boundaries are respected by employers.” I recognized that some psychologists face challenges to be heard when they draw a line for their needs or their health. I was challenged in the past over needing time for my health. I recalled thinking how bizarre it was that I needed to defend that I needed time to take care of myself – especially while I worked in the health care field. I had to explain and fight to care for myself. I recall, at that time, being appalled. Mostly, I was sickened – hurt to think that my workplace had so little
consideration for my wellness. I knew I was not alone in that thinking. As much as I agreed with Wilma, recognizing, “…adults are responsible for their wellness and health”, I still knew that organizations needed to demonstrate a more caring work culture.

I mused after Xandra spoke about building relationships at work to gain support, writing, “Of course if you make relationships you have that help but does nothing come from work?” Ending with Yvonne’s comment about the psychologists primarily being on their own, I pondered, “Could regulatory [or advocacy] bodies make an expectation of psychologists’ employers to make room to be helpful?” If there were work place responsibilities to support and encourage self-care or efforts to reduce the stigma psychologists felt about getting support, I believe there would be a healthier work culture. Fitness and health would not be left to the psychologist alone.

**Employers need to support psychologists’ self-care**

Throughout the conversation the thought of employers having more of a role to support psychologists particularly in creating room and permission for self-care resounded. Veronica highlighted that there is a half-hearted effort from employers to support:

‘Have you done something to take care of yourself today?’ I mean we do that once a year in Occupational Health and Safety. We will put stuff on the board for fun and we do it for self-care and people write stuff down and that's all good. So that is a good reminder but again that happens every couple years
because it is not the theme every year and I am on that committee and I know we do that sometimes.

Musing further, Veronica noted (looking frustrated here. Rolling her eyes and shaking her head), “I think its resources, a lack of money for someone to cover for you…You're stressed out and I don't find it always that supportive and that is very disappointing to me considering we work in the field…In other companies there is a lot of other money for people to do things that look after themselves”

Wilma also recognized the value in workplace support being actively encouraged, “…I think that supports from your supervisors in your workplace, or your workplace, in general, needs to be supportive of self-care and encourage it.”

The value of being supported was evident:

But it was self-care, huge self-care, completely initiated by my supervisor so I was very supported, right…and even just in evaluations with my supervisor and when my supervisor and I are talking about that, self-care and how you get that in there, and what are you doing for yourself, and acknowledging that needs to be done is huge.

Wilma’s look of appreciation was strong when she continued, “I know that supervisors constantly remind me to watch my schedule and lay off, if I am looking overworked, which is good. Because I think, often times, I, myself, put me in that position.”
Equally aware of the need to be reminded to balance, Zena spoke up *(seeming matter-o-fact but frustrated)*, “If it is not supported by the organization and then sometimes it can be difficult because you can be so busy and it is not a priority.”

Conversely, Yvonne acknowledged how there was not adequate employer encouragement from her perspective for balance, self-focused time and time to connect to talk about needs at work with colleagues, she said:

…you know, the employer doesn’t, there's no protective time. There's no knowledge of that. I would say that I don't even think that that is a consideration from this standpoint… Nothing, at all. I don't even know if the organizational structure would acknowledge that, that is it exists or that it happens. There's no mechanism to formally have a conversation about that…Maybe as a discipline we are disorganized.

A sensation of loss washed over me in the realization that there are workplaces that do not create supports. After talking with Wilma, where she punctuated how essential the feeling of camaraderie was to her and connected she felt in her workplace, all I could think was, “What a supportive workplace! They aren’t all like that.” But then, I felt hopeful, working together we can make it so. Still later, in reaction to reviewing our conversation, I posed this question in my own notes:

Could regulatory bodies support in this? Could employers? Could advocates? By getting governments to regulate employers’ supports [of psychologist’s self-care, care and supportive mechanisms - balance]…I don’t know…it makes sense to be more helpful so practice fitness comes out.
“Maybe psychologists need to do public announcements to get more of what they need from employers too? Like those billboards you see for nursing in Saskatchewan”, I noted following talking with Yvonne. The ‘change through media’ concept continued after I talked with Veronica, I mused:

There are radio and television ads out for mental health awareness for the public… shouldn’t there be more for reminding employers about what they need to be doing…or, reminders that professionals need support…there is stigma within the field that needs to be exposed and broken.

**Supervision is needed**

Awareness of psychologists’ professional needs certainly should be starting in the workplace; however concerns related to lack of supervision became obvious during the discussion. Zena observed this problem about her workplace, stating that psychologists are, “not having the support from colleagues or from supervisors for sure”. She went on:

There is a perception that when you get to a certain level you no longer need support. That is usually a bit of a weakness as opposed to a strength to know when you need support and to ask for it. There are just no external organizational supports for that.

She stressed, “Again, there is nothing set in place in terms of … supervision.” Zena highlighted:
Unless something drastically changes or unless you ask for supervision, there is no way to tell if you're working with the client and if they are changing their suffering. Most clients in mental health won't complain. They will go away and not come back but they won't complain.

The idea that little supervision is noted was further elaborated by Xandra, she remarked, “…unless you are doing co-therapy with somebody, it is very much working in isolation.” Veronica similarly noted, “Nobody would know what is up with my clients unless I tell them. I don't have supervision anymore. Nobody supervises me.”

Yvonne concurred, “Well in my job and even when I started here, I don't have a psychology supervisor because of the structure of the workplace. There isn't a psychology-working group.”

Worry. In that moment I remembered feeling the worry of being unsupported in past work situations. This sensation popped up when Veronica said that nobody would know what is happening in her work, I jotted, “Seems unethical and dangerous…”

Again, I felt worry and fear, when Zena spoke about how supervision stops as seniority increases. I’d driven to a park to sit following time with Zena and wrote, “How illogical. As humans, we always need support. As a professional taking on more and more across time, likely with more expectation to take on more complex cases, it would be sensible to provide support all along.”
Following Yvonne’s comments I was concerned for psychologists’ protection. I noted, “The workplace has limited accountability. What if something when wrong? The employee would be accountable, not the employer.”

Years ago, I recall a situation where I had seen classic ‘scape-goat’ behaviour by an employer. The upper managers were blaming an incident on staff members, when one manager had not done his job. Staff had no power and no support to deal with the situation. Inadequate communication between management and supervisors had been a terrible norm at that workplace and danger in that situation fell back onto clients and staff. The power of supervision can be building rapport, growth, strength and safety.

**Supervision in suicide work is necessary**

Supervision, the women agreed, was important however, related to work with suicide, open supportive talk and strategizing is even more protective for clients and psychologists. Wilma highlighted, when referencing how her supervisor is helpful around suicide work, “Like she's there - she's easily accessible and easily able to talk to. You can sit down and talk with her and you know she's reaffirming, or, she's giving you some other pieces to think about or to look at.” Xandra spoke similarly about the benefit of debriefing, “Luckily I still have colleagues that I can still access but I think that is very important to have that ability to debrief with other professionals about high-risk clients.”
Conversely, Zena (*in an irritated manner*), stated:

In our organization, our managers aren’t necessarily trained in the same area. So they might have never even have worked with someone, had any experience with someone with suicidal ideation or behaviours and they are not therapeutic supervisors.

Zena went on, “It was never with colleagues on my team but just someone in the agency who has an influence on my practice and who I looked up to and who I felt they had lots of experience with this clientele.”

Veronica sought consultation from a colleague as well, she noted:

So if I am not at a team meeting, if I don't bring up what concern or don't bring up a high-risk situation, suicide, or just something that I want some consultation on nobody would ever know. It can be very isolating. You have the ability to know you need that support and that it is important to throw that out there and get some consultation because three minds are better than mine. I think it is there but unless you are a newer staff and getting clinical supervision, you have to set that up yourself, which is a good professional strategy anyways. Get somebody to supervise you on occasion. I have had workers where we would do that. We just do it. Every once in a while you would say I just wanted you to observe me on these particular areas. This is what I want to work on. Then they would observe us with a client. So we built it in even though we were not novice staff anymore. So different workplaces do things differently. Here, where I am now, there is not any of that.
After talking with Veronica, my thoughts drifted to problems of rural Saskatchewan, “Resourcefulness demonstrates healthy choices here. If there was not a team, if there was rural isolation, the team would not exist.” My hope is that support for suicide work, whether urban or rural, is organized. Thorough work with suicide-ideated clients requires a network, not isolation, certainly as I noted after talking with Xandra, I penned, “It is smart that Xandra inserts this [consultation]…a safety and self-preservation.”

Having had the ability to talk with an individual’s family, other workers in their life, and their treating physician when a client has been mulling over suicide has created more safety for the client and peace of mind for me. Debriefing about a safety plan, and about my decisions in helping a person at risk of suicide has made me reinforce feelings of competence.

**Supervision, when positive, improves quality of psychologists’ professional life**

Talking through situations helps as Zena observed, with reference to her professional life and the value of talking with colleagues or mentors, “…supportive and positive and encouraging supervision just really makes a difference, too, I find. And even seeking that out, that certainly influences my quality…” Her work and mental state were also more settled and focused.

Similarly described by Yvonne, while talking about a previous positive supervision experience, she stated (*appreciative in this description*), “I [came from] where there was a professional practice leader in the health region, so if you
had ethical issues then a group met and it seemed really cohesive.” Wilma voiced
the value of her connection, “Our supervisors, I think, are very much along side. I
almost feel like they are working along side you as your colleagues would. They
are very hands on, “Hey, I’m here to help if you need it” but then also give you that
independence if you need it.”

“We all need supportive positive encouragement to grow”, I penned, after
talking with Zena. My thoughts were strengthened. As emphasized by Wilma, there
is security and power in supervision. I wrote as she spoke, “Help is so important.” I
remember thinking that private practice can be isolating. This is why I seek
mentorship and connections to talk and debrief now. Work environments with
absent or disconnected supervisors are isolating. Connection and cohesion of
collaboration is needed for best outcomes. Supervisors have such influence to
support the shaping of quality safe work.

Suicide Work has an Impact

“What have been experiences and learning related to clients who think and talk
about suicide? Or, learning related to suicide behaviour?” I queried.

Suicide work is frightening

The women took time and thought in this discussion. Zena spoke (slowly and
thoughtfully) about the impact of working with suicide, “It really scares me…” Zena
grew on:
I tend to, in moments of anxiety, avoid suicide. I know I can’t avoid and I know that when I see them for the first time and start talking to them, my “own-ness” will reduce in getting over that initial meeting with them.

Zena (…appearing stressed, nervous, and somewhat on edge) highlighted that suicide work was, “Well, it is the worst-case scenario.”

Yvonne responded quickly and candidly (…so honest in acknowledging her unpreparedness) talking about her initial professional experience watching a mentor deal with suicide, “Well, my initial perception was, “Holy, what do you do with that?” and so it was interesting to see how someone would be very calm under those circumstances.”

Xandra spoke more slowly and thoughtfully, she described the probability of client suicide, stating, “It is sort of this ominous thing. It's probably going to happen…it's probably going to happen, and I guess we can talk then about what happens. To be honest I'm not a hundred percent sure how I will feel about it. I'm unsure.” Reacting to a client suicide can bring on varied feelings and remembrances.

Veronica noted pain, recalling, “I don't remember people specifically saying that they were feeling traumatized or re-traumatized [by a client suicide] but it was, kind of, for me just to have to re-live things (…tears welled in her eyes and then suddenly, tears were hot in mine) - it brings up your past experiences.”

“I know that supports are in place for suicidal clients and high-risk clients that your supervisors are easy to access and you can be consoled…some of those
things”, Wilma talked about how helpful it was to know colleagues and supervisors would be available to her. Then, acknowledging her fear (…looking anxious as she talked), “…working with [an] adolescent population who's impulsive you have to do something - you need to make sure that they are safe, it’s scary.”

My guts churned when reviewing these comments. Thinking about Zena’s comments related to fear, I wrote, “I know this feeling well…‘Afraid’ that the client will suicide.” I knew in my heart that Xandra was correct about the eventuality that working with suicide-ideated clients will increase the odds to experiencing client suicide and I noted, “There will be suicides. This is so hard to accept at times.” And, I realized, for me, it does not make it easier. I know that it is, “Important to not try to be a ‘savior’.” But, I need to do everything I can. Regret is hard to live with.

**Suicide work requires more time and effort**

The women observed that energy needed for suicide work was significant. Zena (conscientious and concerned) stated, “So there is no recognition [by management] if you have a client with suicide ideation they are going to need twice as much work and suicide behaviours in the hospital are going to take twice as much work.” Zena went on, highlighting the intensity of the work, “They see it is very serious and most of the therapists I know, or psychologists I know, would use their own self-care and their own time [to follow up] so that [personal time] begins to suffer as opposed to the client care but again that is internal. That is a personal decision…”
Veronica also remarked about how focused suicide work can be, “I find that suicide work, that, should be done even more intensively, that advocacy work, if I can't do that, that stresses me out or makes me feel tired or frustrated.” She lamented:

Yes. I know because I know what kind of job they want me to do with these kids and what they need but it takes a lot of legwork and a lot of time. I mean I could be on the phone and hooking them up with resources, hooking them up with this that and every thing. All day… for two or three clients. Really! Some days. It depends, but that can happen and then other things don’t happen.

Yvonne observed how effortful suicide work should be, “And, I also really took from that, taking real, I mean real, time and real effort to talk to people and I think that's just a general thing about human beings that we all need to be heard.”

Wilma (…animated and concerned... A bit of fear seemed to rise from her voice) targeted the energy necessary to work with suicide, highlighting:

… when we talk about the suicidal stuff there's definitely clients that I meet with and then I am sending off to the hospital and, for me, following through and checking in and making sure that they follow the plan and how I can be of support outside of those sessions that I have had with them. So that’s definitely demands that are beyond face-to-face and writing your notes…you are on the phone checking in and supporting…
The seriousness of “…life and death weigh[ing] in the balance…” was my note as I listened to Zena description of how little recognition was available. To feel there is a lack of support is gravely concerning. I thought about Veronica and her awareness of what clients’ needs are and that she wanted to create safety, “Veronica was so passionate about the need for advocacy and supports. She commits herself until she is worn.”

Psychologists should not be worn down because of their work with suicide. If anything there should be more recognition of how much extra support should be extended. Intervention takes time and with Yvonne’s comments of really allowing someone with suicide thinking to be heard, it resonated that the thoroughness of “Listening and not assuming or taking over…[is] respect.” I thought back on workdays, where after six or seven hours completely focused on talking about suicide and shaping safety, there can be intense exhaustion. I remember in some work circumstances having little time left over for paper or assessment writing. I recalled returning home, spent, after putting extra hours in to get caught up. Face-to-face safety rose far above paper. The amount of focused energy seemed to be accentuated by the level of threat a client was facing. The seriousness they had about suiciding and the acuity with which I needed to respond was intense. Responsiveness is a direct reflection of respect for needs.
Suicide work impacts personal life

Respect was described in another way as Zena spoke about the seriousness of suicide when she thinks about her clients, “That is the population that I have few clients in and those are the ones that I took it home because I worry about them because that is something that is serious and people do commit suicide. That it is a big burden I guess.”

Veronica talked further of the burden of thinking about an inpatient client’s suicide. Because the debriefing took place over the course of a year along with planning preventative measures, Veronica related, “It was sort of re-traumatizing. It just feels like every time you talk about it, even though you know it is a good thing because you are looking at the future, it was also difficult and probably more for me because I sort of deal with things and move on quickly.”

The awareness of how demanding it can be to work with clients who present with suicide ideation was outlined by Xandra, “I feel like I give a lot of myself to my work. I don’t have family obligations and certainly I am very aware of the amount of energy that it takes.” Wilma also noted the intensity of focusing on suicide work and about the impact of suicide loss, “You suffer from that if you aren’t able to cope with that and you end up depressed.”

The idea that, “Suicide of a client, unresolved, can create illness”, rolled over and over in my mind after my time with Wilma. This shook me. I thought of a client with whom I had spent energy with and felt progress. I was so significantly impacted by that death that I felt lost for a long period of time.
Like Veronica’s words about being re-traumatized, I wrote, “A suicide at work creates a focus on the ‘why did it happen?’ If processes are slowed in the workplace then the employees’ doubts can fester.”

Why suicide occurs is not just about the psychologist. I have had moments of needing to remind myself of this. I jotted, after Zena had highlighted the extra energy that goes into suicide work pulling her away from personal time and self-care, “Fear and worry can become burdensome and play into personal time. Taking away from renewal [during time] away from work.” I pondered with regard to Xandra’s remarkable client focus, “Xandra dedicates herself to her work primarily – an employer would do well to ensure that such dedication is rewarded or can continue.” I suspect the employer does not recognize the selfless concern. Energy for suicide work does not come magically – time must be spent recharging.

**Self-doubt in suicide work**

The conversation sprang into the idea of how reinforcement of an employee is helpful. To offset risk of harm is a focus of suicide intervention. Fear and risks creep into that work. The psychologists pointed out that working alone or in isolation with suicide work is not ideal-doubts can arise. Zena outlined, “I find I will go seek some kind of consultation to make sure that I am on the right track…” She went on, “I sought consultation through a colleague and so I was supported in terms of having someone to listen to what the client was saying and give some suggestions about what I can do or making sure that I am doing the right thing.” There is risk
with suicide, as Zena noted, “Again probably more on the fear and anxiety and wondering if I was doing enough. Lots of self-doubt or thinking of that.”

Veronica continued to build on the idea of self-doubt [“… speaking quickly and with an energy of fear”], “I mean even with attempts where people didn't die, that was a big part of the learning. “Did I engage? Did I do everything that I could? Did I try to understand the situation and the person really well? Did I contact everyone that I needed to?” It's about how thorough I was and was I really present for that person, for that situation in the best way that I can be?”

“Doubt and fear play[ed] on Xandra’s face” as she spoke about a client who continually demonstrated suicide ideation and repetitiously engaged suicide behaviour. She noted, “Is it possible it could be something else? Like are we missing something?” Wilma seemed to carry Xandra’s very thought forward, “I second-guessed the work that I’d done with this client.”

As Zena talked about risk and described her fear and anxiety, I noted, “Self-doubt is so painful, fear so consuming.” Notably, Veronica’s voice also carried fear as she talked about a debriefing, I wondered later on, “Ethical practice would be called into question.”

I know in debriefings that I had participated in related to client suicide, doubt played on my mind, questioning: ‘What did I miss?’…‘What else could I have done?’…‘Am I a good therapist?’…‘Should I be doing this work?’

As noted after talking with Wilma, “Fear of doing the wrong thing related to suicide seems to be a common theme.” I did not feel alone in my own fears and it
brought to bear the importance of talking through suicide work and getting support from colleagues.

**Younger psychologists have more challenges around suicide work**

Some of the insights about support and the necessity to access help comes through learning. Discussion of developing confidence and knowledge across time was a reflection of how newly trained psychologists may struggle related to suicide work. Veronica highlighted the challenges of suicide work when she was a younger psychologist, “I started to look at myself to see it was much more serious and was much more stressful in that time, back then, and maybe it is, now, that I am more experienced, I handle it better.”

This idea of early inexperience also resonated for Xandra as she stated:

I think I may have thought more when I was younger and less experienced. That may have been my own self-generated fear that, ‘Oh my God I can’t admit to having problems because what if I don’t get work?’ But as I have gotten more comfortable, I guess in my professional world, I have no illusions about my challenges, my personal challenges I have.

Yvonne also spoke about the struggle to feel competent as a young psychologist and how she worried about how others may judge her:

…I wouldn’t have been as worried what the front staff receptionist knew, thought, but I was new in my job and you're trying to prove that you are good at what you do and I was very embarrassed of what was happening. If it's just
a different point in my life I think I would've had a different response today
than I did then. Especially with suicide work, different how I was then to now.

Feeling judged is difficult. After my conversation with Yvonne, I had noted, “Not
knowing what to do, being embarrassed, trying to prove oneself – it feels that there
is such a high standard and no room for error or acceptance of being human.” Being
a professional feels pressurized, folks look to you for guidance or answers. When
things are not improving there can be a sense of failure.

As Xandra had remarked challenges might feel like a barrier to being a good
psychologist. After we’d talked, I penned, “Problems in the work means
incompetence? Personal challenges mean incompetence? There is a lot of fear
here.” After Veronica and I met, I summarized, “Young clinicians may have trouble
managing suicide ideation [and behaviours]. They need more help and training.”

**Suicide work is stressful**

Even with help and training there is still stress in suicide work for seasoned
psychologists. Zena noted how fatigue builds, especially, “…if I have a lot of heavy
clients that want - it can be draining whereas there are clients I feel are not making a
lot of movement for whatever reason. Suicidal clients…” *(she broke off, reflective
and eyes downcast)* and then went on, “My perception of the experience is that it is
a lot of pressure to work with this population.”

I responded, “Suicide work is burdensome, stressful, fatiguing…intense and
there is need of more debriefing, I suspect?”
Zena continued, “I think it [suicide work] is draining because it is very intense sessions and every session there is a tentativeness that you are particularly ‘on’ and it’s intense because you’re dealing with intense emotions about suicide, life and death. That’s all.”

Working on “suicide, life and death”, as Zena noted, is strenuous and requires support. Xandra clarified, “Well, this is a profession where we have colleagues but at the end of the day, unless you are doing co-therapy with somebody, it is very much working in isolation.” Working so independently is taxing as Xandra revealed:

…we work in isolation and I don’t know what it is like for other people but I give a lot of my resources internally certainly by the time I am done my day, I can be ready for bed within an hour. I am not exhausted when I am done with a client. Usually I am feeling satisfied, like we did some good work and that’s fine but then my brain and body knows that I don’t have to work anymore. I just shut down.

I noted after, Xandra talked, “Exhaustion leaves little time for renewal or connecting with others.”

Reflecting further Xandra (…looking so afraid …) shared, “People can really die and what if he had died in that week?” Dealing with suicide thinking there is instability, an uncertainty, Xandra stated, “But to say, in that language, that we can’t guarantee that it [suicide] won’t happen because how does one ever guarantee human behaviour, that’s so challenging.”
“People, parents, partners and others want guarantees…we can’t.”, I responded.

The ability for humans to change their mind and be in changeable circumstances means more weight is carried by the psychologist as Veronica (..look[ing] pained) outlined, “So there is a lot more responsibility put on you and I remember feeling there was a lot of responsibility put on me.”

“So, heavy…” I noted.

I sat in my vehicle after talking with Xandra and recorded, “Saying that one is working in isolation feels unsafe…yet I do this all the time.” I, we, need to rethink how to connect professionally.

Isolation is not helpful.

**Suicide work is hopeful**

Zena had spoken about the stress of working with suicide but then also leaned in on the idea that there is a positive aspect:

Knowing that and reminding myself at the end that it is serious and they attempted and it is a huge cry for help and that people can recover and I can help them in that process so I hope, I guess, and that is what you want to distil in the client too but I can’t lose that hope.

Similarly Xandra tried to support a perspective around how to create balanced thinking. She focused on seeing potential in individuals who struggle, musing:
Not trying to save, just trying to help people. At the end of the day, I am a firm believer of healing in terms of I think most people can heal themselves. I see my role as speeding up the healing process for them. If I can help them to feel a little less pain in their life, for a short period of time in their life, that’s good.

Xandra went on to talk through the need to talk and weigh out the questions and pain that provoked suicide thinking:

I think people have a right to question because I think if you question whether or not your life is worth living or not, I am hoping that even with the question, if you come around the other side that you may discover the true benefits of living once you have wrestled with that quintessential question.

These conversations were powerful. The awareness Xandra had about being helpful but not needing to take on all the responsibility of the client’s life was wisdom. I noted that psychologists can be a, “Catalyst, not a saviour” and this seemed so much more helpful in defining the role of the psychologist – the pressure is removed. I never believed I was here to ‘save’ but I suspect some might get caught in that bind. This talk created reflection about times when people avoid encountering a subject head-on because there is fear that they cannot fix the situation. No one can simply erase thoughts of suicide but a shift within the individual matters. A shift captures the idea of hope. A client taking time to wrestle with existence and redefine a new way of being in life would be helpful. Of course with help, when help is needed, most things have potential to improve.
As Zena had hope in talking about suicide, I reframed, “Asking for help is about hope.” After chatting with Zena, I wrote about my hope that all those providing intervention could see that, “Discussion is key and being open to the discussion is about learning how to help.” Really, even wanting to learn what has put an individual in a place of thinking about suicide demonstrates caring that perhaps that could be catalyst alone to support a possibility of life for the individual. Not feeling alone can create change. The person at risk of suicide wanting to talk about their hurts and pain demonstrates a desire to share their pain and not carry on alone.

**Suicide work is more in the open**

Hope seems to be brewing in a different way, where there is an increased openness about suicide talk in other settings, public or other professions. Veronica made this observation about more openness in suicide talk, she said talk is happening more frequently:

All kinds of places and it seems to be more transparent now than before…I don’t want to say acceptable but it’s much more there and there is more awareness of it. Even though it is important, it seems to be more minimized, more than it was say 20 years ago, and maybe it’s from the general public.

Veronica’s observation resounded for me. This has certainly been my experience and, undoubtedly, the experience of the hundreds of folks I have worked with who have chosen to attend suicide intervention training. Breaking stigma occurs as more people talk about suicide. Lessened stigma around suicide allows permission to get help about thoughts of suicide. Therefore more people are
realizing they need the training to know how to intervene. Old myths fall away to shape new realities, “Suicide thinking is happening and that is why it should be talked about. Talking about suicide does not make it contagious. They are already thinking about suicide because it is one of the options to resolving pain. People are there already and they want help”.

Thankfully, there is the beginning of talking and as noted before by Zena and Xandra - talking is the beginning of hope. I noted after time with Veronica, “There is more openness and, therefore, everyone needs training. Suicide is everyone’s business and we all need to own helping.”

**Suicide behaviour in mental health should be anticipated and prepared for**

The discussion evolved to the notion that suicide thinking is common in mental health work. Suicide behaviour, resulting in harm or death, although less common than suicide ideation, must be anticipated when working as a psychologist. Zena spoke about preparedness and reflected on her clients who had demonstrated suicide behaviours, and survived, “Only like 6 or 7. Not many. I mean I work in Mental Health so it is really not that many…No, it was 13. So that is not many.” Zena went on to describe that suicide behaviour, a client suiciding, is not necessarily a reflection of therapeutic efforts, she noted:

It’s the fact that I know amazing therapists have been in that situation so it’s really not about your profession in the end. It’s just about what the client was going through and, sometimes, you can not predict what they will do.
Become prepared for suicide as it can be an eventuality, Xandra noted, when speaking about a client with repetitive suicide behaviours, “He is one person that I know I have talked to colleagues about and said, “I really think he is going to kill himself one day.”” Xandra went on (…look[ing] so pained here and saddened. But, yet, matter-o-fact…a painful realization) about how odds increase, saying:

Certainly I think we were always warned in this profession that likely throughout the course of your profession people are going to commit suicide and you need to prepare for that and to be honest the likelihood has greatly increased.

Veronica acknowledged helplessness (her face - pained, her tone was almost angry):

…if a person is wanting to commit suicide, they are going to go commit suicide and try everything they can to figure it all out….I believe people have free will to things and I am only there as a catalyst to assist them to make good choices to get some help.

As Zena spoke about her clients with suicide behaviours surviving, even though she seemed to reflect relief, I noted, “This doesn’t mean it did not take a toll…” as her tone was so serious and there was an intensity of distress in her manner of relating. I continued to reflect on the need to stress the eventuality with new psychologists that a suicide can occur. I wondered, “How will psychologists prepare themselves better? Who will you have planned to get help and support from?”
For me, despite this awareness through the years, I still felt like I had received a physical blow when learning of a youth that had suicided about one year after my work with him had ceased. I reeled for days, recounting had I done right by him at the time. There was an operational debriefing – it was determined that all that could be done was done, but, I still had to process that he suicided. I wrote after Veronica had stated that when a person at risk of suicide seriously chooses suicide they will follow through and you cannot stop them, I wrote, “We can help. Folks are not certain about suicide. They just don’t want to live in pain.” I know in my heart, that youth, had he had other options would not have chosen death. If only someone had intervened and helped him with the other options.

**Suicide-Specific Training**

“Has there been a professional change, influence or awareness that resulted from the experience of client suicide work?” - I asked.

**Suicide-specific training is necessary**

With suicide becoming more openly expressed, with the expected presentation of suicide thinking and behaviours, and with the possibility that suicide behaviours could result in death. Zena began speaking about ASIST training, “Yes, with the training, all suicidal behaviours should be taken seriously.”

Yvonne built upon this thought of the importance of training, stating, with regard to her university preparations:
Early on…in my MA days. I think it was my first practicum experience, which was more of an observation experience. We had virtually nothing formal in Grad School. I had a supervisor managing a client who had attempted suicide. It was a very peripheral experience because I was a student so I didn’t have a lot of ownership.

In talking about the experience her supervisor had gleaned working with suicide, Yvonne noted, “I sort of watched the things that he did and did without the apparent panic or just having a very clear strategy.”

Xandra stated, with regard to learning how to train others related to engaging suicide interventions:

To be honest, that was a really good experience to have gone through that and have to train others that it really gets you a lot more comfortable asking the questions about suicide because to be honest, we get really little training in our [Graduate school] education about it, even when you come on to the workplace. I have to say there is not a whole lot of suicide specific training. So for me, now, I am actually very, very comfortable asking about suicide, asking about people wanting to die.

Xandra went on to speak about a client who struggled with suicide and made the observation about other mental health caregivers working with her client, “He has had other people try but I think sometimes people don’t have, training, and, I don’t know what the word is, maybe a lack of language to really say, to really tell somebody what they are feeling.”
With regard to training specific to suicide-intervention, Veronica stated, “I have had various other ones that I had the two-day, ASIST training, and it was the longest that I really had ever done.” Veronica noted, “My experience [says] and I am trained to take it very seriously and [with] very specific steps that we are supposed to pay attention to and plans and resources and even some changes on how to manage it, how to assess risk – all of that.” Veronica remarked about her self-awareness of seriousness with suicide, “Professionally I would say I have always taken it as a serious threat because that’s how we were trained to do it.”

When Yvonne and Xandra spoke about very little training in their clinical psychology graduate school programs, at the masters and doctoral level, I was taken back. As I thought it through, I noted, “Truly it seems stunning that at a masters level there is little training. Many in Saskatchewan register with a masters...this is worrisome.” Just as Zena had noted all suicide behaviours should be taken seriously, I noted sadly, “One would think so...not all are.”

When Xandra went on to talk about her increased confidence from training, it was validating, “Training others about suicide…talking about it increases comfort to do the work in intervention.” Similarly, as Zena noted the value from ASIST, I wrote, “I am so thankful that ASIST is helpful. It reinforces my work.” Just as Yvonne outlined that she was impressed by the smoothness with which her experienced supervisor dealt with client suicide thinking, I noted, “Tools help. Training is needed.”
Suicide work includes informal and formal external supports

Part of training and reliance on tools comes through supports being active in the safety planning to ameliorate risk of suicide. Zena highlighted the importance of involving those close to the individual at risk, “So especially with suicidal thoughts, to work with the family about how to respond to those and what to do.”

Various layers of mental health professionals and other helpers need to be apart of the support system, as Xandra noted with regard to one client repetitively at risk of suicide, “Certainly he has had various different kinds of support too, not just mental health professionals.” More involvement from various helpers will prove helpful, Xandra noted as sometimes there are limitations in how well a client’s needs are understood, “I believe that even though we think we know our clients very well, sometimes, not really.”

That need for other resources was important. Yet, Veronica highlighted her sense that there appeared to be a lack of organized help, “I still think they need to work on that, where there is not a lot of suicide resource support.” Additionally, she noted that there is energy expended as caregivers communicate together offering support, “…you do have to contact a lot of people around the client, you are always having to consult with somebody.” Despite Veronica’s awareness of needing to put in the effort to set up adequate supports, she noted the importance to, “pay attention to plans and resources.” Veronica noted that even with safety plans, there is still doubt that comes up, she referred to a client suicide, “And, I wondered if I should have done something else, if I should have, maybe, engaged somebody else.”
Building more upon the need for supports, Yvonne focused on the need for respect for the individual at risk of suicide. She pointed out, “And, the other thing is, like one health professional can think that this treatment is best but it should really be trying to find it, in terms of, what do patients or clients have a right to say, “No” to.”

Wilma further elaborated the importance of respect for the client, related to explaining the availability of supports. Wilma noted, “There are times when they will have to access other supports if needed outside of my time.” Natural boundaries a psychologist may discuss relate to having a need to attend to their personal life and not be too available to clients.

Details in appropriate supports that are both formal, with other professionals, and informal, with family or friends, are needed in safe planning. The awareness of what fits the individual at risk will only come through discussion. Discussion takes time. I mused after Veronica made the note about paying attention and collaborating with resources, “Do employers encourage giving time and attention?” I thought about my own past experiences. Sometimes the time you give is not within the timeframe your employer has engaged you for. I gave of myself and of my personal time. Of course, I always wanted to.

Paid caregivers could get caught in giving too much beyond the time recognized by their employer. In some circumstances that lack of reciprocity may be a barrier to giving adequate care to a person at risk of suicide or a barrier for the caregiver to remain balanced and healthy. Support should be shared so that the caring provided
is ethical, balanced and competent. After talking with Veronica and hearing the pain of wondering what else could have been done, I jotted, “External supports for the caregiver need to be activated.”

**Post-Suicide Supports**

“Considering your experiences, what might be helpful considerations for psychologists dealing with client death by suicide?” I pondered.

**Client suicide creates grieving**

Building from the need for caregiver supports, Veronica identified needs related to how to be supported following client suicide. She spoke about a client suicide and the connection a colleague provided to help her get through, “We could both reminisce about him.” Further identified related to grieving, Veronica felt it necessary to know details around the death and have time to honour ritual, “…letting that clinician get more information and letting them have time to do that and connect to families and go to funerals.”

Xandra acknowledged the intensity of client loss:

To be honest, that really affected me and still does affect me.” *(Xandra was tearful)* …. it’s a loss and we grieve losses just like all losses in our lives and we don’t do them in a week. We grieve losses over time…We don’t get over things. It’s like everyone else, you know how it is to go to the funeral home and it’s never to be spoken of again. People don’t realize that it is.
The intensity of suicide was identified as significant by Wilma, “I think personal therapy or self-care would be important especially when you’re dealing with a client death by suicide and I think that would be difficult, I think, to work through.”

Client suicide was, and still is, difficult to work through. “I get this. I still think about my clients who have suicided. It still hurts”, I noted, after Veronica talked about reminiscing about her client. I thought it would have been valuable to be able to engage in the memories of a client who suicided but there was no one to talk with at a work level. I needed to organize my own support. That individual was special – more than a client, a person who I took genuine compassionate interest in. I enjoyed seeing and talking through things with that client. That person meant a great deal to many people. Yes, it was a professional relationship but a psychologist is still human with depth, of course they will care about clients. Genuineness, unconditional positive regard and empathetic understanding - how can you not see the person?

“Grieving time should be anticipated in the workplace” I penned, as my reaction was so clear when Xandra spoke, of course going to the funeral and taking time to honour the person makes sense. Personal therapy and self-care may be necessary post-suicide. The psychologist is a person as are all others. Yet it occurred to me after Wilma spoke, those helps are perfectly acceptable and should be encouraged, “Just as long as judgment and stigma don’t block help.”

It concerns me that there could be judgment. I recall suggesting to a manager that I attend a client funeral years ago. She countered with a scowl and a very clear
message that it was inappropriate. What could be more appropriate than demonstrating respect for life?

**Client suicide creates increased thoroughness in psychologists’ work**

The self-examination that follows a client suicide is intense as Veronica noted her learning:

Well I think for me a big part of it is that I really remembered was being thorough. I had to really learn first of all to make sure that I covered everything. It really made me think about that over the years to make sure that is something that I do because it is easy to sometimes miss something when you’re busy that sometimes you need to stop everything else and just do what you need to do. Focus on what’s important…

“Doubt and second-guessing can spur more thoroughness … I appreciate this. Reviewing can help look at how to tune in more.”

Questioning can help create professional growth.

**Client suicide creates professional doubts**

There is a fine line where doubt can create growth or cause pain as Zena observed, “I think if one of my clients committed suicide. I would really take it, not personally, in terms, of they did it to me, but, in terms of, I am not a good therapist. I should have helped them.”
Veronica, in reflecting on a suicide was open to the learning, she reflected, “Whoa. Did I miss something really big here?” Because it was sort of within that time frame and that rarely ever happened to me in my career.” (Veronica looked so saddened and hurt. The awareness of ‘what could have been’ is so hard. Support is needed to deal with loss.) Veronica went on, “We failed her in a lot of ways…”

Zena’s reaction reminded me of a state I was once in, I noted, “[Suicide is ]So powerful. Does it mean you are not a good therapist if suicide occurred?” I was there in the past. After Veronica talked about missing something with a client suicide, I recognized learning can develop from loss providing the mindset is positive, “Doubt is helpful if guided and harmful if not.” It seems that support and supervision can assist this process for growth. Reflection and therapy can allow for processing to growth as well.

**Need for post-suicide supports**

Zena highlighted the importance of support after suicide:

Self-care. I really think that is huge. Support from organizations and colleagues or who ever they are working with would be huge to have that support and I think talking to someone who has been through it, having access to talking to another psychologist who has been through it and depending on the relationship with the clients and the circumstances…seeking out therapy would be a good support and making sure to keep on track with the self-care and the thinking, getting, catching, those thought distortions.
Zena had no illusions about what did exist, she stated, “Again, there is nothing set in place [at work] in terms of supports.”

Xandra noted the importance of being human, she shared, “I did go to the funeral and it was interesting, helpful, at the funeral home.”

Therapy was an important aspect that Yvonne could identify with:

Probably taking advantage of the extended health care benefits. So we have private services in the…program. We often have client deaths, children die and it's obviously not suicide that we would see, but if suicide was an issue that is exactly, what the manager or administration would direct you to the EFAP to use six sessions at $80. Something like that...

Yvonne went on to note that formal services may be less accessible than someone who has been there with you at work, she noted that, “Finding a colleague, recreating some of that support system, have a colleague that you can have a conversation. Everyone has a different way of managing self-care, making sure that you look after yourself.”

Wilma weighed in acknowledging the impact and need to be prepared to deal with loss of a client to suicide, “What supports can you access? How does it affect your future work? It would impact your work. It would have to have an impact, especially the work that we do because we do work with people. You can just not let that affect you somehow. You can deal with it and you can work through it.”

Recognition from the workplace is important as Veronica outlined:
…acknowledge[ment] and a plan from your supervisors that it is a very traumatic… to give them some time off… *(Veronica looked so thoughtful and so compassionate. She knew how it felt first hand. It causes pain. These are needs expressed firsthand.)* To me it is very traumatic thing when you’re working with someone and they die by suicide…sitting down and having a meeting…support them. It is because you know there are going to be questions and inquiring…that person is going to be questioning if they need support and maybe offer to give them the name to see somebody if they want to go talk to a counsellor or if they need some time off…it is difficult and whether you need it or not I would like to give that to you or maybe options of what they would like…Then an opportunity to review how things went with your manager is a good thing, you are going to be going over the file. You are going to be talking about it.

All of the dialogue was powerful. I was conscious of the self-judgement and doubt that I felt following a client suicide. I reflected after Zena talked about negative thinking patterns, “Thought distortions come in the work when there is challenge and suicide. Doubts and fears can damage working capacity.” Early help can ensure a productive career. Effort on the part of the employer can prevent problems later. I managed myself and sought support for my own struggles but having an employer be supportive would have been a wonderful thing. I remembered years ago, before I began work as a psychologist, one manager calling me at home after an assault when I worked with youth in custody. The assault resulted in an injury, for which I remained home for a couple of days. The manager
was supportive when she called, “Stay home and do whatever it is that makes you feel better. Would you like someone to talk to? A professional, I can recommend someone I talk to when I feel overwhelmed at work or in life. It is okay, you know, to take a mental health day.” Her words have stuck with me. Her encouragement to get help and to normalize help seeking for a professional was powerful. Based on the comments that Yvonne made about how limited therapy benefits were, it struck me that there has not been advancement in all settings related to supporting the needs of caregivers. Really, I thought, “[It] Seems like very little investment for the health of an employee.” Front end spending on health and wellbeing will be a tremendous savings and a stronger system - we need to invest in our psychologists more readily to ensure they are healthy and competent.

**Organizations, post-suicide, appear less supportive of psychologists because of legal focus**

As the conversation flowed to how employers were supportive after a client suicide, Zena mused (…looking a little uncomfortable as she described this. Her voice seemed agitated), “I would imagine professionally working in an organization, in terms of legality, I’m sure it wouldn’t be that great either because you have to pull their file and do the review and analyze everything you did or didn’t do. Again like I was saying the manager, their role is to “account for” as opposed to support you.”

Xandra was aware of the process, highlighting, “…what happens then your file is audited and they want to make sure that you do everything that you supposed
to…not so much that someone goes to be supportive necessarily.” She clarified, “So my perception of that is that it is more about covering the agency more then caring for the clinician.”

Post suicide, Veronica outlined an elongated process that had discourse over a year-period, “[audits] come up with what would you do differently next time. What do we think needs to change. The recommendations would be made - all of that stuff. It was sort of re-traumatizing. It just feels like every time you talk about it, even though you know it is a good thing because you are looking at the future.”

Veronica elaborated on the drawbacks of auditing:

People got more defensive, worried that people were criticizing their work or what they did but I think in that way there was more of that. I don't remember people specifically saying that they were feeling traumatized or re-traumatized but it was kind of for me just to have to re-live things - it brings up your past experiences.

When Xandra was talking about the audit process, I was reminded of a conversation that I had with a colleague years ago. A mental health practitioner and I spoke about the audit process and the colleague fumed, although my recollection is not verbatim, she said something like this, “And, if it doesn’t go well, there is fear of firing…slander…being thrown under the bus…the employer needs to be clean. Blame will fly.” All I could think of when Veronica spoke about a yearlong examination was, “Of course people would be defensive! They are being scrutinized and fear blame. The system needs to be expedited and helpful.” I know
I was sensitized during these conversations – the vulnerability in being a psychologist is that somehow it is possible that someone could place blame of suicide on lack of competent intervention. It is an anxiety-provoking position if you are not sure you will be backed.

**Stigma, a Barrier to Help and Support**

“Are there barriers to activating help and support for psychologists?” I asked.

**Stigma around accessing supervisor help**

As much as the discussion pointed out that psychologists need help and support it was highlighted that it was a challenge to approach supervisors to get needed help. Zena pointed out, “If you seek it out too publicly then it is almost seen as a weakness as opposed to strength because it is seen as though you are struggling.” Wilma noted the same stigmatized perception, “To seek help from a supervisor can be seen as a weakness too and it should be a strength”

The very profession of psychologists are focused on helping to improve or reduce life’s challenges. No one is exempt from challenge. Zena was so aware that there is a problem perceived in seeking help. I was incensed but remembered I had felt this scrutiny before, “Help-seeking is [seen as] weakness, how sad – what a terrible way for mental health professionals to view [one another].” I recall a conversation with a colleague I cared about, a friend. I worried about her work-life balance impacting their physical health and suggested she might benefit from support. I recall how she recoiled as though attacked. The stigmatized notion, that help seeking was a weakness, was clearly part of her frame of reference.
Barriers to psychologist accessing personal therapy

Stigma was noted to be a barrier to seeking personal therapy. Yvonne identified other barriers related to accessing the employee benefit package, which she observed was not particularly adequate, “I have been told about that benefit, I had been told this particular plan has the least mental health coverage and has the most difficult to deal with EFAP program but they are very limited. The hourly rate, the going rate for our EFAP to my understanding, is a very low rate.”

Zena expanded on the EFAP program and accessing therapy:

So we are covered for 8 sessions and time is a barrier and finding time to get away and money is a barrier and in a small city, there are barriers to find someone who you don’t go to every conference with or on a committee with so that is a barrier as well.

Yvonne spoke similarly:

Well, it is a small city, so my being a psychologist and, to me, one of those first barriers is who do you go see if you're having really significant mental health issues? Who do you set out to see that you don't already know on an acquaintance level?

On a different tangent, Veronica remarked about work as a psychologist, “It can be very isolating. You have to have the ability to know you need to have that support.”

I noted, “You need strong self-awareness.”
Building further, Xandra stated, “My perceptions [of supports] are that they are only there if you make them.” Both of these thoughts by Veronica and Xandra leaned into the need for insight. Insight is good when we are doing well.

Based on all the statements, barriers are many: lack of personal time, inability to take time away from work, fears related to anonymity, limited EFAP coverage, little encouragement, and few options. Unless your insight is intact how readily will you acknowledge the need to acquire help? After Veronica spoke about having the insight to realize a psychologist may require support, I processed how some psychologists may not know their impact on their clients’ therapy. Colleagues would not necessary know how another psychologist is providing therapy as a result of working in isolation. In my concern, I wrote, “The employer [or colleagues] need[s] to help especially if a psychologist is struggling, they may not realize what their own needs are.”

**Stigma to access mental health therapy or supports**

The discussion of stigma continued with highlights on additional problems in accessing supports. Wilma noted “there is stigma around mental health…[and] then a psychologist also needs to access help…psychologists cannot necessarily get counselling or support because they are…supposed to be all ‘together’.” She noted that the need to be all ‘together’ makes her have, “That feeling that you are putting on a show.”

Xandra, when asked about the stigma related to psychologists accessing mental health support, stated (...look[ing] so agitated here. Like fear was coming off of
her), “…[psychologists] feel pressured to have our stuff together, “Oh my God how could you ever give somebody else advise if you don’t have your life together?”

Xandra mused, “I’m not sure if it, stigma and judgment, comes from ourselves…”

She went on, “Oh my God I can’t admit to having problems because what if I don’t get work?”

Talking about psychologists seeking mental health support, Veronica (...disheartened when she spoke) stated, “I know it is taboo in our profession for sure. So that’s a barrier because it is not really overt.” Veronica punctuated:

Again there is even more stigma if you are a mental health worker to then have a mental health illness…all you need is a couple people gossiping about it and who knows who else they have said it to. If I had that insecurity when I was a younger clinician or something I think I would be very careful of who I was talking to.

Zena stated, “Lots of barriers can affect a person’s ability to access that internally. Externally from the organization there are tons of barriers. Stigma prevents getting help and being judged.”

Yvonne gave voice, to the judgement she had heard and felt, “Well, why would a psychologist need to go see a psychologist, right? So, it's still the stigma of mental health services.” In order to dodge the stigma, she suggested, “Or, you call it something else because it is way easier to be off for three weeks”

“A lie is easier to avoid being judged”, I noted, as my stomach turned. This part of the conversation was hard on my heart. What struck me after talking with Wilma
was that, “Breaking barriers needs to happen. Education, in-services…” need to be brought forward. Veronica pondered the taboo within the profession. This pained me, “It is a sad state of affairs to see stigma within the foundation of mental health.” I recall cringing and noting, “Gossip in mental health workers…they, of all people, should know how damaging that can be.” Fear of judgement, job loss, not being advanced…why would anyone talk? It struck me as cruel…we all need help at different times as circumstances change.

After the conversations ended, I felt a sense of emptiness at first. I enjoyed the conversations – the exchanges, the momentum these professional women had about psychologists’ needs. I valued the differences in their views. It seemed as though the thoughts expressed were so layered and powerful. These women had shared very personal journeys. I was moved to feel the connection in those hours, aware that it is so uncommon to talk so freely about suicide work. I was filled with gratitude for the passion and depth that these conscientiousness and skillful psychologists brought to intervention. They were honest in highlighting that responsiveness to suicide-ideated clients is dependent upon many factors. Caseloads that are manageable, in their control, with diversity for creativity and growth help psychologists in feeling that they can provide quality work and better responsiveness in their general practice and in suicide work. Employer support of suicide-specific supervision, collaboration and training helps to create quality in suicide work but more safety is organized for the client. Self-care and support of help seeking, as part of self-care, is not just up to the psychologists. Stigma in mental health prevents activation of supports for psychologists. Removing stigma
allows for better mental and emotional health and processing of difficult events.

Employers must generate increased access to supports for psychologists to be cared for and remain healthy in their practice. Encouragement of self-care, therapy, or mentorship supervision that allows for growth is important for quality of work and in anchoring responsiveness in suicide work. Having room to be human and grieve allows psychologists the time to process client loss through suicide.

**Narrative Emerging Themes**

**Professional quality of life**

Emerging themes that developed related to interviewed psychologists’ professional quality of life, specifically feeling a level of satisfaction, were numerous. It was noted that participating in and supporting client progress and identifying their growth creates satisfaction. Receiving feedback from clients was noted to be satisfying as well. The theme unravelled that collaborative work within teams promotes satisfaction and allows for increased capacity to do better work as teams offer perspective and support. Psychologists expressed that having control over their workload, including number of cases, control over their tasks, what kinds of client presentations they worked with, and diversity of psychology work throughout the day increased their sense of feeling satisfied. Adequate opportunities for training were noted to improve satisfaction and quality of work.

Lean initiatives were identified as not improving quality of psychologists’ professional life but, instead, creating dissatisfaction as narrowed mandates appeared to prevent positive engagement in client needs, workloads were strained, opportunities for collaboration scrutinized, and pushing for tracking of numbers rather than the pushing
for importance of client engagement. Another theme that was revealed related that personal losses were identified to change the quality of professional life. There can be learning with increased desire to grow and learn but in some cases there could be pressure placed on the satisfaction and work quality.

**Self-care**

Regarding self-care of psychologists, themes emerged identifying that: self-care is essential for good physical and mental health and the resulting quality of work that psychologists produce improves. Psychologists primarily seek self-care independently. Conventions for creating space in the work environment to support self-care are limited. The theme unfolded that employers need to create supports and advocate for psychologists to have increased opportunity to access self-care in order to generate the quality of work anticipated of them.

**Supervision needs**

Themes emerged that identified that supervision needs are essential for the growth and development of psychologists, not just when new to a career but along a developmental trajectory throughout their careers. Lack of adequate supervision in psychology practices was observed in both private and public-funded settings. Specific to supervision for suicide work, a theme revealed that there was limited discussion and support in this area.

It was noted that such supervision in suicide work would be imperative and that not all supervisors are approachable, or therapeutically able to offer suicide work supervision. Supervision, when identified as positive and encouraging, was observed as improving psychologists’ satisfaction and the quality of suicide work.
Suicide work has an impact

With regard to emerging themes that were highlighted regarding discussions of suicide work, it was observed that suicide work was described as frightening at times, and the toll of the work can be unsettling for psychologists. Suicide work was identified as requiring more time and detailed effort than other work. It was observed that suicide work had an impact on the personal lives of psychologists, where thoughts of client work can become part of after work hours. Client suicide could generate excessive hours being worked to ensure ethical care was in place and employers did not necessarily recognize the extra efforts.

Self-doubts related to suicide work were described as being present within psychologists. Insofar as suicide work was identified as stressful, it was also noted to be a place of hopefulness where lives and realities can be positively impacted and improved. It was identified that younger psychologists may experience more distress and challenge in providing suicide work. There appears to be an increased sense of overtness or openness around suicide work, or at least increased public awareness and more talk. This is not to say that there is more help being activated necessarily.

Lastly, there was an emerging theme that suicide behaviour should be anticipated in mental health populations. Subsequently, psychologists should prepare themselves because they work with a population where there is an increased likelihood that there will be suicide deaths. This reality of the seriousness of suicide work having a potential death outcome was observed to be sobering.
**Suicide-specific training**

An emerging theme highlighted that suicide-specific training was very necessary to generate ethical and quality suicide work with appropriate responsiveness to suicide-ideated clients. Suicide work required involvement from informal and formal external resource supports so that clients are adequately connected to other helpers for optimum safety.

**Post-suicide supports**

Following client suicide an emerging theme highlighted that psychologists need to acknowledge and be given the opportunity to grieve. As a result of the client suicide, the thoroughness of the psychologists’ work increased. Professional doubts around effectiveness in suicide work were identified in the psychologists who experienced client suicide or they second-guessed how they had dealt with suicide behaviours. It was highlighted that employers could advocate for the needs that are necessary to create post-suicide support for psychologists whose client had died. Organizations were identified as being solely focused on the legal concerns resulting from client suicide but were not identified as supportive to psychologists who experienced client suicide.

**Stigma, a barrier to help and support**

The emerging theme of fear of judgment and stigma was highlighted as a barrier for psychologists to access help from their supervisor. Barriers to therapy seeking were identified related to: bias being present because of relationships being previously developed with psychologists; small community settings prevented confidentiality; and fear of judgment regarding lack of capabilities and reduced professionalism in the
psychologist who seeks support. Stigma prevented psychologists from accessing personal therapy for help related to stress or mental health issues.

**Themes spiral and undulate**

It should be noted that themes spiral and undulate - one moving fluidly into the other and, at times, there is connection and overlap. The following table offers visual support of the themes outlined previously.

Questions and the responses around psychologists’ satisfaction, self-care, supervision, suicide-work, suicide-specific training, post-suicide needs, and the influence of stigma and support have been summarized to provide a brief overview.
Table 12
*Summary of emerging themes from interviews*

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<tr>
<th>Professional Satisfaction and Work Quality?</th>
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<tr>
<td>Client progress creates satisfaction.</td>
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<td>Collaborative work creates satisfaction.</td>
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<tr>
<td>Control and lack of control over workload affects satisfaction.</td>
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<tr>
<td>Control over diversity of work is satisfying.</td>
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<tr>
<td>Training improves work quality.</td>
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<tr>
<td>Lean initiatives are stressful.</td>
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<td>Personal losses affect work.</td>
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<th>Self-care?</th>
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<tr>
<td>Self-care is essential for good physical and mental health and work quality.</td>
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<tr>
<td>Self-care is self-sought.</td>
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<td>Employers need to support psychologist self-care.</td>
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<th>Supervision?</th>
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<tr>
<td>There is a lack of supervision.</td>
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<tr>
<td>Lack of suicide work supervision is/would be problematic.</td>
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<tr>
<td>Supervision, when positive, improves quality of professional life.</td>
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<th>Suicide work?</th>
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<tr>
<td>Suicide work is frightening.</td>
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<tr>
<td>Suicide work requires more time and effort.</td>
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<tr>
<td>Suicide work impacts personal life.</td>
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<tr>
<td>There is self-doubt in suicide work.</td>
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<tr>
<td>Younger psychologists have more challenges around suicide work.</td>
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<td>Suicide work is stressful.</td>
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<td>Suicide work is hopeful.</td>
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<td>Suicide work is more in the open.</td>
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<td>Suicide behaviour in mental health should be anticipated and prepared for.</td>
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<th>Suicide-specific training?</th>
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<tr>
<td>Suicide-specific training is necessary.</td>
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<td>Suicide work includes informal and formal external supports.</td>
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<th>Post-suicide?</th>
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<tr>
<td>Client suicide creates grieving.</td>
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<td>Client suicide creates increased thoroughness.</td>
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<td>Client suicide creates professional doubts.</td>
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<tr>
<td>There is a need for post-suicide supports.</td>
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<td>Organizations, post-suicide, are not supportive of psychologists because they have a legal focus.</td>
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<th>Stigma and support?</th>
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<tr>
<td>There is stigma to access supervisors’ help.</td>
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<tr>
<td>There are barriers to therapy.</td>
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<td>There is stigma to access mental health therapy or supports.</td>
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Narrative Master Theme Development

The following narrative descriptive pieces also hold elements of my interpretation and continue to elaborate on essences. There is intention to create some organization in this section as well. Indented headings that are bolded represent my choice of wording that appears to match meaning from emerging themes that have now been examined more closely. Redundancy has been removed and larger meanings are represented in the headings. These headings are utilized as a guide for my collection of ideas to form master themes.

**Choice, control and diversity of work is important for satisfaction**

Developing satisfaction in the workplace was contingent upon a number of factors. Having some measure of choice over client presentation, control of when clients are seen and what the composition of the day looks like supports psychologists’ satisfaction. Variety of work within psychology practice and having the flexibility to meet the psychologists’ needs about challenge and creativity instilled a sense of satisfaction.

Having control over diversity of the work and balance of client presentations proved helpful for Veronica:

I like to have a good balance of different kinds of clients. I like to have a balance of clinical work, seeing people, and, where I also get to do writing in reports, do assessing but also doing a variety of activities. For me, I like to do groups. I like to do individual work. I like a variety of things. When I'm doing one thing, one type of clinical problem over and over and over again I find I get burnt out
or I get bored…It's too repetitive, too much of the same thing for me because maybe overall I start thinking, “I'm feeling not satisfied”.

Interesting challenges, variety, building mental flexibility and utilizing a diverse skill set allow for good health in the work environment. Balance is key.

Wilma indicated that balance, although challenging to maintain, at times, was also a focus in her work-life to ensure she felt satisfied:

I put myself in a weird position because they like counselling and I like assessment…I don't think I can do straight assessment because I miss that face-to-face client contact and seeing growth and that work done. But I just love assessments. I don't think I could just let that go because it's so fascinating, right? So I just think it's the best of both worlds if I can figure out how to manage it properly.

The humour in Wilma punctuated her last comment about how to manage. There is challenge that comes with diversity. Her employer values her desire to have diversity and Wilma recognizes that she has to put energy into ensuring that her driven style does not allow her to take on too much. Diversity of the work is necessary for growth and there is the challenge of balancing workload particularly when there is opportunity for numerous ways to engage work. Being able to have that flexibility was a source of freedom and enjoyment for Wilma. Freedom in a work role allows for increased quality in how she experienced working. This freedom allowed her to appreciate her employer. Freedom affords a measure of control, which, in turn, offers work-life balance.

Zena observed that balancing varied client presentations and controlling times of direct client contact is helpful to her satisfaction:
Balance between even, in a day, report writing and how much contact there is. Then type of clients and services I am offering, in terms, of having a balance of them, so it is not… I try not to only see anxiety, or, only see depression I try to balance a range of clients.

Balance and freedom about contact, time to write, and services offered allows Zena to have control as well. Shaping the caseload and the day based on client presentation was also helpful for Zena so that she had variety and challenge. Quality of work grows where diversity allows flexible thinking. Being able to think and to have room in a day to manage whom and what work is engaged matters.

Professional and personal satisfaction is contingent not only upon control over caseload composition but also the volume of work to be managed and how many cases one has to be mindful of. Control over caseload numbers allows for an increased sense of calmness, of not feeling stressed. Taking on too much offsets the ability to feel good professionally and personally, as Yvonne notes:

It helps to feel, not stressed…like you have some control of what comes onto your caseload, numbers, and when you take on things. You can manage better when you have some sense of control - feel better too, professionally better, and personally.

To feel stressed as a result of too many numbers or too many of a particular type of presentation saps energy and wellbeing.

Creativity also lends itself to a sense of wellbeing. The dynamic of balance and diversity along with cognitive challenge and rising to the needs of the client based on
formulating and knitting together various hypotheses was important to Xandra in activating her logical, emotional and creative mind:

It depends on what you are doing as part of the day. I don’t do it as much now, but, my previous job, I did a lot of court reports and I quite enjoy using that other side of my brain and thinking and putting information together and processing it and putting it together to form my hypothesis whereas when you are in counselling, it is much more instantaneous. You have to do that and I like both. I truly enjoy both. For me satisfaction in counselling is that idea of having to think on my feet and having to gather a lot of complex information particularly if you are working with couples there is a whole other dynamic where you have to manage all of that. Lots of things to manage all at once but I enjoy the challenge of that, thinking on my feet.

Xandra’s need for variety challenge was strong but the demonstration was for control of the challenge, so that it is satisfying – unlike a demand to do work that she had no control over.

**Client growth and positive outcomes generate psychologist satisfaction**

Satisfaction in the work develops when there is progress for clients and feedback that demonstrates movement toward the collaborative goal established between client and psychologist. Zena highlights how making a difference is the intrinsic motive that drives her to psychology work:

I guess it is having the satisfaction of really knowing that I can make a difference. Being able to do what I am doing. Just knowing that I am helping people reach their goal and so that is real and what drives me at work.
It is real and fulfilling and satisfying to see goals met to have a sense of accomplishment.

Seeing goals met is satisfying. Allowing families and individuals to understand their situation and be understood is as important as reaching a goal. Recognizing that the work provided has been a good service where there was a positive potential outcome provided, with meaning and understanding, provides satisfaction as Yvonne notes, “When you feel like you've done good service or you get kids the services they need when you get them connected, when a diagnoses leads to something positive, not just a label, when you make connections with families.” Connections to resources or to opportunities are powerful and life changing.

The awareness of connections and opportunities may or may not be identified when a diagnosis has been provided however direct feedback from clients can provide a depth of understanding that provides a sense of satisfaction as well. Client age, development and ability may change the manner of feedback provided to identify progress, as Xandra observed:

Of course, it is when you are getting good feedback from clients, expressing appreciation, expressing they felt understood, particularly if they come back, when you see them again and they have spent a lot of time talking about what we have talked about and thinking about things we talked about in the previous sessions. Yeah, I would say it is much easier to get a sense of satisfaction working with adult clients as to adolescents. Certainly you don’t get that immediate feedback to the extent that you do working with adults, which is for me why it is nice to have a mix.
Rapport of shared meanings and assisting in perspective and possibilities is important to allow client’s to feel understood and genuinely cared for. To be understood is healing – to know you have understood, and it mattered, is satisfying.

The psychologist becoming aware of client change, resulting from the client reports of using new tools and strategies is affirming. The increasing sense that clients feel understood also builds satisfaction in quality of professional life, as Wilma acknowledges:

I think when I see people make positive change that definitely reaffirms for me that I am where I am supposed to be and it's just fantastic. Right? When you see...they are taking their tools and using them. It's just, it's fantastic and then I just even think with some of the assessments I do and parents feeling like it just takes weight off because they understand and somebody's trying to help them…those pieces. I think helping people and knowing that people are working to change themselves and feel appreciative for the work that you are doing. That definitely builds into the quality.

Knowing there is appreciation for the work done as a psychologist is powerfully satisfying and builds into the quality of professional life and, in turn, the quality of the work done. Affirmation of what is working allows for the desire to follow up with more positive work.

**Collaboration is helpful to psychologists’ growth and quality of work**

Collaborative learning alongside other colleagues is also a place to develop professional satisfaction and afford improvement of the quality of one’s work. Learning from clients’ progress is also a point of professional satisfaction, as Zena notes,
“Learning from other professionals. I have always worked on an inter-collaborative professional team so that is really satisfying from learning from other people and learning from other clients too. Learning from them as well.” Not working in isolation makes a significant difference to the quality of work. The desire to learn from clients reflects the ability to appreciate their wisdom and the possibility, through exploration, what their answers may be to resolve their struggles.

Collaborative efforts related to suicide work are helpful so that clients are more supported and psychologists are more balanced. While talking about collaboration as a supportive mechanism, Xandra made the observation that debriefing with colleagues is helpful related to suicide work, “…where you are working in isolation, you don’t have that. Luckily I still have colleagues that I can still access but I think that is very important to have that ability to debrief with other professionals about high-risk clients.” To be lucky to have colleagues, really suggests that working in isolation is challenging and the intensity of risky situations, like that of suicide work, increases. Debriefing allows for learning and for a more full awareness of what needs to be covered in suicide work. High-risk clients and high-risk situations are more stressful when working in isolation.

**Encouraging supportive supervision impacts quality of work**

Supervision being provided to psychologists that is encouraging, supportive and positive was helpful in increasing wellbeing and quality of work produced. Work balance and self-care when encouraged and supported by the supervisor allow psychologists to generate improved client service and responsiveness. Recognition from supervisors to be flexible and supportive, demonstrating care and respect for the
psychologists’ work balance, was helpful to encourage psychologists to invest in self-care which supported their professional satisfaction.

Wilma discussed feeling very supported in her workplace by her supervisor, as though there was strong camaraderie, “Our supervisors, I think, are very much along side. I almost feel like they are working along side you as your colleagues would.” Zena noted that interactive, supportive, positive and encouraging supervision helped not only her satisfaction at work but also the quality of her work:

I have received a lot of supervision through the registration process and throughout all the practicums I’m in. Good, interactive…like, supportive and positive and encouraging supervision, just, really makes a difference, too, I find and even seeking that out that certainly influences my quality.

Zena would seek out that style of supervision she thrived with in order to have the sense of improved work quality. At times she would seek out mentors in her work place to get what she needed in terms of feedback and support.

Wilma noted that supervisors that attend to and encourage balancing self-care within work is helpful, as she sometimes could allow herself to overwork:

I know that supervisors constantly remind me to watch my schedule and lay off, if I am looking overworked, which is good. Because I think, often times, I, myself, put me in that position. It's not my supervisor saying, “You got to do what you got to do!” More, it's me saying, “Oh, but I could do more - I could do a little bit here.” Then I get myself caught and then I try to go ahead with it, right? So, for me, it's finding that balance, right? So work is super-supportive
in that way - I’ve never felt the need to work harder than I am. If anything they are saying you need to watch and manage a little better.

There is the temptation to be driven and work too hard and reminders from supervisors, especially with highly autonomous and independent professionals, can prove helpful.

Veronica outlined how when she had limited room to take on work her supervisor was conscious of the need to share workload with the team, thereby supporting balance in the work and supporting her self-care needs:

I think that there is recognition, like my manager is very much aware. So there is definitely a recognition and an acknowledgment and thinking beyond that, there have been a couple of times where I said “I can't take another assessment” and, it's been, “Yes that's fine we will find so and so” and he has gone out to help with that as long as I ask.

This reflected that Veronica was conscious of the need to ask. Upon asking, her supervisor was responsive to her needs. This is an example of being supported in the boundaries that can reflect self-care, balancing a workload, so as not to become overburdened. Boundaries that consider the needs of the psychologist are a means to avoid burning out.

Managers support self-care when personal and professional balance through flexible work schedules is honoured. Yvonne, with respect to her quality of professional life commented:

One of the things I would say is having a manager who supports. Like I’ve asked for reductions in hours, come back to work less than full time so being
able to keep my position and have some flexibility in the number of hours I work has actually been really big in helping to find balance. Having the ability to control hours of work is helpful to manage personal and professional boundaries and create balance. Work and life balance is essential for satisfaction. Having supportive managers acknowledge the need for reduced hours, flexibility to navigate personal needs demonstrates respect and value of the psychologist in the workplace.

There is limited supervision and lack of support in organizations, particularly in suicide work

Lack of developed support structure for psychologists is noticed in employers and various organizations. Psychologists create their own supports when the employer, organization, or discipline does not create or acknowledge the value of supports related to discipline guidance groups, supervision, or practice leaders. Yvonne noted:

I don't have a psychology supervisor because of the structure of the workplace. There isn't a psychology-working group. I came from a residency…where there was a professional practice leader in the health region, so if you had ethical issues that a group met and it seemed really cohesive. A similar thing doesn't exist in this system so I think the things that exist are the things that you build, so with colleagues but, that's kind of self-created, that kind of stolen moments or an evening phone call, you know there's no protective time. There's no knowledge of that. I would say that I don't even think that that is a consideration from this standpoint. So if you need to do that you create it. You are finding it all your self, I would say.
Stolen moments from personal time or stealing from the workplace hours is where support is found. Rather than creating a ‘protective time’, a structure to acknowledge the need for support and protection of the valued efforts and energies of psychologists, some employers and organizations are blind to the needs for the collegial connection that allows growth and balance.

Some organizations, like the one Wilma works within are supportive, as she self-identified but she was sorely aware that this is not the larger picture of workplace dynamics. Wilma was very conscious that not all psychologists’ have the experience of support that she has had, “I think outside of this organization, I have heard talking that says it is not as supportive, that the support is not there.”

Yvonne questions whether the discipline of psychology or regulatory bodies should examine the lack of organization around formal support mechanisms for psychologists, “There's no mechanism to formally have a conversation about that. I don't know. Maybe as a discipline we are disorganized.” Formal support mechanisms should be organized but money is a bane of this issue.

Limited funding appears to be part of the struggle around adequate supervision and employee resources, as noted by Veronica, as she has had to ask for help to deal with her workload:

‘I need some help managing this…I need this many days to catch up on this…or, can somebody please help me with this?’ You have to ask. If possible that help would be done on a long-term basis. Not really here, you get a short-
term quick fix, but it's really not how I would like to see it, it could be better. I think it is resources, a lack of money for someone to cover for you.

Psychologists are working short of adequate resources. Being spread too thin reduces satisfaction and does not allow best quality work. With suicide work, lack of quality may create dangers.

Supervision limitations, specific to suicide work, are particularly problematic, as identified by Zena:

In our organization, our managers aren’t necessarily trained in the same area. So they might have never even have worked with someone, had any experience with someone with suicidal ideation or behaviours and they are not therapeutic supervisors. They are more managerial, in terms of, doing the books. They are more personnel management as opposed to professional support.

As a result of this lack of support, Zena sought help about her suicide work and engagement with suicide-ideated clients through colleagues whom she trusted within agency. Zena stated, “It was never with colleagues on my team but just someone in the agency who has an influence on my practice and who I looked up to and who I felt they had lots of experience with this clientele.” Again, Zena highlights how mentoring is sought out as a result of her own awareness. She identifies she sought out trusted colleagues who were influential on her practice, individuals she aspired after. Zena self selected who she would go to for supervision. When her supervisor and team were not able to help in suicide work to a degree that afforded her comfort, Zena had the savvy to seek out support and leadership. Some psychologists may have that ability to know what they require for growth to improve the quality of their work. Zena seemed
particularly confident and strong. It is unlikely that she is representative of all psychologists.

Mentoring and guidance through supervisors, colleagues, or, teemed casework is helpful. Wilma made this observation about accessibility to seek collaboration with her supervisor and colleagues to gain perspective and clarity in her work:

Like she's there, she's easily accessible and easily able to talk to. You can sit down and talk with her and you know she's reaffirming, or, she's giving you some other pieces to think about or to look at. She's just there and, the same with my colleagues…right? Even easy to access when we’re not busy because we have time to collaborate.

A rapport and connection with colleagues and supervisors creates comfort and safety to discuss needs without judgment. Work environments that have supports accessible and one need not ferret them out, as Zena had to, demonstrate insight about psychologists’ needs and are respectful of the intensity of suicide work.

The sense of isolation that Zena identified related to having to seek out guidance and supervision was a shared sentiment. Xandra observed how psychologists, by the nature of their work roles, tend to work in isolation:

…we have colleagues but at the end of the day, unless you are doing co-therapy with somebody, it is very much working in isolation.

Suicide work cannot be done in isolation as Zena highlighted, the work is too sensitive and outcomes can be detrimental.
Suicide work is demanding and pressured and, without balance, fatiguing

When providing suicide work, there is a need to create awareness around balance as the intensity and pressure of the work is strenuous. Zena recognized feeling pressure when providing suicide work:

My perception of the experience is that it is a lot of pressure to work with this population. That is the population that I have few clients in and those are the ones that I took it home because I worry about them because that is something that is serious and people do commit suicide. That it is a big burden I guess. Zena experienced thoughts of her clients entering into her after work hour’s thinking. Personal time and self-care would be interrupted. The worry is real but can be offset by reality of the situation of working in sensitive mental health populations with suicide ideation, where the odds are there may be suicide at some point in the psychologists’ career.

Preparation about the eventuality that clients may suicide is an important reality to be considered in psychology work. An uncomfortable awareness and uneasy acceptance of the potential for suicide allows for some perspective. Xandra acknowledges this, “Certainly I think we were always warned in this profession that likely throughout the course of your profession people are going to commit suicide and you need to prepare for that and to be honest the likelihood has greatly increased.” Xandra goes on to identify that even though she knows she should be prepared for the eventuality of suicide in a client, it is scary for her, “…it is sort of this ominous thing. It’s probably going to happen…it’s probably going to happen, and I guess we can talk then about ‘what’ happens. To be honest I’m not a hundred percent sure how I will feel
about it. I’m unsure.” Working with individuals in mental health who present with suicide ideation certainly increases the possibility that there will be the experience of client suicide, talking about the idea that it could happen, in terms of the odds, does not necessarily create preparation for the effects of client suicide. Dealing with suicide work has a scary underpinning. Death can occur.

Outside of mental health practices, psychologists are providing suicide work as well. Veronica observed that school psychologists and other professionals are dealing with suicide ideation and behaviours much more frequently, and noted that suicide ideation and behaviour appears to have increased, “But I'm thinking school personnel and paraprofessionals, as well, have to deal with that suicide ideation a lot more. That it's maybe just so much more common, more overt than it used to be, that part had changed.” This observation indicated a change in her awareness of who was dealing with suicide from the beginning of her career until recent years. More pervasive communication about suicide in varied environments requires more interventionists are trained, including school and other professionals. Suicide work is not exclusive to mental health and clinical practices. Opportunities to provide suicide interventions fall on school personnel and other front-line professionals and their ability to be responsive to suicide is a need.

Potential suicide work increases pressure of psychologists’ work, whether in schools or in clinical settings. The pressure pushes on doubts and fears in professional judgment. There is need to activate other external resources and involve supervisors. Wilma observed:
So I think that point has made me question other persons that I'm working with where I see there's a real need for further intervention [that] I can't provide outside of my session. Then I'll still go to my supervisor and say I don't know if this is the right call but, time and time again, I am reaffirmed after a talk with her.

Accessibility to a supervisor’s input is helpful to create ease when working through decisions around client safety. The supervisor would have to be readily accessible. Other external resources are also helpful to safety outside the session, as others know and offer connection with the client. Xandra noted that there are limitations to how much the client may connect and let you in, “I believe that even though we think we know our clients very well, not really.” This acknowledgement stresses that other resources, formal and informal make connections with clients and there is increased likelihood of safety if more are involved. Only a fraction of what the client experiences is shared with a psychologist. Potentially, each individual in the client’s life may have a different view of the client’s stress, strengths and experiences. With regard to suicide work, the more networking supports involved, the safer the client can potentially be. The stress of suicide work reduces as other resources can collaborate to generate more opportunities for safety.

Over time and with gaining experience, the stress of suicide work changes somewhat. A new psychologist may not be as prepared and practiced around suicide work and stress can increase. Veronica recalled her early experiences around suicide, “I started to look at myself to see it was much more serious and was much more stressful
in that time, back then, and maybe it is now that I am more experienced I handle it better.”

Xandra felt similarly about her experiences in suicide work at the beginning of her career, reporting:

…I think in the past there would have been a time where I might have been a bit more nervous when I just started practising and more freaked out about it. It’s more like anything you face, you face, head on. You have much more control and ability.

Until such practice and experience has been accumulated there is the need for more help and supervision so that the new psychologist has the support to manage the emotions suicide work provokes. Fear, left unmanaged in a new psychologist can bode for a significantly reduced quality of work-life and potentially can cut into personal time.

Suicide work requires detail in planning and awareness of boundaries. Utilization of external resources, formal and informal, is important so that there is balance. Wilma made this observation about the extra demands of suicide work:

…there’s definitely clients that I meet with and then I am sending off to the hospital and, for me, following through and checking in and making sure that they follow the plan and how I can be of support outside of those sessions that I have had with them. So that is definitely demands that are beyond face-to-face and writing your notes…you are on the phone checking in…parents need that extra support. It is learning to set boundaries because of parents feeling in crisis and needing that access and immediate access. Being able to support them but identifying that there are boundaries and that there are times when I can’t
support them. There are times when they will have to access other supports if needed outside of my time. So I guess the nature would be the parents but also my clients that might be suicidal and that is…they are more demanding in that way.

With details and planning and then potentially working independently there is a burden of energy loss, a risk is run for fatigue. Xandra outlined that for her a great deal of energy is spent in managing suicide work by the end of the day:

So having said that, we work in isolation and I don’t know what it is like for other people but I give a lot of my resources internally certainly by the time I am done my day, I can be ready for bed within an hour. I am not exhausted when I am done with a client. Usually I am feeling satisfied, like we did some good work and that’s fine but then my brain and body knows that I don’t have to work anymore I just shut down.

As much as good work can be rewarding and the client interaction satisfying, the mind and body is spent after intense work focused around suicide.

**Suicide-specific training is limited in workplaces and training programs**

Having adequate training offers the opportunity for some ease as increased awareness of how to provide ethical and responsive suicide work affords peace of mind. Suicide-specific intervention training is described as being limited in workplaces and in university training programs. Yvonne noted that in her graduate level clinical psychology program her suicide-specific training was very limited:
… in my M.A. days. I think it was my first practicum experience, which was more of an observation experience. We had virtually nothing formal in Grad School. I had a supervisor managing a client who had attempted suicide. It was a very peripheral experience because I was a student so I didn't have a lot of ownership.

The experience was observation and not practical. Doing is most often highlighted as being the gold standard of learning. As observed by Xandra when she volunteered the influence of taking ASIST training, her practice therein allowed her increased comfort:

To be honest, that [ASIST] was a really good experience to have gone through that and have to train others that it really gets you a lot more comfortable asking the questions about suicide because to be honest, we get really little training in our education about it, even when you come on to the workplace. I have to say there is not a whole lot of suicide specific training. So, for me, now, I am actually very, very comfortable asking about suicide, asking about people wanting to die. I am not shy about it.

The training provided the confidence to talk directly about suicide and ask directly about suicide, creating comfort to do so.

Veronica outlined her experience with suicide intervention training and also noted that the longest training she had in her formal and career training was ASIST, a two-day training on intervention:

I mean I have other kinds of training like to be trained in CBT and nonviolent crisis interventions, all these things and I do have a variety over suicide risk assessment training that I've had over the last 25 years and I may not remember
them all by any means…we do have the ASIST program, as you know. So we do get trained and updated with that. I have had various other ones that I had the two-day, ASIST training, and it was the longest that I really had ever done. A two-day program is the longest suicide-specific training provided. This was noted in both a clinical and an educational psychology master program, as compared respectively by Xandra and Veronica.

Zena noted her level of discomfort in working with suicide despite having worked with suicide behaviours ongoing and having a graduate education, “I find I will go seek some kind of consultation to make sure that I am on the right track…” Consultation, regardless of training, is still necessary to support psychologists providing suicide work.

**Lean changes have been challenging to psychologists’ sense of control**

Caseload volume, composition of caseloads, lack of control over referrals, transitions to the Lean approach, and lack of support influence fatigue in psychologists. Zena made this observation:

Yeah there is all those externals, not controlling, not being able to control my cases. Not having control of who comes in the door, who I will be seeing, not having the support from colleagues or from supervisors for sure and the organization that I am working for is making big changes, Lean changes, that everyone has to go along with but are not having a positive impact. It’s not the clients but that other stuff is what affects fatigue.
In organizations providing Lean streaming, to accommodate clients needs, there can be a push and pressure placed on psychologists to extend past their comfort around work hours. Zena noted:

I think that the organization would have a huge impact on someone’s satisfaction and fatigue because the work organization makes so many decisions for you. Again it goes back to they decide how many clients you get and if the support isn’t there, in terms, of your own immediate supervisor to set those boundaries, which can be difficult. If the support is there then you leave at 5 or work a set number of hours a day but if there is pressure, or, a push to do more, work longer hours, offer after hour service.

Needing to work into evening hours cuts into family and personal time and self-care suffers. Having limited choice, in addition to little support for protection of needs, a role a supervisor would play out in advocacy, the psychologist is under more pressure.

Doing more work over longer hours and dealing with mandated care pushes against the provision of ethical caring. Veronica made this observation regarding the pressures of Lean:

There's just a heavy, heavy workload and lots of paperwork demands and lots of new Lean initiatives and demands placed on you without losing things. It is making me very tired. So I find that those particular areas, there are a lot of new things coming on but I don’t find that things are being taken away.

Balancing more and more demands affords less and less time with clients.

Veronica went on to identify that having so many demands, along with few resources, reduces the time to focus on client activities leaving suicide work demands
either incomplete or pushing her into a position where she feels that her work is suffering, and quality of satisfaction is reduced:

So when I have to do all these other things, I can’t do that yet, that’s what needs to be done for these clients - that tires me out. Like I said it’s a lack of resources. I find that frustrating, and, again where I feel dissatisfied that, I’m not doing as good as I can be.

In this case Veronica worries that suicide work details that support the needs of clients are not adequately being managed under duress of time and lack of work supports. Money has become a barrier to people.

The idea of ensuring that clients are getting their needs met and being treated ethically, as individuals with individual needs, is satisfying to psychologists. When it appears that clients cannot be served well through a mandated program there is frustration. Yvonne made this observation:

This whole movement is in the health region towards the Kaizen efficiency. That whole philosophy, that whole approach is very much looking at data…how many clients you see in a day…what your wait list is... Managers are much more interested in your wait list, in your numbers of clients you see, the number of visits you have and so when you are perceived as having work that is out of the mandated program, there is a very strong encouragement to move that on. Which would fit really nicely into Kaizen model because it creates efficiencies within the system and I mean there are pieces of that whole philosophy which I like and that philosophy is built in an assembly line. It's not human beings with more complex needs. Anyways, that, to me, is frustrating.
People have complex needs. Both the clients and the psychologists are complex and are not as simplistic as mechanisms in manufacturing. Suicide work is unique and has an impact on personal lives of psychologists.

**Suicide behaviour intersecting psychologists’ personal lives has impact on practice**

Despite training and ongoing professional work with suicide, the manner in which suicide influences the psychologist in their personal life is still very real and pulls up from the depths of the psychologist a sense of discomfort and fear. Doubt and helplessness can play on their thoughts:

So someone in my family who has attempted and goes through bouts in time where he is suicidal and so as a family member, I feel much less helpful. I feel that I am not actually nearly doing the right thing or as helpful as I am in my professional life and that's probably because of the relationship and what I can offer and can't offer and all those dynamics and it makes good sense. I know I feel that way. I feel like as much as I think I am doing what I can do, it feels like in that situation it is never enough. Right?

Veronica went on to outline that she has increased expectations of herself to help around suicide with her family member. Family have excessive expectations of her to do more because of her professional abilities:

I feel like maybe I should have done more and I need to do more…it comes from my family as well…so it's kind of like you can never really do the right
thing. That’s kind of the idea, or, maybe I am seen as the person who needs to do it all.

Personal lives of psychologists are not necessarily their own. Family and friends seek help about their emotional pain. Working with stress and personal losses creates an impact that bridges into professional life.

Having personal losses to suicide can create distress and can tune up awareness and increase the seriousness with which suicide work is acknowledged. Personal losses, such as death of a loved one, can create the motivation to work as suicide interventionist. Wilma outlines the impact of her loss experience and the subsequent learning:

In a situation that I couldn't help essentially and now ultimately, I have made it like my life goal to help other people in that situation…Sure maybe because the personal experience that I did have, I understood the seriousness of it to begin with, so when you have clients that come in with suicidal ideation and they do have plans, and there is no way of contracting and there's no hope for them at that point I really don't care if the parents don't want to take their kids in to the hospital and understand that I'm especially working with adolescent population who's impulsive you have to do something - you need to make sure that they are safe. It’s scary. So for me I don't know that I've never not taken this seriously…

Desire to make a difference as a psychologist, increasing safety and intervening with suicide and activating necessary resources when safety is a concern are intensified as a result of the impact of a family member suiciding. Feeling the danger, having
experienced suicide as an insider increases the understanding and the motivation for suicide work.

**Stigma is a problem in accessing support, therapy or supervision**

The community of Saskatchewan is small. Many psychologists know one another and there is fear that there will be a lack of non-bias and concerns around confidentiality should there be effort to seek out a therapist. As Yvonne puts it:

Well, it is a small city so my being a psychologist and to me one of those first barriers is who do you go see if you're having really significant mental health issues? Who do you set out to that you don't already know on an acquaintance level?....It's the confidentiality, not that I think it's a one off and it was a bad experience but I think it really makes you cautious as to who is booking the appointments and who was phoning and following up.

Concerns extend to leaving messages and fear that colleagues in a workplace might identify that the psychologist is seeking out mental health services. Stigma is a powerful deterrent, so much so that a psychologist may avoid seeking services despite need.

Stigma and judgment can come from others in the profession as well as from the public view. As Yvonne noted, “Well, why would a psychologist need to go see a psychologist, right? So, it's still the stigma of mental health services.” Mental health has been stigmatized for years. Although progress is being made for the public consumer of mental health services, there is still the question about the capacity of the psychologist who may have need for support around their mental health needs. Seeking
therapy is not always about mental health illness, or incapacity. Sadly, this is a generalization made from stigma.

Veronica made this observation about judgment from colleagues or even self-judgment related to requiring emotional or mental health supports:

Absolutely and I hate to say this but it is so true, when professionals, themselves, have a mental illness, let's say they themselves struggle with a chronic mental illness or a situational one I see this mix of support for them and a lot of time, in patients, there is a lack of acceptance for that. You're stressed out and I don't find it always that supportive and that is very disappointing to me considering we work in the field. Again there is even more stigma if you are a mental health worker to then have a mental health illness, sort of, “Why couldn't you have stopped it…couldn't you have prevented it…couldn't you have seen it coming?” I think that it is another thing and that is a stigma and I do see it and it would only take one comment, or something from somebody, that would make somebody else think if it would happen to them why would I say anything about that?

Having psychological knowledge means, somehow, that the psychologist would be impervious to being influenced by stressful situations, relational concerns, experiencing traumatic events, or somehow averting dispositions genetically for development of illness. Fear of judgment creates a barrier to seeking help.

Younger clinicians may be more wary of seeking help out of fear of judgment or fears for the security of their job. Veronica remarked about the vulnerability of younger
clinicians, “If I had that insecurity when I was a younger clinician, or something, I think I would be very careful of who I was talking to.”

Xandra also recalled the pressure she felt when she was new to psychology:

As I reflect on that more, I think I may have thought more when I was younger and less experienced. That may have been my own self generated fear that, “Oh my God I can't admit to having problems because what if I don't get work?” But as I have gotten more comfortable, I guess in my professional world, I have no illusions about my challenges, my personal challenges I have.

There is undue pressure on psychologists to be without problems, which may seem more daunting to those younger or inexperienced. To find a confidante is a challenge as there could be judgment and lack of understanding. Xandra remarked:

I think a lot of people in this profession feel pressured to have our stuff together, “Oh my God, how could you possibly ever give somebody else advice if you don't have your life together?” So I think if you have not found a trusted colleague, have never been lucky enough to find one of those, I think it's more difficult for health care providers to seek help and to acknowledge that they need help because they may be that fear of judgment by other colleagues.

Choosing to talk to a colleague could be a challenge if you are uncertain whom to trust.

Despite the open acknowledgement that psychologists must take care of their own mental health, there is a strong awareness that there may not be services being accessed. Wilma observed:

So that I'm always aware of, I know that the stigma of mental health with a psychologist…and, then a psychologist also needs to access help. I don't think
that people, psychologists, are accessing it. I think that maybe some are…maybe. I think that how help is being accessed is by going to the gym with your colleagues. My guess is that that is where they do get support will be the people that you work with. Hopefully it's a supportive environment because if it's not…then what?

If there is not a supportive environment in the workplace, Wilma went on to identify:

Then I hope they are not burning out. I hope that they're not overtaxed because she thinks that as a psychologist that you have to have it all together…It's like you're putting on a show because you are a person but you are a psychologist. The idea of being a fraud is brought forward, in that you cannot be a person with needs for help if you are a psychologist. Otherwise you are a fraud – not worthy of providing true psychology work.

Being honest about needing help around emotional or mental health issues is not accepted and so, it would be easier to state a physical health issue, to avoid scrutiny. Yvonne observed that some mislead those at the office for self-preservation, “Or, you call it something else because it is way easier to be off for three weeks.” When it comes to needing help with work through supervision, there is also the idea that there is weakness in asking for a supervisor to be helpful, Zena outlines:

There is a perception that when you get to a certain level you no longer need support. That is usually a bit of a weakness as opposed to a strength to know when you need support and to ask for it. There are just no external organizational supports for that.
Organizations and employers can strengthen the workplace accessibility to support for psychologists. The stronger psychologists are in the quality of their work and the quality of professional satisfaction, including well supported through team collaboration, supervision, or therapeutic help, the better clients will be served.

**Psychologists require additional support following a client suicide**

Client suicide is identified as traumatic and entails special consideration for the psychologist in order to manage their very human reactions to the death. Veronica outlined that the supervisor needs to meet with the psychologist and offer support while explaining the upcoming process:

Well I think first of all acknowledgement and a plan from your supervisors that it is a very traumatic thing for them and to give them some time off for that. I think it should be an automatic thing. Whether a person wants to. To me it is very traumatic thing when you're working with someone and they die by suicide. I mean there is that acknowledgment that happens now but I think there should be something beyond that. Just sitting down and having a meeting and letting them know that you support them. It is because you know there are going to be questions and inquiring. You are going to be looking at the file and there's going to be a lot of that. You know that I was going to be happening and that person is going to be questioning if they need support and maybe offer to give them the name to see somebody if they want to go talk to a counsellor or if they need some time off. I think even just saying to them, “Have a day.” Where they say, “I want it” or “not” - it's a good thing. We acknowledge that it is difficult and
whether you need it or not I would like to give that to you or maybe options of what they would like.

Taking time off is seen as necessary and acknowledging special self-care needs of the psychologist or specific needs of the psychologist in the work environment is imperative in allowing room for the psychologist to strengthen following a significant emotional loss.

Grieving processes need engagement by the psychologist when there is client suicide in the same way anyone would grieve the loss of a connection with another human being. Veronica noted it being a necessity to talk about the client with a colleague, understand more about the circumstance, make the connection with the family and have resolution through the funeral. The processing of grief allowed her to move forward:

…we could both reminisce about him…So that helped. I think it took a while to stop thinking about him when we heard what happened. I think going to the funeral and then getting to see the family and everything was really good but of course really hard… I think that is getting information and finding out a bit more about what happened and letting that clinician get more information and letting them have time to do that and connect to families and go to funerals.

Allowing closure to form is part of the process of talking through the loss, releasing the individual through the formality of the funeral, and gaining understanding of circumstances around the death allows for the mind to settle, learn and grow.

Veronica noted that organizational recognition and support for the psychologist in the event of client suicide should be an automatic response. Zena sees this similarly
and identifies that engaging self-care, gaining support from colleagues who have worked through a client suicide, and accessing therapy would also be means to deal with client suicide:

Support from organizations and colleagues or who ever they are working with would be huge to have that support and I think talking to someone who has been through it, having access to talking to another psychologist who has been through it and… seeking out therapy would be a good support and making sure to keep on track with the self-care and the thinking, getting, catching, those thought distortions.

Distortions around efforts to care give and intervene with suicide can create doubt in the psychologist.

Taking time to process the suicide and the effects upon the psychologist are essential. Wilma considered a personal loss of suicide in her family and went on to outline the need to process feelings to be cognizant of how work would be influenced:

I think that to experience the client’s death you would need to process a lot of your own feelings and emotions and identify how it would impact your work...I know how my personal experience has impacted my work, so, professionally how does that experience impact you and what you do and then does that create a greater risk factor for you for and just mental health struggles. Does that create something and how can you protect against that? You suffer from that if you aren't able to cope with that and you end up depressed. What supports can you access? How does it affect your future work? It would impact your work. It would have to have an impact, especially the work that we do because we do
work with people. You can’t just not let that affect you - somehow. You can
deal with it and you can work through it I think. Like, it can be worked through.
I don't think that is the question. It is just that having a support to be able to
work through it and make sure you are feeling supported and helped through it.

Being human comes first. Psychologist comes second. To be able to work through
grief needs to be honoured so that work quality does not suffer.

There is awareness that recognition of being human and needing support is
sometimes not recognized. Support mechanisms are missing in some organizations.
Xandra, when asked about supports related to client suicide, noted that there were not
supports unless the psychologist forged personal connections with colleagues, “My
perceptions are that they [supports] are only there if you are making them and you make
them through your own personal relationships forged with other colleagues.” Xandra
went on to identify that the organizations do a file audit and the process is not
supportive of the psychologist, she explains:

…[the] file is audited and they want to make sure that you do everything that
you’re supposed to. That is what I have heard happens, not so much that
someone goes to be supportive necessarily…So my perception of that, is that it
is more about covering the agency, more then caring for the clinician…

Supportive mechanisms for psychologists are seen to be necessary but not currently
well organized across all organizations and employers. The effort to investigate the file
is set up to offset legal concerns against the organization or employer, while the
psychologist is left to find their own supports. Again, being real and being human
needs to come first, so that being well cared for by the employer can yield psychologists who are well and healthy to provide suicide work.

Master themes have been outlined in summary and are identified in Table 13 that provides an overview of the interviewees’ shared experiences.
Table 13

*Interview Shared Experiences Master Themes*

<table>
<thead>
<tr>
<th>Interview shared experiences master themes</th>
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<tbody>
<tr>
<td>1. Choice, control and diversity of work are important for satisfaction.</td>
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<tr>
<td>2. Client growth and positive outcomes generate psychologists’ satisfaction.</td>
</tr>
<tr>
<td>3. Collaboration is helpful to psychologists’ growth and quality.</td>
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<tr>
<td>4. Encouraging supportive supervision impacts on quality of work.</td>
</tr>
<tr>
<td>5. There is limited supervision and lack of support within organizations, particularly in suicide work.</td>
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<tr>
<td>6. Suicide work is demanding and pressured, and, without balance, fatiguing.</td>
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<tr>
<td>7. Suicide-specific training is limited in workplaces and training programs.</td>
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<tr>
<td>8. Lean changes have been challenging to psychologists’ sense of control.</td>
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<tr>
<td>9. Suicide behaviour intersecting psychologists’ personal lives has impact on practice.</td>
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<tr>
<td>10. Stigma is a problem in accessing help, therapy or supervision.</td>
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<tr>
<td>11. Psychologists require additional support following a client suicide.</td>
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Qualitative Findings

Over-Arching Themes

Over-arching themes are discerned based on the overlap and replication of meaning across interview and survey open-ended responses such that a higher order of meaning develops (Fereday & Muir-Cochrane, 2006; Smith, et al., 2009; Tesch, 1987). It takes time to think through survey responses and their emerging themes and master themes. Then consideration of the interview stories and the emerging and master themes therein takes time and energy again. Converging the two sets of information was reliant upon my understanding, connection to and interaction with the survey participant responses and interview participants. Development of my interpretation of over-arching themes is, of course, my interpretation. This is a very personal ‘sense-making’ journey – in some ways, I feel I am an advocate to represent the various levels of story from participants.

I appreciate that it may feel reductionist to develop over-arching themes after hearing rich discussion and description from the voices in conversation or after reading poignant comments that lift experiences from the pages. The complex meanings and experiences described in the interviews can easily stand, alone – a narrative that provides meaning to whomever engages the stories therein. The descriptive responses from the surveys also offer deep understanding for reflection and reflexivity. My effort to develop over-arching themes is connected to understanding and organizing so that a connection can be made to the other method in the study. Theming is not intended to reduce rich meanings to a few simple answers, throwing everything into the kitchen-sink as David Silverman might indicate as problematic, risking the loss of intricate
meanings (Silverman, 2010). Some organizations and readers require various ways to consider, understand and develop meaning. It is hoped that different deliveries of meanings and experiences can speak to the reader, whether it be through themes, descriptive voices or vivid written comments.

A metaphor comes to my mind that describes the thinking process in this timeline of processing the survey and interview data. Cream rises from a whole milk because of the self-straining that occurs dependant on the structure, integrity and texture of the constituents of the milk. Once the cream rises to the surface of milk after a period of time stabilizing and settling, so, too, have emerging and master themes settled and the essence of their meanings moved upward to the development of a weightier texture. These thicker, weightier essences that rise to the top of my mind, after mulling through and going back to the written and recorded stories, offer a larger understanding and are referred to in this section as over-arching themes. Clustering master themes into a summary, and then providing an over-arching theme, to each cluster, is intended to provide more clarity in analysis, as a reflection of organization for understanding for and by the analyst (King & Horrocks, 2010). To offer additional organization, visually, particularly as this is a learning style for myself, over-arching themes have been placed into a chart and it is demonstrated where each over-arching theme was derived whether from interview or survey contexts.

The four over-arching themes that emerged from my interpretation of the surveys and interviews were:

1. Suicide work must be recognized and supported with ongoing training, supervision and collaboration.
2. Quality of professional life shapes outcomes in suicide work.

3. Supports for psychologists post client-suicide need to be established.

4. Stigma prevents psychologists’ help seeking.

Although the over-arching themes are represented in a linear format, it should be noted that the constituents of themes appear to pull together and apart and spiral over one another. It would be unseemly to assume that the depth of thematic content can be readily and easily represented in a simple table.

Table 14 is a representation of over-arching themes derived from the master themes gleaned from the participant interview master themes and from the open-ended survey response master themes.
Table 14. Over-arching Themes

<table>
<thead>
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<table>
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<tr>
<th>Narrative Master Themes</th>
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</tr>
</tbody>
</table>

Suicide work has high intensity and impact on psychologists requiring increased balancing efforts in how many cases are managed – consideration must be given to the client needs and psychologist demands.

Psychologists’ help seeking is stigmatized and advocacy to engage supports is necessary.

Responsiveness in suicide work increases when psychologists are present, health, cared for and not overburdened.

Supportive supervision, mentorship, collaboration and suicide-specific training increase competency and practice fitness.

Recognition of psychologists’ human needs of self-care, recovery time and working through grief processes related to suicide work and client suicide is important for health and practice.

External resources are necessary to support suicide-identified clients in safety and this allows for psychologists to be supported in their practice.
CHAPTER 6 - INTERPRETATION

Convergence

Meaning from mixed current methods, is primarily recognized at the point of converging the two data sets when considering a concurrent design (Creswell, 2003). In the quantitative results there were a number of non-significant and significant findings. In the qualitative over-arching themes there are many layers of valuable understanding. Converging the two sets of knowledge is necessary to understand the bigger picture of the quality of professional life of Saskatchewan psychologists as a determinant in responsiveness to suicide ideation.

The following interpretation sections will examine the participant group of Saskatchewan psychologists’ quality of professional life, responsiveness to suicide-ideated-clients, and the influence of professional quality of life on responsiveness to suicide-ideated clients. Caseload volume, years in psychology practice, self-care practice, stigma for psychologists to seek supports, suicide-specific training, psychology discipline, supervision influence, and organizational supports will also be considered.

The survey responses are a reflection of the participant group and there are generalizability limitations specifically to the survey data from the ProQOL5 and SIRI-2. When considering the open-ended responses and the narrative essences there is likely more application vetted from the readers’ subjective and contextual perspectives. Chapter 7 offers more discussion with regard to limitations and strengths related to the generalizability, application, and truthfulness specific to findings and interpretations.
What is the Experience of Saskatchewan Psychologists with Regard to Their Professional Quality of Life?

**ProQOL5**

The three scale scores of the ProQOL5 are a representation of the professional quality of life for the Saskatchewan psychologists who participated in the survey. Due to limited participation (11.5%) there is difficulty in generalizing the correlation to the entire population. It was noted however that in this group, 70.5% expressed scale scores consistent with low levels of compassion satisfaction – no one in the group scored with high levels of compassion satisfaction. On the burnout scale 100% of the participants scored in the low level rating. While on the secondary traumatic stress scale 75% scored in the range demonstrating low level ratings, and no participants scored in the high levels of secondary traumatic stress.

Burnout is described by exhaustion, frustration, anger, depression, hopelessness and difficulty psychologists experience – primarily being influenced by high workload and/or a non-supportive work environments (Figley, 2002, 2007; Maslach & Leiter, 1997; Stamm, 2010). 100% of the respondents scored within the low levels for burnout. With a normal distribution for an average caregiver population, 25% would typically score in the low level scoring demonstrating no signs of burnout, 25% would score in the high level of scoring demonstrating high risk or presence of burnout and 50% would score in the average range. Respondents’ scoring reflects no reported indicators that would be consistent with burnout.

With regard to secondary traumatic stress, defined further with the majority of the same descriptors highlighted in burnout, but with the addition of fear, work-related
trauma, sleep interference, intrusive thoughts and/or images and avoidance of events that may create reminders of trauma (Figley, 1995, 2002, 2007; Stamm, 2010), 75.4% of the group (46 respondents) scored in the low level secondary traumatic stress range and 24.5% (15 respondents) identified that they were in the average range of experience, reporting some indicators but not beyond what the average caregiver typically reports. Hence, no respondents reported high-level indicators consistent with presence of secondary traumatic stress.

Compassion satisfaction is derived from feeling successful in psychology work, realizing that contributions with clients are positive. Compassion satisfaction is also experienced through a healthy work environment, characterized by happy thoughts, and a sense of positive feelings about colleagues (Arnold, et al., 2005; Grant & Campbell, 2007; Kadambi & Ennis, 2008; Linley & Joseph, 2007; Radeke & Mahoney, 2000; Stamm, 2010). Psychologists’ quality of professional life would be punctuated by a sense of satisfaction that the work is effective and enjoyable. They would feel their contributions matter and affect a greater good. Additionally, feeling supported in the work place through supervision and organizational structures that demonstrate consideration for their work, their clients, and the psychologists, also creates an increase in compassion satisfaction. Although the ProQOL5 is not a diagnostic test, when low-level compassion satisfaction scoring is identified in individuals there can be overlap associated with depressive profiles (Stamm, 2010).

In this group of psychologists, 70.5% reported experiencing low levels of compassion satisfaction, 43 out of 61, participants. In the average range of experience regarding compassion satisfaction was 29.5% of the group, 18 out of 61 respondents.
No scoring was reported reflecting high scale scores in compassion satisfaction. Scale scores for compassion satisfaction did not match an anticipated normal distribution, where 25% of a typical caregiver group would be in the low range of scoring, 50% in the average range, and 25% in the high range with high compassion satisfaction. The participant group is neither particularly happy nor satisfied in their quality of professional life. The majority reported low compassion satisfaction.

**Caseloads Influence Satisfaction**

Psychologists’ compassion satisfaction was correlated with lower caseload volume. Psychologists with lower caseload numbers demonstrated correlation with increased Compassion Satisfaction Scale scores on the ProQOL5. Higher caseload numbers correlated with increased scores on the Burnout and the Secondary Traumatic Stress scales of the ProQOL5, respectively.

Overwork and overburden create distress and disillusionment with a work environment (Norcross & Guy, 2007; Skovholt, 2001). Balanced workloads, with the opportunity to feel the effects of good work that allow for compassion satisfaction was called for throughout the narrative and open responses. It is not surprising that there would be correlation with lower caseloads and increased compassion satisfaction and higher caseloads correlating with increased ratings of burnout and secondary traumatic stress. The group of survey participants, along with the narrative stories, described overload of work from too many cases and a lack of ability to ethically keep up with all the pressures of workloads. Further, the qualitative descriptions related how lean initiatives were causing stress for psychologists in government and health practices because workload was burdensome.
Discussions noted that increased workloads, with challenges around time and too many tasks to navigate carved away a sense of feeling satisfied and positive in the work environment. When psychologists had control over their workloads and had the ability to manage their paperwork they felt more satisfied. When there was time for client advocacy and connections could be made with external resource supports, particularly for suicide-ideated clients, psychologists felt ethically grounded and confident they were doing good work. Establishing adequate safety for the client increased a sense of the psychologists feeling safe in practice. Extra resourcing let them feel protected from collegial judgment, ethical breaches, operational scrutiny, or legal repercussions. The concern expressed was that there was not time to do the extra suicide-related work, even though it was a best practice. In addition, workloads that are too burdensome weigh down the potential for suicide work to be well monitored as fatigue can prevent the perspective and insight necessary to respond to suicide. ‘Quality of professional life shapes outcomes in suicide work’ (Table 14) and the correlation, of lower caseloads with higher satisfaction ratings, is a direct reflection of the theme.

Doing good work was part of satisfaction and having diversity in the work was also important. Flexibility to be diverse in their work roles was highlighted as challenging, interesting, enjoyable and allowing for creativity. If there was overwork, the sense of control, flexibility and creativity was sapped. Lean initiatives were also noted as taking away control that the psychologists needed and wanted to have diversity in their work. In environments were participants had the ability to create their own balance around case quotas, the number of suicide-ideated clients on their caseload, how many assessments in a day, and number of therapy appointments, it was noted that
creativity and enjoyment were felt in the work. With mandates determining how many and what kinds of cases are seen, satisfaction wanes.

**Years of Practice Influence Satisfaction**

A significant correlation was observed that supported more years in practice as a psychologist was demonstrated with higher scoring on compassion satisfaction in ProQOL5 findings. Higher scores on individual profiles of burnout and secondary traumatic stress correlated with psychologists having fewer years of practice.

As noted in survey descriptions and narrative responses, overall supervision is inadequate for psychologists. It was also highlighted that suicide work was not receiving adequate supervision and was not well supported in many organizations. Many psychologists described seeking out colleagues to offer support, debrief with, or receive guidance from with regard to their practice or suicide work because supervision was not offered. Psychologists with less experience may not, independently, have confidence in accessing colleagues or their team for collaboration. They may not have established friendships necessary to allow for the needed connection to debrief their work challenges. Newer employees may not feel comfortable developing mentorship connections to access supervision necessary to feel confident in client work. Their reflections identified that there were challenges in gaining adequate supervision as it may be frowned upon to seek help. Support was identified as necessary with suicide work.

Providing suicide work and experiencing client suicide were described as carving out self-doubt, fears, and anxieties. Less experience in suicide-work can feel more distressing and increased doubts can play into feeling less in control and out of
balance in the work setting. Psychologists often work in isolation as identified by participants-some isolation is based on rural practice, work on First Nations reserves, or simply in their own office without specific connection to a team. Private practice can be particularly isolating if there is not intentional connection to other psychologists in the practice. Doubt and uncertainty are unlikely to improve when a psychologist is isolated. Not being supported or talking with other psychologists about the influence of doubt does not allow for rebalancing, redefining boundaries or feeling cared for. Isolation prevents sharing of stories about the hope that underscores open direct talk about suicide – such that talk about suicide thought demonstrates a desire to be helped and moved toward safety.

Within in any psychology work context, learning from others’ lived experience allows for a non-threatening means to connect, feel supported, debrief and rejuvenate. Should there be need to access help and support, stigma and judgment were identified to prey even more on less experienced psychologists, particularly if they had not yet developed a network of trusted colleagues who can offer consideration and supportive mentoring.

**Self-Care Influences Satisfaction**

Increased frequency of self-care activities significantly correlated with increased scores of compassion satisfaction. Literature advocates that self-care allows for a stronger sense of wellbeing, physically, mentally and spiritually (Baker, 2002; Case & McMinn, 2001; College of Registered Nurses of British Columbia, 2008; Maltzman, 2011). Despite overall group compassion satisfaction being reported as low, the correlation identified that those individuals with higher frequency of self-care matched
higher compassion satisfaction ratings. Correlational statistics are not causal, however there is the ability to appreciate through the descriptions in the qualitative themes that this group was consciously aware that their health, wellbeing and quality of work was very much dependent on embracing self-care.

As noted in the survey emerging themes, “Psychologists are more emotionally stable when self-care is engaged” and as noted in the interview emerging themes, “Self-care is essential for good physical and mental health and work quality”. Being well cared for allows for increased enjoyment at work. The majority of survey participants described regular self-care, daily practices in most cases. Feeling more present and competent in their professional role was reflected as a direct benefit from self-care. Improvements in self-awareness, health and relationships, professional and personal, were described as a result of self-care.

The narrative and survey also outlined that there is a need for employers to encourage and support psychologists to take time to engage self-care. It was noted that such support was lacking in most instances. When there was encouragement of self-care, it was highly valued and the exception was remarkable in making a difference to the participants’ engagement with work and feeling more satisfied, thus increasing their productivity. Insight with clients, feeling valued, and having a stronger sense of professional accomplishment was described as linked to self-care.

Self-care was seen by participants to include therapy, collaboration, and supportive supervision. Engagement in practices that allowed for reflection and development increased participants’ enjoyment of work, quality of work and the sense that safety was provided in suicide work. Adequate training and time to take in
professional development supported psychologists with professional-oriented self-care. Training, when given room to take it on, increased satisfaction and provided a stronger sense of competence at work.

Notably having time to engage self-care during work hours was also described through making collegial connections and was highly valued by participants. Collegial connections allowed for time to process client cases, reflect, take care of emotional needs following client work, debrief and collaborate with colleagues, and discuss cases with supervisors. Lean functioning appeared to take a toll on how the participants’ felt they were encouraged by supervisors to engage self-care, personally and professionally. They noted that lean mandates appeared to supersede emphasis on self-care, subsequently reducing how refreshed, prepared, engaged and responsive they were to client needs. Additionally, collaboration with colleagues was not necessary supported in lean functioning as per participants’ descriptions.

**Stigma Prevents Psychologists’ Help Seeking and Satisfaction**

There was a very low response rate on the survey. Certainly a variety of factors influence survey participation or drop out (as highlighted in Chapter 7) but one reason can be related to stigma. Stigma can be a barrier in survey participation when the survey is focused on psychologists’ appropriately responding to suicide-ideated clients. Additionally, examination of psychologists’ fitness to practice and competence can also generate fear.

In keeping with the point that fears and stigma have power over action and inaction, stigma was described to operate within psychologists. Stigma was described to function in mental health systems with consideration to psychologists taking care of
their health. Very clear descriptions outlined that psychologists are afraid to seek support from supervisors or colleagues. Help-seeking with regard to psychologists’ own health, personal and professional limitations, work needs, suicide work collaboration, or setting boundaries were challenged as a result of stigma. Seeking support or having any personal or emotional challenges was viewed negatively, identifying that the psychologists would be considered less than competent, unprofessional, or not fit to practice.

Barriers to help seeking were specific in that there was judgment and gossip that were described when psychologists attempted to access help from their supervisors related to work, or connect with therapy. Psychologists identified that help seeking should be applauded. Being self-reflective supports self-care. Choosing to take care of health, or needs offers improvement and strengthened quality of work. Narratives highlighted that organizations equipped to be supportive in helping their staff increased the satisfaction of the psychologists. Acknowledging the value of therapy, providing supportive supervision, and encouraging self-care are management strategies that are considerate of psychologists. Less judgment increased satisfaction. Workplaces putting energy into their psychologists generated more ethical caring because better practices could be maintained.

When cared for psychologists independently identified that they were more emotionally stable and engaged in their work. Psychologists identified that they had more self-awareness, were increasingly present and competent professionally as a result of self-care. Therapy was identified as useful to psychologists when they needed to process a client suicide. An additional barrier was related to the size of Saskatchewan’s
psychologist community where fears related to anonymity were also problematic for attending therapy. The literature had highlighted that rural communities struggle around accessing adequate carers for clients and that stigma was intense in rural communities. The majority of participants practiced in urban centres but highlighted the same struggles identified in rural communities. Caregivers cannot access help easily in Saskatchewan urban centres – everyone knows the psychologists in the province. There are inadequate external resources for clients – this increases stress on the caregiver. Stigma is more noticeable in rural settings. Perhaps, the *ruralness* attitudes of Saskatchewan are still very much a throwback to rural agrarian attitudes. Psychologists are not superhuman – just human. Their needs to receive help and support demonstrate that they are just human. Efforts to reduce and eliminate stigma related to psychologists receiving help must be a focus and requires effort since there is stigma systemically in organizations and throughout the province not just at a consumer level, but, at a provider level.

**According to Saskatchewan Psychologists, How do Their Professional Experiences and Professional Quality of Life Influence Ethical Competent Responsiveness to Suicide-ideated Clients?**

**SIRI-2**

Responsiveness of the SIRI-2 is a determinant of the level of competence in suicide interventionists in providing the most appropriate intervention responses to effectively engage a suicide-ideated individual. Scoring that would reflect most appropriate response selections would demonstrate little or no discrepancy compared to scoring of expert suicidologists. The average participant group response, with
comparison to the expert panel of suicidologists, reflected a mean of 173.84 ($\mu = 173.84$). This sum is a reflection of the total mean discrepancy, the sum of squares. Perfect scoring would be reflected as $\mu = 0$. The participant group, on average, demonstrated close to 60 errors when differentiating highly appropriate or highly inappropriate responses. The discrepancy scoring demonstrates there is room in the respondent group for improvement in interventionist skills.

The errors are representative of a number of common suicide interventionist errors including: superficial reassurance, avoidance of strong feelings, using professionalism as a tool that creates empathic distance, inadequate assessment of suicide intent, failure to identify precipitating events catalyzing suicide ideation, interventionist passivity, insufficient directiveness, advice-giving over genuinely listening, stereotypic responses, and defensiveness (Leenaars, Maltsberger, & Neimeyer, 1994). These identified suicide interventionist errors can be alleviated through adequate suicide-specific intervention training and supervision that helps the psychologist appreciate where their attitudes may be problematic (Chiles & Strosahl, 1995; Lang, et al., 2014; Neimeyer, et al., 2001; Neimeyer & Neimeyer, 1984; Neimeyer, et al., 2004; Schmitz, et al., 2012).

The participant group had different educational backgrounds (educational vs. clinical psychology) and varying levels of suicide-specific training. All identified that they must be sensitive, responsive, and interactive with suicide-ideated clients as 100% of the group identified that they would be required to provide suicide intervention in their client work. The variances in scoring reflect that there is a range of interventionist skills and suicide-related attitudes that may not be helpful in intervention.
Based on qualitative feedback, some attitudes that prevent intervention related to the belief that if an individual is serious about suicide then there is nothing that can be done to intervene. Such a belief can be a deterrent in intervention. That belief was countered by the attitude that if an individual is speaking about suicide, that, in fact there is hope. Additionally, errors around directiveness were outlined indicating that not all psychologists accessed additional external resources, whether formal or informal, specific to networking around the suicide-ideated client to ensure help when the primary caregiver is unavailable. Again, lack of active listening for meaning and connection in the suicide-ideated clients stories was observed. Connections to suicide or client stories were identified as being overlooked when psychologists’ self-care is limited, or workloads prevent full engagement. Active open direct talk about suicide was noted to be a concern as some psychologists noted that they did not want to give their client the idea of suicide by asking or directly talking. These misleading or fear-based ideas were countered by comments from psychologists who noted the value in active listening, reflective engagement, and focus on clients’ needs.

**Training Differences in Clinical and Educational Psychology Programs**

Participants trained in clinical psychology programs demonstrated significant correlation over participants from educational psychology programs in appropriate responsiveness scores on the SIRI-2.

The descriptions from the surveys indicated that training in the clinical psychology program offers more suicide-specific supervision and experience as a result of the presence of internships in clinical practicums. According to both survey and narrative accounts, not all clinical programs offer adequate suicide-specific training.
Preparedness for suicide intervention and suicide work was limited even in clinical psychology programs, whether master or doctoral level.

A number of the respondents with clinical psychology backgrounds in this study were working in clinical and therapy settings, where there is more potential for ongoing suicide work, subsequently resulting in “on-the-job” suicide training. The majority of psychologists working in clinical settings had ASIST training as well.

Educational psychologists were more often described as working in isolation. It was noted that they do not necessarily have a collaborative therapeutic team with specific suicide work experience. This was considered limiting. Increasing opportunities to learn more about how to best engage suicide work was identified as a need.

Some school boards and divisions have support in place to increase the learning of educational psychologists specific to suicide training. However, based on the feedback from the interviews and from the open-ended responses, it would appear that there is more need for suicide-specific training and increased need for collaboration to increase responsiveness and awareness of how to effectively intervene with suicide and develop support to the interventionist. As noted in Veronica’s interview, there is more and more pressure on educational psychologists and other professionals to become engaged in suicide intervention because there is more suicide “out in the open” – there is more suicide ideation being discussed and there is a need for more ability to intervene on the front line. The theme that ‘suicide work must be recognized and supported with ongoing training, supervision and collaboration’ provides a backbone to the arguments to increase educational psychologists’ abilities through suicide-specific training.
Further to the awareness that was observed in four of the interviews, there is genuine need for more training as graduate programs are not necessarily offering what is necessary for new graduates to have confidence in suicide work.

**Suicide-Specific Training**

Training specific to clinical doctoral internships, residency and supervision that had ongoing focus on suicide work, and/or training that provided the rigor of Dialectic Behaviour suicide-focused training, demonstrated higher appropriateness scoring on SIRI-2 interventionist responses. Both were described as highly practice-based. The ASIST (Applied Suicide Intervention Skills Training) 2-day, practice-oriented, training ranked second which demonstrated the next highest correlation with appropriate responsiveness on the SIRI-2. Least appropriate responsiveness on the SIRI-2 was identified with training that was non-practical in nature and taken in a day or less, which included basic university class discussion, project, reading or reporting on the topic of suicide. Experiential learning, practice and feedback allow for increased responsiveness and appropriate connection to suicide ideation. One-day sessions do not allow for adequate training and ownership of material for interventionists. Opportunity to increase effectiveness in intervention and appropriate responsiveness with suicide ideation develops from suicide-specific training, supervision for suicide work, and collaboration that allows for better practices to be developed.

Based on the fears that were described from participants and the value they placed on training, it seems prudent to ensure that more suicide-specific training can be engaged. Training allowed more direct talk about suicide and increased comfort in suicide work as outlined by a number of descriptions. Training removes interventionist
errors that get in the way of effective intervention. Xandra noted how much easier it was to ask about and talk directly about suicide because of her ASIST training experience. Zena noted that ASIST stresses taking all suicide-communication seriously and planning to offset behaviours from developing. A number of survey responses outlined the value in training but also highlighted that organizations do little to ensure suicide-specific training. There is opportunity here to pursue more training at an organizational and university-education level.

**Master or Doctorate**

No significant correlation was observed between more adaptive responsiveness on the SIRI-2 and whether there was a master or doctoral degree held by the survey participant. With consideration of the nature of programs and the subjective experiences that can occur in case study, work there may be inconsistency in what is offered in a master or doctoral practicum or internship.

Additionally, evidence that respondents were seeking out therapeutic and interventionist suicide-specific training opportunities would demonstrate a motivation to learn more about suicide work. Experience can be the best teacher. It was noted in the interviews that master or doctoral education does not necessarily provide adequate preparation for suicide work. Highlighted by Yvonne, Xandra, and Veronica graduate programs may be very limited in suicide-specific training. Many participants indicated that engagement in suicide specific training offered increased comfort in suicide work.

Suicide-specific training opportunities within programs or suicide intervention training and intervention experience are much more apt to develop skills related to appropriate responsiveness in suicide work. Additional supervision or mentorship
collaboration would further develop interventionist skills as highlighted by Zena and Wilma in their shared descriptions.

**Quality of Professional Life Shapes Outcomes in Suicide Work**

For this participant group, no correlations were found specific to the Professional Quality of Life Scale, 5th edition (ProQOL5) scale scores for compassion satisfaction, burnout, or secondary traumatic stress when run with the Suicide Intervention Response Inventory, 2nd edition (SIRI-2). This measure can be interpreted in a positive manner. Regardless of the lower overall measure of compassion satisfaction in the group there is not a correlational pattern connecting poor responsiveness to low work satisfaction.

Respondents, regardless of feelings of low satisfaction, were able to discern how they might interact with a suicide-ideated client. Conversely, this measure is somewhat artificial in that it is not specific to the interventionist independently producing the best response without prompting. SIRI-2 responses were supplied and the participants selected the most or least adaptive/appropriate response. It may be, too, that within the confines of completing a survey there are fewer distractions, interruptions, and components of the workday to create interference. Having a client in front of a caregiver can change the emotional reaction.

Regardless of the scoring found, the qualitative descriptions from survey and narrative spoke otherwise. There was a resounding support for the idea that professional quality of life does influence the ability to be responsive to suicide-ideated clients. Survey respondents identified that to offer appropriate ethical responses in suicide work, psychologists must not be overworked. They stated that high intensity
work, specifically, suicide work, requires more attention, self-monitoring, reflection, collaboration, mindfulness, strong connection and active engagement with the client. They went on to state that more efforts to balance personal life and professional time are necessary. Personal lives pressured by stress and caregiving for loved ones who are presenting suicide ideation or behaviours, created challenges for psychologists at work. Narratives described that because suicide work is stressful, anxiety-provoking, time consuming, uncertain, challenging and pressured there is need for additional organization support. Suicide work requires external caregiver involvement for ethical care and safety of the client. Caseload management was necessary - balance was necessary with consideration given to how many suicide-ideated clients are in a psychologists’ work queue. Supervision, that is suicide work specific, was missed but very necessary. Suicide work was highlighted as being fatiguing if there was not adequate balance. Regardless of the quantitative measures, the qualitative voices resonated that there is unquestionable professional quality of life issues that interfere with appropriate responsiveness to suicide-ideated clients. Adequate consideration must be given to ensure that the elements that contribute to professional quality of life are attended to so that responsiveness can be ethical and within best practice guidelines.

Supports for Psychologists Post Client-Suicide Need to be Established

Throughout the survey and the narrative, emerging themes of the humanness of being a psychologist were described. The need for psychologists to grieve their clients’ deaths was identified. The need to be supported by colleagues and supervisors and their employers was reinforced. Work time to participate in rituals that allow the transition through death, such as funerals or reminiscing was recognized by psychologists as
essential in healing. The lack of supportive processes within organizations was uncovered in their descriptions. Debriefings were organized for legal consideration related to the employer, but little consideration was provided for the psychologists. Operational debriefings were long and drawn out and left psychologists in positions of fear and uncertainty. Debriefings in organizations needed to have an emotional component in order to consider the health and wellbeing of their staff.

Psychologists were not given the permission to do the normal human tasks that allow processing of suicides. Some psychologists were very clearly more distanced from their clients’ suicides, not reporting much reaction. These psychologists had prepared and rationalized that suicide is inevitable when working with suicide-ideation, mental illness, and depression – eventually, a client will suicide. Despite this awareness in others of the inevitability of mental illness producing casualties, the majority of participants responded as one might expect anyone would respond to suicide, in a real human way – with doubt, fear, shock, disbelief, second-guessing, deep sadness, and real heart-wrenching grief.

Resilience and competence were identified to increase in psychologists when they had time and support to process the client suicide. Time off was helpful for reflection and healing. Supportive supervision that allowed perspective and focus on what went well and what lessons can be put into practice in future work was useful. Debriefings that had an unconditional supportive stance were releasing and growth-oriented. Colleagues that would listen in a judgment free way was healthy for the psychologists who needed to express pain, fears, and doubts. Throughout the commentaries and stories it was noted that organizations needed to improve their
support of psychologists. There was a sense that psychologists were blamed for client suicides, rather than the recognition that organizations were responsible to set up the framework so the psychologists could provide the most ethical suicide work possible. The employer is responsible to create a safe environment with support.

**Suicide Work Must be Recognized and Supported with Ongoing Training, Supervision and Collaboration**

Throughout the narratives and survey commentaries there was strong identification that training, supervision and collaboration must be organized so that suicide work can have the recognition it requires. Suicide work is challenging, demanding, and intense. More effort needs to be organized to support psychologists in their work.

Suicide-specific training instilled hopefulness and confidence in the psychologists. They described that best practices are adhered to when there is adequate time to focus on suicide work with and for clients, when they feel they are doing good work and can genuinely help their clients. Active listening and engagement with the suicide-ideated clients is supported when psychologists have adequate suicide-specific training. External supports allow for more caregivers to create involvement with persons at risk, thereby increasing hopefulness for the individual and lessening the pressure on the psychologist. Without suicide-specific training, an inexperienced psychologist who has had fewer opportunities to experience life-affirming shifts in client suicide work may experience more self-doubt. An additional problem identified was that supervision is not necessarily well established around suicide work and organizations offer limited opportunities for collaboration on teams. Inexperienced
psychologists may not have the confidence or tenacity to seek out mentorship when supervision is lacking. Private practice psychologists may not have the infrastructure of potential colleagues to collaborate with.

Organizations must take on more responsibility in supporting psychologists in their suicide work. Similarly, private practitioners must seek out mentorship so they are less isolated in their suicide work. Employers may require clarity around their responsibilities to recognize their role in supporting their psychologists. It is a consideration that regulatory bodies may need to offer advocacy for psychologists to have adequate supportive mechanisms in place.
CHAPTER 7 – DISCUSSION

This chapter summarizes the research process and offers conclusions to the outcomes of the mixed methods examination of Saskatchewan psychologists’ quality of professional life as a determinant in work with suicide-ideated clients. Strengths and limitations of the study are discussed. Recommendations for future research will be highlighted, along with considerations for potential application of what has been learned. A brief word on the research experience is offered in closing.

Summary

Fitness to practice, the demonstration of knowledge, skills, and competence to practice as a psychologist safely and effectively, in response to suicide ideation, is a professional and ethical expectation (Schmitz, et al., 2012). Professional quality of life, defined both by how positive, healthy and supportive the work environment is and by satisfaction derived from one’s work, is one determining factor for positive client outcomes in psychology practice (Stamm, 2010; Figley, 2002). Self-care is essential to maintain psychologists’ fitness to practice and work quality (Smith & Burton-Moss, 2009; Skovolt, 2001; Raedeke & Mahoney, 2000). Quality of professional life is measured on three constructs: compassion satisfaction reflecting how positively a psychologist embraces their work place, with successful client work and collegial engagement collegially connected; burnout, or chronic occupational stress, reflecting long-term exhaustion, dissatisfaction, and reduced capacity to produce quality work; and secondary traumatic stress, the cumulative effects of working with traumatized persons, where burnout symptoms exist along with fear, and physiological-emotional disruptions of sleep, fear and stress responses, and more significantly abraded mood.
Competent psychologist interventions along with activation of suitable resources are pivotal in suicide work (Neimeyer, et al., 2001; Schmitz, et al., 2012). This mixed methods study examined Saskatchewan psychologists’ quality of professional life as a determinant in responsiveness when working with suicide-ideated clients.

In the quantitative aspect of the research, 61 Saskatchewan psychologists participated in an Internet survey, establishing responses on the Professional Quality of Life Scale, 5th Edition (Stamm, 2010) and the Suicide Intervention Response Inventory, Revised Edition (Neimeyer & Bonnelle, 1997). ProQOL5 results demonstrated that the group of participants do not demonstrate compassion fatigue, high levels of burnout nor secondary traumatic stress. Compassion satisfaction demonstrated by the majority of the participants was below the average of what would be expected from a typical caregiver population - no participants scored in the high range of compassion satisfaction. The group was not particularly happy or satisfied in their work.

With regard to the SIRI-2, on average the group generated 60 errors when distinguishing best responses to suicide-ideated client statements. Errors were typical of a population that requires additional training to avoid making common suicide interventionist and attitudinal misattribution that would negatively influence suicide intervention.

Increased compassion satisfaction was correlated with lower caseloads, increased self-care, and more years in psychology practice. Experiential suicide-specific training (i.e., supervised suicide focused internship/training or Applied Suicide Intervention Skills Training) demonstrated correlation with increased appropriate
responsiveness in suicide intervention. In a means comparison, respondents who are clinical psychology graduates rather than educational psychology graduates demonstrated increased appropriate responsiveness to suicide-ideated statements.

In the qualitative methods, developed from 61 open-ended survey responses and 5 interviews developed into a narrative. Qualitative themes emerged stressing that psychologists’ quality of life and responsiveness in suicide work improves when: psychologists engage self-care; employers advocate for psychologist self-care; client caseloads are lower and balanced in case presentation; psychologists have more control over their work; work diversity generates creative and healthy interest in the work; lean management matches best practice guidelines for suicide work and considers needs of psychologists as well as clients; adequate and appropriate supervision is provided in suicide work; suicide-specific training is accessible and supported; and, barriers are removed that prevent psychologists from receiving emotional and professional supports. Psychologists identified that the demands of suicide work are not necessarily recognized and supported by workplaces and that suicide-specific training is necessary for appropriate responsiveness. Supportive practices, post-client suicide, require development to be expedient, consistent, and considerate of psychologists. Employer-psychologist debriefing practices, post client suicide, must be helpful to psychologists to facilitate resilience and growth, rather than solely focused on legal and operational matters. Psychologists’ needs related to having time to grieve a client suicide require more consideration from employers.

Generalizability limitations are recognized in the quantitative results because the response rate was 11.5%. Qualitative themes derived from the open-ended responses of
the 61 and the 5 interviews are valuable to regulatory bodies, training facilities, employers, supervisors, and organizations generating parameters for work and support of psychologists.

**Conclusions and Implications**

The research focused on a group of Saskatchewan psychologists who demonstrated quality insight into their needs for necessary elements in their professional lives so that they can provide competent and fit caring and responsiveness in suicide work. Quality of professional life and fitness to practice is not identified as the sole responsibility of the psychologist in private, public or government oriented settings. Workload demands and lean practices are identified as potentially creating unrealistic expectations for psychologists to work within, therefore it is essential that organizations/employers acknowledge the intensity of suicide work and extend adequate support mechanisms to psychologists who engage this work. Without adequate organization-based supporting mechanisms in place, psychologists’ competence in suicide work is challenging to maintain. Themes reflected that consideration must be given to caseloads, work diversity, suicide-specific training, consultation with external supports for client and for psychologists’ benefits, time for self-care, suicide knowledge-based supervision, supportive debriefings, preparation for client suicide, and personal therapy (Arnold, et al., 2005; Azar, 2000; Chiles & Stroshal, 1995; Digiuni, 2011; Grant & Campbell, 2007; Kleepsies & Dettmer, 2000; Linley & Joseph, 2007; Neimeyer, et al., 2001; Norcross & Guy, 2007; Schultz, 2004; Talbot, Manton, & Dunn, 1992; Weiss, 2004).
Participants identified that suicide responsiveness improves when psychologists have particular workplace needs met. Control over caseloads, both volume and client presentations, are supportive. Access to supervisors, collaborative teams, and mentors or supervisors that are therapeutically knowledgeable specific to suicide work improves work quality and safety-considerations are more readily addressed. Connection with external resources to share the responsibility of client safety is essential to both the client and the psychologist. Ongoing suicide-specific training is essential for appropriate responsiveness to suicide-ideated clients. When suicide work is a focus, there must be recognition of the needs for engagement in self-care and the employer must actively support psychologists’ self-care. Balance in caseload number and case presentation must be given careful consideration. Self-care is reflected in psychologists’ abilities to be present and responsive. If there is not balance of work, no amount of self-care can offset the demands of overworking.

Discussions reinforced that quality of professional life does indeed have impact upon psychologists’ suicide interventionist work. Hence, the professional environment must be highly supportive to psychologists to develop a platform from which professional practice fitness can develop. Being well and healthy for practice is dependent on work environments and the psychologists. Accessibility to therapeutic supports is also necessary and efforts to alleviate stigmatized responses around psychologists’ seeking support of supervisors or from mental health supports must be openly advocated for and encouraged.

Independently practicing psychologists need also consider active means to generate connection to supervision, collaboration, and external resourcing. Professional
quality of life is also a reflection of being adequately supported and encouraged to think clearly and openly about client needs. Support to think outside one’s own perspective would be helpful for professional practice fitness and growth. Openness to support and awareness related to professional practice would provide a better stance related to suicide work. Professional self-awareness, consciousness of areas for growth and insight around practice fitness is more likely to be embraced when there is self-examination activated through observation and reflective work with a colleague, supervisor or mentor.

Responsibilities of psychologists include abiding by ethical and legal standards and boundaries as highlighted in the Canadian Code of Ethics for Psychologists. Consideration must constantly be given to respect for the dignity of persons, responsible caring, integrity in relationships and responsibility to society (Sinclair & Pettifor, 2001). Within these boundaries, Saskatchewan psychologists recognized their responsibilities to ensure their physical and mental health along with the quality of their psychology work. Their engagement in self-care, adequate study and updated training, and appropriate suicide work are part of the fabric of the rich work that psychologists provide. Certainly the role of psychologist is weighty and cannot be carried without organizational undergirding of support.

Clinical and Educational psychology graduate programs vary. Within the interview descriptions alone, very limited suicide-specific training was reported in the clinical and educational psychology training programs. Responsibilities of psychology training facilities must include obligation to provide suicide-specific training so that all graduates working with high-risk populations have the ability to reliably respond to
suicide ideation within context of best practice. The role of suicide interventionist is not only for clinical psychologists. Educational psychologists are in the front line to identify suicide ideation, communication and behaviours on an ongoing basis. If graduate programs cannot offer in-house suicide-specific experiential practice-based training, then programs such as ASIST would be helpful to create the professional preparedness necessary for frontline caregivers.

Employers must consider that clinical or frontline workers are all required to be responsive to suicide at various points. Organizations responsible for clinical service delivery were identified as needing to consider increasing accessibility to suicide-specific training on an ongoing basis. Some participants observed that there was lack of access and support for training. Reflections on adequate training identified that participants accessed additional opportunities for training, to support suicide-specific knowledge in intervention and therapy, on their own time and used their own resources so they could be better prepared in their work. In addition to seeking additional training to support their work, participants reported independently seeking out suicide-specific supervision or mentoring, as little was available in their workplace. Managers were not always knowledgeable about therapeutic suicide-oriented supervision which must also be readily available to psychologists providing suicide work. Direct work experiences with suicide offered powerful teaching but without support and direction, there is potential for doubts, fears, and errors to occur. Activation of more uniform suicide-specific training and supervised suicide-specific practice experiences would prove beneficial in creating common suicide language and interventionist responsiveness
based on best practice guidelines. Human service work requires knowledge of how to intervene with suicide.

Regulatory bodies are responsible for regulating and disciplining psychologists. However, the role of employer is not commonly regulated specific to ethical workloads or initiatives that are supportive of psychologists’ health or work practices. Psychologists are generally not in positions of power to guide outcomes with organizations, however psychology advocacy bodies, such as the Canadian Psychological Association or regional psychology advocacy organizations, may have a voice about what is ethical in terms of professional parameters, client rights and supports for environment management to support psychologists’ work. Workplaces should be responsible to provide suicide-specific supervision in suicide work. There must be acknowledgement that such supervision would include positive debriefing specific to suicide work. Private practitioners identified that they are in positions where supervision is necessary to ensure ethical and supported practice. Specific to private practice, it may be useful to have a declared supervisor/mentorship relationship developed and reported such that support is monitored or can be checked on as a regulatory requirement. Rural practitioners may require additional mentorship support outside of their communities in order to get the assistance necessary. Rural isolation prevents ready accessibility and consideration must be given to offset the challenges of working independently. Psychologists practicing in rural First Nations communities require additional support to increase community skills to provide external safety supports when suicide-ideated clients return from urban care. These needs would be readily addressed with a specific suicide prevention strategy either at a regional or
national level, providing considerations are reflected related to suicide interventionists and ongoing suicide work providers.

Post client-suicide, needs of psychologists become more intense as they work through human reactions of grief and loss. Personal and professional impacts can influence quality of personal and professional life, professional self-doubts, and stress reactions. It is important that organizations are more oriented to supporting the psychologist. Operational debriefings and file audits must become more streamlined and efficient so that a healing process for the psychologist involved is not protracted.

Stigma, within mental health or other employments, that suggests psychologists are unprofessional or incompetent should they ask for emotional or professional support must be addressed. Related to post-suicide access to support, there is stigma that infers that a psychologist should not participate in activities of grieving. Proactive efforts of employers and regulatory bodies would be useful to reduce barriers to support. Perhaps a public campaign could help to reduce stigma. Media, workplace, or service announcements, among practitioners and within employers might reduce stigma. First steps of thorough open discussions of embracing self-care and being supported to have more work balance would be a starting point. Supervisor support and encouragement for psychologists’ self-care would be very useful to reduce barriers.

Quality of professional life has influence on psychologists’ ability to provide responsive suicide work. It is sensible that not only psychologists carry the weight of this work but rather that responsibility is also placed on those that are employers, educators or regulatory bodies. Such efforts will protect psychology providers and consumers of psychology services.
Strengths and Limitations

Strengths and limitations are identified with respect to survey response rate, generalizability and applicability of the outcomes to practices of psychology or adjacent human services involved in suicide work.

Low Survey Response Rate

There was a low survey response rate of 11.5% population representation. Typically, response rates acceptable for web surveys are 24.8% (Penwarden, 2014), 50% for postal response rate and 70% for institutional response rates (Nulty, 2008). Sample error can occur when respondent numbers are small (Nulty, 2008). Drop out rates can range upward to 42% on web surveys (Galesic, 2006). Of the 82 original surveys began, only 61 were completed. Drop out was not as high as is seen typically in web surveys. Nonetheless the completed survey number was small. Only email invitation and web survey was used. A number of factors have influence over low responses including: on-line survey format, stale-dated email addresses, survey invitation received at work, survey saturation, topic sensitivity, lack of interest in topic, burden of participation, fears of breach of anonymity, survey design, lack of adequate incentive, and disposition or personality of targeted candidate group (Cook, Heath, & Thompson, 2000; Galesic, 2006; Holbrook, Krosnick, & Pfent, 2008; Kolek, 2012; Kwak & Radler, 2002; Nutly, 2008; Penwarden, 2014; Sheehan, 2001; Sheehan & McMillan, 1999).

In some populations, paper surveys elicit better response rates than on-line surveys (Sheehan, 2001). Use of on-line technology, in some populations that are not familiar with access and engagement with on-line survey format, is a deterrent (Kwak &
Radler, 2002; Nulty, 2008). Multiple methods of disseminating the survey could have been used to boost survey response rates, such as an optional postal paper mail-outs (Nulty, 2008). Work browsers may not be set up to accommodate technology that extends into the internet as a result of firewalls or local intranet access limitations. Email addresses may not have been up to date and because the bounce back would not have come directly to me, I would have no means to identify who would require additional efforts for contact to encourage completion of the survey. If emails were directed to a work environment, the work pace and pressure, particularly with lean practices or demanding schedules, psychologists may have felt they could not participate in research during their work hours.

The study topic may have been a deterrent for participation either because of lack of salience, sensitivity, burden of experience or difficult to answer questions (Kolek, 2012; Galesic, 2006; Sheehan, 2001). Pure disinterest in study of quality of professional life, suicide work, or general limited desire to be active in research can influence nonparticipation. Responsiveness to suicide as a topic is highly charged and sensitive (Lang, et al, 2014). Others may have considered whether their capabilities were being judged or may have feared a breach of anonymity hence the survey could raise sensitivity and defensiveness. Although the researcher did not have any leverage or power over students, colleagues, training facilities or regulatory bodies, the survey invitation and link were sent out through the email from the Saskatchewan College of Psychologists. The Saskatchewan College of Psychologists is the discipline and regulatory body for Saskatchewan Psychologists subsequently there could have been the association that the study served as an investigation and assessment of abilities for the
College. Although there was information to indicate that no raw data or identifiers of participants were being shared directly with the Saskatchewan College of Psychologists, it could still be a point of interference in psychologists’ choice to participate.

Survey design matters in sustained participation for participants where completion is encouraged through interesting and interactive questions, color scheme, ordering of open or closed questions, time progress markers, survey brevity, and questions clarity can all influence survey completion (Galesic, 2006; Nulty, 2008). The interview length was estimated between 25-45 minutes as noted in the email invitation, notably interviews averaging 20 minutes increase participation while interviews of 40 minutes may illicit refusal (Collins, Sykes, Wilson, & Blackshaw, 1988).

Pre-notification, repeat emails and reminder calls boost on-line survey response rates (Kwak & Radler, 2002; Nulty, 2008; Penwarden, 2014; Sheehan, 2001). Email invitations were sent and then a reminder email was sent about one month into collection, there was effort to attempt a third contact as a reminder near the end of survey collection but the SCP had member feedback that demonstrated concern that doctoral research was being advocated for by the SCP and it was unfair to other members, demonstrating favoritism to the researcher, and so the third reminder could not be sent. Additional efforts were made to elicit connection with registered psychologists through other psychologist membership bodies, but the response was that since the Saskatchewan College of Psychologists had engaged the process they would choose not to support additional contact with their members. Effort to access additional email connection was made through several private practices to further e-vitations. It was brought to the researcher’s attention that several psychologists took the liberty,
without my request, to forward the survey to live mass email addresses within their work environments, to their colleague psychologists in their staff compliment. The data collection period was not rushed as participants had a 3-month timeline to complete the survey, not being pressured around timing can be helpful in responsiveness (Nulty, 2008). Respondents could select when to complete the survey and this can be advantageous.

Incentives can be a powerful tool to enhance participation in surveys. Involvement improves when incentives are considered to be: a philosophical benefit (such as knowing their responses will be used or their work dynamics can improve), an altruistic reason (such as supporting research or student work), or a material benefit (such as cash or goods) (Goritz, 2006; Kolek, 2012; Nulty, 2008). The chance to win a spa treatment can be viewed as incentive in this study. It has been identified that lottery incentives are commonly used in surveys with positive significant activation of interest (Kolek, 2012). Concrete monetary incentives immediately received upon survey completion increase responsiveness (Goritz, 2006). An opportunity, like a lottery style draw, with a larger incentive is attractive and can increase completion rates (Sheehan, 2001; Nulty, 2008). Spa services may not have been viewed as particularly large and there may have been a bias regarding the value of a spa survey simply because spa services may be more highly valued by females.

The question of who responded to the survey requires consideration. Sample bias can be problematic in this case because who answered may be very different from who did not answer (Nulty, 2008). Those who participated may have more formed opinions about the research topic or have a personality that connects with being engaged
with surveys and/or research (Kolek, 2012). Age range and social class can also influence participation (Goyder, 1987; Kwak & Radler, 2002). Those who are invested in what is happening in their workplace regarding standards, structures, and provide suicide work may have responded to the survey. Conversely, negative opinions may be more readily expressed than positives (Kolek, 2012) and this may support sample bias. Personalities that are more social, female, or enterprising tend to become involved in survey responding (Kolek, 2012). This may be consistent with the research as it is demonstrated that more females participated in the web survey and only females responded to the interview request. Conversely, these numbers are a reflection of the gender break in Saskatchewan psychologists being a female majority.

Saskatchewan has a small population and it can be a factor when participants know the researcher. In cases where a participant may have believed a particular action or outcome can occur or will not occur as a result of conclusions or recommendations, then there is a possibility around decision to participate as well (Kolek, 2012).

**Generalizability**

A low response rate influences generalizability. Sixty-one psychologists responded, 20 of who experienced client suicide. Correlational results can be skewed. There is a voice of psychologists not reflected. The results of the SIRI-2 and ProQOL5 can only reflect participants. Absolute statements cannot be made about the overall Saskatchewan picture of practice, quality of professional life, and interventionist response outcomes from a quantitative perspective.

The SIRI-2 is an isolated assessment instrument that considers interventionist responses and is not a direct measure or reflection of quality of therapy. Respondents
outlined a variety of different therapeutic styles in their demographics and the responses of the SIRI-2 are limited to a selection of most adaptive versus least adaptive responses based on the provided intervention comments. As a result, the SIRI-2 does not reflect interventionist self-produced statement or statements produced by psychologists in their own therapeutic strategies.

Further to discussion of the SIRI-2, literature reviewed posits how psychologists respond to clients communicating suicide-related ideation and communication will determine if a client will continue to help-seek, furthermore, amelioration of suicide-risk is also indicated as resulting from successful communication with clients in treatment (Chiles & Strosahl, 1995). There is not a quantifiable measure being suggested to appreciate how many clients will cease to seek help or help seek based on the instrument’s use. Additionally reduction of suicide-risk cannot be determined through the quantifiable measures selected.

The ProQOL5, although it does provide a sense of the quality of professional life, as reported by the respondents, is not generalizable to all Saskatchewan psychologists. There were very limited responses that came specifically from rural or geographically isolated psychologists and, as a result, there is not any way to make inferences about the experiences of compassion satisfaction and compassion fatigue (burn out or secondary traumatic stress) in those populations. Literature would indicate that frontier and rural experiences are different than urban experiences of psychology practice and more stress along with lack of resources may be noted in those environments.
The quantitative data collected regarding psychologists’ caseloads, how frequently external resources are accessed, engagement in self-care, and access to suicide-specific training may be useful objectively with consideration to needs that psychologists may have for best outcomes. Readers seeking direct applicability of quantitative outcomes to other populations or demographics that may match contextually would benefit from considering additional meanings layered in with the qualitative ways of knowing – this is important that the work not be taken from only a positivist perspective.

Although quantitative results have limited generalizability, the themes derived from the open-ended responses of the 61 and the themes derived from the 5 interview discussions do offer opportunity for consideration of current practices related to suicide work and quality of professional life as aforementioned in the discussion section. One might take the perspective that because the quantitative results are limiting there is increased value in the qualitative data.

The qualitative data will be more specific and reflective of lived subjective experiences and may be less likely to be directly generalizable to large populations. Some might argue that a small sample size is limiting in the qualitative interviews and despite effort to capture diversity in the participants, through making effort to have informants interview with differing backgrounds and experiences, the interview informants could be seen as either too varied and therefore knowledge is not transferable (King & Horrocks, 2010; Hesse-Biber, 2010; Pringle, Drummond, McLafferty, & Hendry, 2011b), or, may be considered purely from surface demographics and thought to be too similar. Notably, the survey participants were more
varied based on their shared experiences and the over-arching themes threaded through both open-ended and interview descriptions. However, as individual readers, collectors, consumers, and users of knowledge, there is self-selection about what resonates in content read – each individual is responsible for generalizing to their own unique context (Rizq & Target, 2008; Smith, et al., 2009). It is anticipated that the applicability of the themes captured adequately document meanings and themes along with relevant characteristics of the group so that the reader can absorb and discern what can be useful to their own context (Hjelmeland & Knizek, 2010).

**Language**

Language may be considered a limitation within the discussion of lived experiences, as “language can be a ‘shortcut’ to communicate questions, ideas, and experiences…it is not always clear that the language is being used the same way by all and is understood equally by all involved. Language also has the potential to confuse and oppress whether intentionally or unintentionally.” (Toporek, 2011, p. 411). Considering that the text data from participants’ survey short answers may be in point form, have a colloquial flavour, or have a specific intention or delivery that is not clarified through writing, there is potential for misunderstanding or lack of appreciation for a larger meaning. However, similarly themed responses overlap, clarifying survey participants intentions. They did not respond in isolation. Other’s responses help to bring validation to development of coding and themes, hence there is an increased probability that the essences were captured.

With consideration specifically to verbal interviews and language there was opportunity in discussion to clarify meanings. Taking time in prompting, probing and
clarifying with participants during the interview is a tool to ensure that meanings are captured. Additionally, having the value of watching responses and interactions of participants, along with having abilities developed through twenty years of therapeutic work, there is a stronger likelihood that meanings are close to the intent in the narrative. Further collaboration, post-interview, with participants was an effort to ensure that meanings were thematically accurate. Again subjective analysis leaves room not only for the researcher but, for the reader, thus, it is anticipated that the meanings will be taken through their lens to generate knowledge that is applicable to their context.

**A Word on Truth**

With respect to qualitative findings, trustworthiness and truthfulness of the knowledge produced is important as it is in quantitative research. A positivist perspective in quantitative research will consider that validity and reliability is based on statistical significance, validity and reliability of the instruments, and the accuracy of representation of a sample population (Creswell, 2007). Truth in qualitative research will rely upon plausibility and credibility of the research process, sensitivity to context, a quality description of thematic content, commitment to the authenticity of the participant’s data (their stories and meanings), and transparent coherent sharing with the reader in a manner that is logical (Connelly & Clandinin, 1990; Creswell, 2007; Sandelowski, 1991; Smith, et al., 2009). As a result of prompting and clarifying statements throughout the interviews and persistent conscious awareness of situating myself, as well as note making for context and reactions, there is better potential for the researcher to connect with intention and essences of the stories shared (Hesse-Biber, 2010; Hesse-Biber & Leavy, 2004).
Detailed listening to audiotaping followed by reading and rereading of transcripts’ data and constant consideration of contextual reference help to ensure meanings were captured. The subjective descriptions have been reviewed at length to ensure that there is not simply a researcher lens being applied. The interviewees’ subjective reflection may not be exactingly accurate but every effort has been made to ensure the participants’ voices were heard. There is reflection of the researcher in the work as would be anticipated in narrative (Denzin, 2004). Despite clarification and consideration of the interview discussions and stories, in addition to collaboration with the participants’ to confirm themes with their verbatim words, subjective meanings can still be biased. “Narratives are truthful fictions, but fiction is itself linked to interpretation in that all interpretation (even scientific explanation) involves human fabrication: the making out of what happened and the making up of what something means” (Sandelowski, 1991, p. 165).

The use of the researcher’s personal notes, ideas, reactions, and self-checks, prior to, during and post-interview ensure that there was a conscious awareness of researcher context. The intention of this conscious awareness was to create more clarity of what was researcher rather than participant. Notes jotted during interviews were used to track participants’ verbal reactions, facial expressions and clarifying moments in the interview - this was helpful in the transcription so that meaning was more readily understood and conveyed when quotations were used in the narrative.

With regard to open-ended survey responses, there is some challenge in developing absolute accuracy of meaning because survey participants could not corroborate directly with the researcher for their feedback as to whether the meanings
were captured from their subjective view or intention. Every effort was made to develop meanings based on the entire text of the individual, as responses were read per individual and then against the group questions, not just once but repetitively, trying to ensure that essences were captured (Saldana, 2013; Tesch, 1987). The effort toward accuracy is based on breaking down segments of meaning to their smallest possible form for coding initially and then moving upward through a more focused meaning before elaborating an emerging theme followed by a master theme. An important facet of coding noted originally by Wolcott is captured in Saldana (2013), “Only understanding matters. We must not just transform our data, we must transcend them…” (p. 260). The work is to deepen awareness of meanings, raise essences for understanding larger appreciation of experiences with the subsequent hope for facilitation of learning linking in to whatever resonates for truth of the individual reader.

**Critical Reflexivity – A Few Shifts**

In my origins of this research, I was passionate to develop understanding of how events of work worlds and interactions shape professional satisfaction in psychologists. I focused on Saskatchewan because this is my frame of reference for my own practice. My passion to understand the events, interactions and knowledge that shape responsiveness to suicide-ideated clients was a driving force. My passion to be present, mindful, engaged and alive in the suicide work I provide with clients at risk of suicide has been the backbone to keep my practice reflective and reflexive. I continue to be passionate to learn and, subsequently, plan to research in the future because I feel that this study has only begun to provide a glimpse of the experiences I hope to understand.
In considering the mixed methods approach, I became increasing aware, in the middle of the research process, of the time and personal resources it takes to delve deeply into a mixed methodology. Hence, I realize now, I have only just began. In many ways, there is so much more to analyze and consider with the data collected, the survey open commentaries, and the narratives shared. Working a dissertation is goal-oriented as there are timelines to work within, this idea of timelines and life is constrictive when there is much to learn and examine. The reflexive process to consider meanings from the interviews alone takes months. I did not have the interaction of another researcher to discuss the process or the understandings – this felt isolating. Additionally, without many discussion and occasions for member checking, there is limitation in how close to understanding one can get. The research allows only a partial understanding and what I have come to realize is that my understanding is only through my subjective lens – try as I may to get full meaning, I still have to contend with how I engage reality. Although the member checking, of quotation text across to themes, was an opportunity to clarify and check on my understanding, it may have felt too reductionist to the participants – as Silverman highlights, “What a nice, simple world it would be if everything reduced to one factor!” (Silverman, 2010, p. 110). There is a risk that full understanding is merely grappled with but not grasped. There is the nagging awareness that I took themes to the participants, in member checking, and they may have agreed but may have still felt not fully heard or understood.

With regard to interviews, initially, I thought the use of ‘semi-structured interviewing’ would be a good choice. After all, a sense of safety seems to be connected to having a structure when taking on a new process. However, when it came
to the actual interviews, thankfully my experience as therapist pushed to the forefront. Rather than feeling safety in the idea of checking a semi-structured interview guide, I realized I felt safer in following the lead of the participant. It was natural for me to be in conversation – this is real for me. The work of Kathryn Roulston (2010) would have been valuable to me in the original planning for the interview-conversations but thankfully some therapist common sense guided me when starting the interviews to be engaged in a way that I could hear and feel the stories being shared. I knew the participants would lead me to their experience – I was so relieved to be less structured, I did not have to ‘interview’ per se. Having a conversation and having ‘a-hah’ moments of understanding are more likely to come when really connecting with the participant stories (Cunliffe, 2004). Conversation about the participants, for the understanding of the participants’ experiences, and taking in the vividness of the stories help to alleviate my situated tensions and insert myself as empathically as possible into the lives of the participants. Participants become teachers. They were the experts and they were leading me to awareness of their lived experiences. In that process, of conversation and the subsequent reflection and processing, there was opportunity to look in my own mirror. Once this awareness of my own shaping around my learning in research ‘struck me’, my mind, interactions, and thinking changed. Ann Cunliffe (2004) speaks to the full mind-body learning experience, where when we really realize there is need to shape ourselves to the experience, we change talk and action – there is an intuitive shaping of who we are in those moments. The co-construction of social reality has occurred in those moments of being struck (Cunliffe, 2004).
I was struck at other moments in this research process. I was originally trying to relate to the narratives by pulling together meanings but not necessarily allowing myself to transform. I had to embrace that I was in the process of transformation through the interactional process of research and had to de-centre myself to hear and feel the meanings of the work and within myself (Esler, 2011). Being off centre, is a little frightening – there is more risk and vulnerability. When earlier drafts occurred in this work, I was at an arm’s length from the shared stories I was learning about and learning from. I am not a ‘at arm’s length’ type of person. I am usually a ‘full-in’ type of person. I realized that I held a fear in inserting myself into the sharing of stories – “I might reveal too much”, “No one wants to hear about my experience”, and, so on. I realized that for me to appreciate their experiences I needed to get as close as I was during the actual conversations. I became increasingly aware that positivistic epistemology was creating a film, almost like a plastic pushed against my face preventing a clear connection with the stories and preventing permission to tell my story as one of value. I was trying initially to be an objective observer somewhat removed and yet somehow be able to provide some universal truth but after some reflection and reflexivity I realized that interpersonal and inter-subjective relationships with the research can allow for a hybrid narrative (Maines, Pierce, & Laslett, 2012). Upon these realizations, it was then, that I choose to place myself within the narrative process and was able to unmask myself in ‘The Story of Six’. I feared introspection would be viewed as self-indulgence but, realized that I, too, was situated in this research (that is why I have an interest in it) and if I did not give of my voice, then I may have pushed it forward in other ways, that would be less straightforward and honest – my voice
allowed me to a mutual collaborator up-front (Finlay, 2002). This transparency afforded a more palatable and appreciable understanding of the conversations.

I am increasingly aware of where this research could go. Although a dissertation process must come to an end, there are only beginnings when there has been interaction through research with participants’ lives. I am humbly aware that I have only revealed small pieces of the knowledge that should and can be revealed. I realize that I have been significantly changed through this process and am thankful that I chose to listen to the moments of ‘struck-ness’ so that I can follow up on better ways of interacting and shaping myself, my therapeutic practice, my social and community engagement around suicide prevention, and my potential to continue in research. In part the learning that this research has provided has given some sense of beginning recommendations that could prove supportive to psychologists, employers, psychology regulatory and advocacy bodies, and graduate programs.

**Recommendations**

**Research**

More research in the area of professional quality of life of Saskatchewan psychologists should be considered. There are far more lived experiences that would suitably inform better practices. Discussions of caseloads being burdensome and lack of control over practice leading to ethical questioning around best client care were highlighted in the qualitative aspect of the study. Stigma was identified as problematic for psychologists’ accessing self-care, supervision, and therapy. More understanding of the nature of stigma and the means to combat stigma amongst mental health practitioners and mental health management seems prudent.
Additional research would be useful specific to responsiveness to suicide in a larger perspective when suicide intervention is concerned. There is a multitude of suicide interventions in Saskatchewan and it is not established whether practical training has been pursued nor how effective current intervention strategies are. This research would inform training strategies and suicide-specific supervision needs.

Narrowing the research would be particularly useful specific to what are practices being followed in organizations to deal with suicide work. Best practice guidelines related to inclusion of external resources being activated in every case of clients at risk of suicide are not necessarily being followed as observed from the study participant reports (Chiles & Strosahl, 1995; Lang, et al., 2014). Problems have been communicated with regard to the influence of lean practices and the pressure these practices put on psychologists such that suicide work with clients may be compromised. There would be value in identifying if lean practice models and mandates follow best practice guidelines for work with suicide-ideated clients.

Based on the feedback from psychologists’ organizational responses to support the psychologists post client-suicide were described as being less than supportive and particularly focused on organizational debriefing in the interests of legal protections for the employer. Additionally, debriefing processes were described to vary significantly with some being drawn out over months and to a year. Research to determine how organizations are currently responding to suicide in terms of debriefings, support to the psychologists or other caregivers, would be helpful to potentially organize a more consistent and appropriate response pattern.
Grieving and rituals, such as funerals, connecting with colleagues after suicide, or reminiscing, were highlighted as important to process suicide for a number of the participants. Improving patterns of organizational response to include morale supportive reactions was noted as important to psychologists. Helpful processes included: honouring psychologists needs to discharge emotional reactions, discussing with supervisors and collegial supports perspectives on cases in non-judgmental but growth oriented ways, therapeutic talking through feelings of loss related to their client, and being encouraged to take self-care time would be useful to psychologists to process the client suicide. These strategies were highlighted as means to develop resiliency and growth post client-suicide. The study indicated that these practices were not being engaged in all organizations that suicide work is common practice in. It would be useful to appreciate in more detail whether these strategies are engaged in Saskatchewan.

**Employer Accountability and Psychology Regulatory and Advocacy Bodies**

Varied feedback from psychologists highlighted ways in which their employers were pushing for increased caseloads with little time for psychologists to be able to manage and keep up with best practices for suicide work. Ethical client care, although being addressed by organizations as improving because of lean strategy implementation, was identified as a struggle to manage. Psychologists questioned if they abided by best practices in suicide work when pressures and expectations are too high. There may be a value to review supportive employer practices with regard to psychologists. Although psychology regulatory bodies do not regulate employers, they do regulate psychologists. Advocacy for healthy workplaces, with balanced caseloads, adequate supervision,
adequate suicide-specific supervision, easy access to suicide-specific experiential training, and reasonable measures to support psychologists post client-suicide would be helpful to psychologists being competent and fit in suicide work.

**Stigma Breaking**

Stigma was identified as problematic for psychologists to seek help from supervisors, colleagues, or from other professionals. Fears of being judged, gossiped about, or not having anonymity were identified as feeding the stigma. Pressure from employers, to do more without support or for psychologists to be immune to problems or illness, fed stigmatized attitudes that psychologists should not require support. There may be opportunity for employers, regulatory bodies, various psychology-based organizations, and mental health groups to advocate with campaigns that could change the awareness of stigma within mental health care providers. We currently have many mental health campaigns to break stigma specific to public consumers seeking help but we have limited media or human resource policies that address how to prevent stigma within mental health organization against mental health workers getting the help they might need.

**Graduate Programs**

Graduate programs in educational psychology do not include practical suicide-specific training and not all clinical programs offer practical suicide-specific training within context of their casework in their practicums or internships. At the bare minimum, ASIST workshops would be a value to ensure that all psychologists receive training that attunes them to suicide intervention that is reliable and effective (Lang, et al., 2014; Schmitz, et al., 2012).
Sharing Results

Upon completion of the research and dissertation, the Saskatchewan College of Psychologists’ Registrar and Executive Council along with the Psychology Association of Saskatchewan will be approached and asked if they would endorse a web-link to a website where study outcomes can be referenced. There has been some remarkably honest and genuine participation that this research has generated. Following closure of the internet survey and completion of interview, numerous psychologists approached me and asked what the research demonstrated. Saskatchewan psychologists appear interested in the influence of psychologists’ quality of life. There appears to be thoughtfulness around factors that influence responsiveness to suicide-ideated clients. To support the commitment of psychologists, it seems prudent to find a manner in which interpretations from the research can be accessed. Those that shared of themselves in choosing to participate suggest that the research has value.

Researcher’s Experience

This work has been extremely valuable in terms of personal and professional growth. The thinking through the essences and meanings that have come through the work has facilitated an increased depth of awareness with regard to suicide intervention, therapy work and facilitation of training trainers related to suicide intervention. I feel that I have increased my tuning capabilities with regard to being with and in support of others. My capacities have increased. Of course, in the outset of research, there is a hope to contribute to knowledge. I believe in a modest way, I have made a contribution and this work has provided me with an awareness of where to go next in research. Really, it feels as though this study was a beginning to consider the ‘now what’ and
'what will I do with what I have learned' aspects. There is much more to consider about Saskatchewan quality of professional life and responsiveness in suicide work. There is work to be done around advocacy for those that provide professional suicide intervention work.

With further consideration to my experience, allow me to go back to the start of this research process. Initially, I was aware that my work and personal experiences likely allowed for first hand subjective and limited understanding of the phenomena I wished to study. I had worked in multiple work environments, some very supportive, collegially connected, with remarkably sound mentorship-supervision opportunities, and I had experienced workplaces that were the antithesis of helpful and supportive. I appreciated contributing factors in the development of quality of professional life. My experiences had been detailed around suicide work and intervention both professionally and personally. I felt I had a strong and varied work background, good intervention skills, experience with ongoing suicide therapeutic work, and personal knowledge of suicide. I had pursued multiple layers of intense suicide-specific training, experienced client suicide, and experienced personal traumatic life events. Earlier life timelines allowed me to understand anxiety and depression, which informed personal understanding of what it feels like to seriously consider suicide. These experiences, knowledge and training acted as tools to ready me for this research. I felt that I had some insight going in.

I was truly amazed when life began to demonstrate a parallel experience during my research process. It forced the learning to not just come through my research and
the individuals who allowed glimpses of their understandings and lives, but through my efforts to complete this work.

Allow me to elaborate. During the course of my research, I experienced three family deaths, very intense personal stressors, and physical illness. This proved to be extremely challenging. Ways in which I was accustomed to working and producing changed dramatically. Having, in the past, the ability to work several jobs, pursue personal interests, engage family and friends, and still be productive in my studies changed. I was conscious that my emotional level of distress, because of caregiving, grieving, and making effort to be present for my clients, reduced my ability to be rapidly productive in my research. I also felt the sting of stigma. I have learned that supports are not necessarily that easy to embrace when one self-judges or is impatient with oneself. I have become increasingly aware that business systems are not always conscious of others’ needs around timing, processing and pacing. This has been a journey of incredible patience to be extended to myself and to systems connected with work and academia.

The parallel of challenge, around quality of life, allowed me to see and feel the remarkable efforts of the participants with a measure of distinct admiration. Numerous intrinsic differences have occurred as a result of this research journey. My engagement in and appreciation for the experience of the other has deepened. The work has informed me to be even more with and in the moment with my clients. The need to ensure that my interpretation is accurately reflecting the stories of those that I am engaging with has critically deepened. I notice in my client work that I tune in even more attentively to meanings and seek to capture essences more clearly. I genuinely
feel that this research process has increased my ability in provision of suicide intervention and therapy.

The research has increased my awareness that being responsive to a suicide-ideated client has connection to how a caregiver is impacted by health, wellbeing, emotions, attitude, connection, listening, interpretation and desire to be helpful. Safety from suicide is entirely about being best able to hear and appreciate what the person at risk really needs from their perspective without the noise of self or organization which can overshadow the collaborative discovery of the client’s pathway that leads to engagement with safety.

Elaborated from the stories and themes a phenomenal commitment is demonstrated from Saskatchewan. All participants are professionals with admirable and deep desire to affect best possible outcomes in the individuals they choose to connect with. Subsequently, I find myself more passionately fuelled to work at supporting psychologists in their suicide work. I find myself increasingly interested to advocate for professional practice fitness and consider next steps to reduce stigma that prevents psychologists accessing support. Psychologists receiving better access to physical and emotional support, adequate supportive supervision, more opportunity for suicide-specific training, with choice and control over their work translates to clients being better supported and more likely to be heard in ways that allow them to embrace being safer from suicide.

The Margaret Atwood quote that has resonated for me throughout this research has been, “In the end, we all become stories.” I have repeatedly thought about how caregivers are storied by individuals who have made effort to support them in safety. I
have hoped that each story caregivers are involved in is one of hope and energy for genuine authentic caring focused on the needs of helping the individual at risk of suicide. I have the awareness that our systems play a part in how the stories will be told. My hope is that the stories and legacies we leave behind reflect absolute best efforts, understanding, compassion and support for individuals whose desperation and pain has become so burdensome that suicide is an option. Perhaps our story will be that work-systems support psychologists, and caregivers alike, ensuring that their health and wellbeing is supported such that suicide work is embraced competently.
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Appendix A
University of Regina Ethics Board Approval

DATE: July 10, 2012

TO: Renee Jody Schmidt
3070 Montague Street
Regina, SK S4S 1Z5

FROM: Dr. Larena Hoeber
Chair, Research Ethics Board

Re: Psychologists' Quality of Professional Life as a Determinant in Responsiveness when Working as Suicide Interventionist – A Saskatchewan Perspective (File #7531112)

Please be advised that the University of Regina Research Ethics Board has reviewed your proposal and found it to be:

☐ 1. APPROVED AS SUBMITTED. Only applicants with this designation have ethical approval to proceed with their research as described in their applications. For research lasting more than one year (Section 1F), ETHICAL APPROVAL MUST BE RENEWED BY SUBMITTING A BRIEF STATUS REPORT EVERY TWELVE MONTHS. Approval will be revoked unless a satisfactory status report is received. Any substantive changes in methodology or instrumentation must also be approved prior to their implementation.

☐ 2. ACCEPTABLE SUBJECT TO MINOR CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. ** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 3. ACCEPTABLE SUBJECT TO CHANGES AND PRECAUTIONS (SEE ATTACHED). Changes must be submitted to the REB and approved prior to beginning research. Please submit a supplementary memo addressing the concerns to the Chair of the REB. ** Do not submit a new application. Once changes are deemed acceptable, ethical approval will be granted.

☐ 4. UNACCEPTABLE AS SUBMITTED. The proposal requires substantial additions or redesign. Please contact the Chair of the REB for advice on how the project proposal might be revised.

Dr. Larena Hoeber

cc: Dr. Heather Ryan - Education

** supplementary memo should be forwarded to the Chair of the Research Ethics Board at the Office of Research Services (Research and Innovation Centre, Room 109) or by e-mail to research.ethics@uregina.ca

Phone: (306) 585-4775
Fax: (306) 585-8693
DATE: July 15, 2013

TO: Renee J. Schmidt
3070 Montague Street
Regina, SK S4S 1Z5

FROM: Meigen Schmidt
Research Ethics Board

RE: Annual Research Status Report (File # 7551112)

Thank you for submitting the required Annual Research Status Report on your project entitled, "Psychologists' Quality of Professional Life as a Determinant in Responsiveness when Working as Suicide Interventionist - A Saskatchewan Perspective".

This memo confirms ethical clearance for an additional 12 months beginning July 10, 2013.

Sincerely,

Meigen Schmidt
Senior Research Officer – Office for Research, Innovation and Partnership

cc: Dr. Heather Ryan - Education
Dear Saskatchewan Member Psychologist:

This letter is an invitation to participate in a study being conducted as a portion of the requirements for a Ph.D. in the Faculty of Graduate Studies by Renee Schmidt at the University of Regina under the supervision of Dr. Heather Ryan.

This research study will focus on the quality of professional life of Saskatchewan psychologists and their responsiveness in working with clients who present with suicidal ideation.

The study is entitled: *Psychologists’ quality of professional life as a determinant of responsiveness when working as suicide interventionist – A Saskatchewan perspective.*

Participation in this study is voluntary. If you have never worked with clients who presented with suicidal ideation or you no longer practice and never interacted with clients who expressed suicide thoughts, you may chose non-participation. However, quality of professional life may be a determinant around potential responsiveness when a client expresses suicidal thoughts or when working with suicidal ideation in the future. So, even if you have not previously worked with clients expressing suicidal ideation, your responses are valuable. Further, you may work with a client expression of suicidal ideation in the future and your responses in the study are valuable.

The online survey involves completion of a demographics form, questions about your practice and two survey measures that you can access with the link noted at the end of the letter to indicate consent to participate in the study. The internet link can be accessed through the web link indicated at the bottom of this letter. Or, after reading the Consent Form found upon clicking on the web link you can click on “Yes” to initiate the survey as an indication of your consent to participate. No personal identifiers will be collected that will reveal your name, your agency of work, or
particulars that can identify you.

If you choose to participate in the online survey your responses will be used in the production of a dissertation that will be used as the concluding requirement for a Doctor of Philosophy degree. All of the information collected during this study will be anonymous. While the results of the research study will likely be shared with other people and may be published in educational or scientific reports your name and the fact that you participated in the study will remain anonymous. The data collection is done online and is protected using security protocols. To help insure your anonymity, please close your Internet browser upon completion of the survey. Your files will be electronically deleted after 5 years upon completion of the study. Access to this information will be limited to the primary researcher. Your name is not linked to your answers in the survey or questions.

There are no known or anticipated risks to you as a participant in this study. It is anticipated that you will recall and think about your practice as a psychologist. There are no direct benefits that you will receive for participating in this study; however, your willingness to take part in this important study is very much appreciated.

The decision to participate in this study is entirely up to you. If you begin to provide responses but do not submit the completed questionnaires, your data will be deleted. You may withdraw at any time during the on-line survey if you so choose. All information collected as part of this study will be stored securely and anonymously. The on-line survey will likely be completed within 25-45 minutes of your time.

In appreciation of your participation and completion of the on-line survey you can choose to enter your name in a draw for a chance to win a spa service, which can be thought of as a measure of self-care that adds to one’s relaxation and quality of life. The draw entry is not connected with your survey answers. The names in the draw are not kept as a tracking of who has participated in the surveys. After you have completed the on-line survey you can enter the draw once.

If you have any questions regarding this study, or would like additional information to assist you in reaching a decision about participation, please contact me at (306) 539-6820 or by e-mail at schmid1r@uregina.ca. Dr. Heather Ryan could also assist you at (306) 585.4002.
The University of Regina Research Ethics Board has approved this study on ethical grounds on February 28, 2013. Any questions regarding your rights as a participant may be addressed to the committee at (306) 585.4775 or research.ethics@uregina.ca. Out of town participants may call collect.

I look forward to your participation. Thank you in advance for your assistance in this project.

Sincerely,

Renee J. Schmidt, Doctoral Student

LINK TO SURVEY: https://www.research.net/s/psychologists_quality_of_professional_life
Appendix C – Consent form embedded in the on-line survey

Faculty of Graduate Studies
University of Regina

Consent Form

Study Title: Psychologists’ quality of professional life as a determinant of responsiveness when working as suicide interventionist – A Saskatchewan perspective

I have read the information in the invitation to participate in research letter forwarded through the Saskatchewan College of Psychologists.

I understand that the study being conducted by the primary researcher, Renee J. Schmidt (schmid1r@uregina.ca or 306- 539-6820) is a part of the requirements for completion of a Ph.D. under the supervision of Dr. Heather Ryan, Faculty of Graduate Studies - University of Regina, (306) 585-4002.

I have had the opportunity to ask any questions related to this study by contacting the researcher via email or telephone as indicated in the invitation to participate letter and I have received satisfactory answers and details that I requested.

I am aware that by clicking on the link and completing the survey, I am providing my permission to use the data provided from the on-line demographic information, answers to questions about my psychology practice, and the completed survey questions to be used in the researcher’s dissertation. I understand that my participation is voluntary. No personal identifiers will be provided in the collated data.

I am aware that the on-line study may take between 25-45 minutes of my time to complete. I have been informed that I may withdraw my consent at any time without any negative consequence. To withdraw your consent during the survey, simply discontinue the survey and close your browser.

If you choose to complete the survey later on, please return to this form and click on the “yes” indicating that you consent to participate in the study. To ensure there is no link to the survey site after you complete your participation, please close the browser on the survey link after you have completed all parts of the survey and submitted your responses.

I have been informed that this project has been reviewed by and has received ethical clearance through the Research Ethics Board of the University of Regina on February 28, 2013. I have been informed that if I had any concerns or questions resulting from my participation in this study, or regarding my rights as a participant, that my concerns may
be addressed to the Research Ethics Board Committee at (306) 585-4775 or research.ethics@uregina.ca. Out of town participants may call collect.

I acknowledge that I have read the aforementioned explanation of this research project, and I choose to participate in this study. By completing and submitting the attached questionnaires YOUR FREE AND INFORMED CONSENT IS IMPLIED and indicates that you understand the above conditions of participation in this study.

☑ YES  A “Yes” answer will immediately start the survey

☑ NO
Appendix D – On-line survey

Psychologists’ quality of professional life

About you

I am:

Married or common-law
Single
Separated/Divorced
Widowed/Widower

I am:

Male
Female

My age range is:

20-29
30-39
40-49
50-59
60-69
70-79
Other (please specify):
Your training?

I am:

- A licensed/registered psychologist in Saskatchewan
- A provisionally licensed/registered psychologist in Saskatchewan
- A licensed/registered psychologist in another jurisdiction
- A licensed/registered psychologist in Saskatchewan and another jurisdiction
- Grandfathered as a psychologist
- Not licensed/registered as a psychologist
- Other (please specify):

My formal area of psychology train is (Check all that apply):

- Educational
- Clinical
- Counselling
- Forensic
- Organizational
- Research
- Other (please specify):

What is the highest level of education you have completed?

- Bachelor
- Master
- Doctorate
- Other (please specify):

Specific training focusing on client suicide ideation has been (please indicate all that apply):

- University class discussion and/or text readings
- Project/paper/reading
- ½ day session
- 1 day session
- On-line internet training
- QPR (Question Persuade Respond)
- safeTALK (3 hour alertness training)
- ASIST (Applied Suicide Intervention Skills Workshop 2-day workshop)
- suicideCARE (1-day therapist or case Manager workshop)
- Other (please specify):
Your Work

I have been working as a psychologist for:

- 0-5 years
- 6-10 years
- 11-15 years
- 15-20 years
- 21-25 years
- 26-30 years
- Other (please specify):

I have worked in an adjacent, or closely related, field to psychology for:

- I have not worked in another related field
- 0-5 years
- 6-10 years
- 11-15 years
- 15-20 years
- 21-25 years
- 26-30 years
- Other (please specify):

If you had worked in a field closely related to psychology, please describe your role:

My work is primarily:

- Urban
- Rural
- Other (please specify):

My area of practice is:

- Private
- School
- Mental Health Clinic
- Hospital/In-patient
- Corrections
- Addictions
- Consultation and Training
- Other (Please specify):
The primary focus of my work is:

Assessment
Counselling/Treatment/Therapy
Education
Research
Other (please specify):

The populations(s) that I currently work with are:

Children
Adolescents
Adults
Couples
Family
Organization/Communities
Other (please specify):

My total caseload averages between:

1-10
11-20
21-30
31-40
Other (please specify):
Your Self-Care Activities

Which self-care activities do you intentionally participate in to alleviate work stress? (check all that apply)

Exercise
Meditation
Spiritual Practice
Prayer
Family-connections
Spouse-connections
Friendship interactions
Time with pets
Debrief work activities or discuss cases with colleagues
Talk with colleagues between sessions
Debrief feelings from work with spouse/family/friends
Receive consultation or supervision
Time alone
Attend workshops
Limiting case load
Diversification of therapy strategies
Journal thoughts
Writing
Professional counselling
Pastoral counselling
Massage
Spa Treatments
Music
Reading for pleasure
Read for advancing work skills
Hobbies
Crafts
Travel
Vacations
Movies
Artwork
Follow Sports
Other (please specify):
Your Self-Care Activities

Summarize the frequency of your intentional self-care activities:

Several times throughout the day
Once daily
Several times each week
Once weekly
Several times monthly
Monthly
Sporadically/inconsistently
Other (please specify):

Please provide a brief description of how your intentional activities support self-care when you experience work stress. Self-care activities can include engaging in self-awareness, self-regulation and creating balance.


Do You Work with Suicide?

Do you work with clients who experience suicide ideation?

No, never
Yes, currently, or, in past jobs

Is the work you are doing longer-term, past the initial identification of suicide ideation?

No, I work only at the initial assessment of suicide risk and pass the client along to a different practitioner for follow-up if suicide ideation is assessed.

Yes, I work in an ongoing or longer-term manner around issues related to suicide.

The therapeutic work I do with clients that present with suicide ideation is best described as (indicate all that apply):

- Behavioural Therapy
- Client-centered
- Cognitive Therapy
- Cognitive Behavioural Therapy
- Dialectic Behaviour Therapy
- EMDR-Eye Movement Desensitization & Reprocessing
- Family Systems Therapy
- Interpersonal Therapy
- Rational Emotive Therapy
- Solution-Focused Therapy
- Other (please specify):

Repetitive suicide clients on my caseload averages between:

- 1-5
- 6-10
- 11-15
- 16-20
- 21-25
- Other (please specify):
When working with clients experiencing suicide ideation, I engage other resources for support of the client:

False
Mostly true
Always true
Other (please specify):

When working with clients experiencing suicide ideation, I engage resources to support myself in my work:

False
Mostly true
Always true
Other (please specify):

How does accessing client supports prove helpful to you in your work with clients with suicide ideation? (Please describe)

What professional supports do you create, engage in or receive from your work environment (including colleagues, managers, debriefings, employee and family assistance programs, trainings, etc…) that allows you to continue your work with clients who may present with suicide ideation? (please describe and if you do not connect with support please indicate)
**Your Response to Client Suicide**

Have clients you worked with died as a result of suicide?

- No/I do not know
- Yes, while they were an active client
- Yes, after they were no longer under my care

**Impact of Client Suicide**

How did you receive news of a client’s death by suicide? What impact did that client’s suicide have on you?

What follow up did you access (i.e., personal connections, persona outlets, self-care activities, counselling, debriefing, spiritual support, family or friends, etc…) or support was provided to you (i.e., supervision, debriefing, management support, time off work, support to caseload, talking circles, employee and family assistance program, etc…) when a client dies as a result of suicide?

What had been most helpful from colleagues, manager or the organization in supporting you when a client dies as a result of suicide?

What else may have been helpful that was not offered to you?

If you have worked with clients experiencing suicide ideation or having worked through a client’s completed suicide, in what ways has your practice changed? How might you work differently? How have you grown in your practice?

Having worked with clients with suicide ideation, what has been your learning about what you need to do for yourself or to ask of your persona or professional support system in order to continue positive outcomes when working with such clients?
As a result of working with clients with suicide ideation or having worked through a client’s completed suicide, in what ways has your self-care, health management and/or personal outlooks changed?

What changes would you encourage workplaces or therapists to make so that there is adequate support and potential for growth when psychologists work with clients who experience suicide ideation?

Are there barriers for a psychologist in help-seeking?

Are there barriers that prevent you or fellow psychologists from seeking or accessing help when there is extreme work stress or pressure?
Appendix E – Professional Quality of Life Scale, Version 5 (PROQOL5)

Professional Quality of Life Scale, Version 5 (PROQOL5) developed by Beth Stamm, 2009

When you provide psychological services to people you have direct contact with their lives. As you may have found, your compassion for those you provide assessment, counselling, therapy or treatment for can affect you in positive and negative ways. Below are some questions about your experiences, both positive and negative, as a psychologist.

Consider each of the following questions about you and your current work situation.

Select the number that honestly reflects how frequently you experienced these things in the last 30 days.

<table>
<thead>
<tr>
<th>1 = Never</th>
<th>2 = Rarely</th>
<th>3 = Sometimes</th>
<th>4 = Often</th>
<th>5 = Very Often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I am happy.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. I am preoccupied with more than one person I [help].</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>3. I get satisfaction from being able to [help] people.</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. I feel connected to others.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. I jump or am startled by unexpected sounds.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. I feel invigorated after working with those I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7. I find it difficult to separate my personal life from my life as a [helper].</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>8. I am not as productive at work because I am losing sleep over traumatic experiences of a person I [help].</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>9. I think that I might have been affected by the traumatic stress of those I [help].</td>
<td></td>
<td></td>
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<tr>
<td>10. I feel trapped by my job as a [helper].</td>
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<tr>
<td>11. Because of my [helping], I have felt &quot;on edge&quot; about various things.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12. I like my work as a [helper].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13. I feel depressed because of the traumatic experiences of the people I [help].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14. I feel as though I am experiencing the trauma of someone I have [helped].</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>15. I have beliefs that sustain me.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
16. I am pleased with how I am able to keep up with [helping] techniques and protocols.

17. I am the person I always wanted to be.

18. My work makes me feel satisfied.

19. I feel worn out because of my work as a [helper].

20. I have happy thoughts and feelings about those I [help] and how I could help them.


22. I believe I can make a difference through my work.

23. I avoid certain activities or situations because they remind me of frightening experiences of the people I [help].

24. I am proud of what I can do to [help].

25. As a result of my [helping], I have intrusive, frightening thoughts.

26. I feel "bogged down" by the system.

27. I have thoughts that I am a "success" as a [helper].

28. I can’t recall important parts of my work with trauma victims.

29. I am a very caring person.

30. I am happy that I chose to do this work.

Note: Where 'helper', 'help', or 'helping' is noted in the above copy, the actual survey made connection to 'psychologist', 'provide psychology services', or 'provide psychology services to'. This modification is deemed acceptable to individualize the caregiver role as noted in Stamm’s work.
Appendix F – Suicide Intervention Response Inventory, Second Edition (SIRI-2)

Suicide Intervention Response Inventory
The following items represent a series of excerpts from counseling sessions. Each excerpt beings with an expression by the client concerning some aspect of the situation he or she faces, followed by two possible helper responses to the client’s remark.

You are to rate each response in terms of how appropriate or inappropriate you feel the reply is to the client’s comment. In the blank, you should record a rating from -3 to +3, corresponding to the chart below. Be sure to respond to each item and try not to leave any blanks.

+3 Highly appropriate response
+2 Appropriate response
+1 Marginally appropriate response
0 Neither appropriate, nor inappropriate
-1 Marginally inappropriate response
-2 Inappropriate response
-3 Highly inappropriate response

1. **Client:** I decided to call in tonight because I really feel like I might do something to myself … I’ve been thinking about suicide.
   
   ____ **Helper A:** You say you’re suicidal, but what is it that’s really bothering you?
   
   ____ **Helper B:** Can you tell me more about your suicidal feelings?

2. **Client:** And now my health is going downhill too, on top of all the rest. Without my husband around to care for me anymore, it just seems like the end of the world.
   
   ____ **Helper A:** Try not to worry so much about it. Everything will be alright.
   
   ____ **Helper B:** You must feel pretty lonely and afraid of what might happen.

3. **Client:** But my thoughts have been so terrible … I could never tell them to anybody.
   
   **Helper A:** You can tell me. I’m a professional, and have been trained to be objective about these things.
   
   ____ **Helper B:** Some of your ideas seem so frightening to you, that you imagine other people would be shocked to know you are thinking such things.

4. **Client:** No one can understand the kind of pain I’ve been through. Sometimes I just feel like I have to hurt myself, so I cut my wrists.
   
   **Helper A:** It seems like you’ve been suffering so much that cutting your wrists is the only way you can make the pain go away.
   
   ____ **Helper B:** But you’re so young, you have so much to live for. How can you think of killing yourself?

5. **Client:** What are you anyway? Are you a doctor? How do you know what I’ve been going through? You’ve probably had it pretty soft.
   
   ____ **Helper A:** So you’re wondering if I can understand how you feel.
   
   **Helper B:** You’re not even giving me a chance. I’ve had a pretty rough life too, you’re not the only one who’s seen some hard time.
6. **Client:** My life has been worthless ever since my wife, Emma, died four years ago. The kids are grown and married now, and I’ve been retired from my job at the railroad for some time. It just seems that I’d be better off dead.

   **Helper A:** But try to think of what Emma would want for you. She’d want you to continue leading a productive life, wouldn’t she?

   **Helper B:** It sounds like everything just collapsed around you when Emma died. But what has happened recently to make things even worse, to make you think that dying is the only way out?

7. **Client:** I really need help... It’s just... [voice breaks; silence]

   **Helper A:** It must be hard for you to talk about what’s bothering you.

   **Helper B:** Go on. I’m here to listen to you talk.

8. **Client:** When you sum up my problem like that, it makes it seem less confusing and not so scary.

   **Helper A:** See, it really isn’t so bad after all. It certainly isn’t anything you would think of killing yourself over, is it?

   **Helper B:** Sometimes talking about problems does make them a bit clearer. I think you realize how dangerous your suicidal feelings were, that’s why you decided to contact me.

9. **Client:** You were supposed to help me, but you’ve only make things worse.

   **Helper A:** I’m sorry. I was only trying to help.

   **Helper B:** You sound pretty angry.

10. **Client:** How could you ever help me? Have you ever wanted to kill yourself?

    **Helper A:** It sounds like you’re concerned about whether I can understand and help you.

    **Helper B:** Sure. I’ve thought about suicide sometimes. But I always found more realistic solutions to my problems.

11. **Client:** I don’t know... this whole thing with my wife really gets to me. [Sobs] I try so hard to keep from crying...

    **Helper A:** Do you think that the reason it’s hard for you to cry is because you’re a man?

    **Helper B:** With all the hurt you’re feeling, it must be impossible to hold those tears in.

12. **Client:** How can I believe in God anymore? No God would ever let this happen to me; I’ve never done anything to deserve what’s happened.

    **Helper A:** Things have gotten so bad, that it’s difficult to see any meaning in the things that have happened to you.

    **Helper B:** Well. God works in mysterious ways. Maybe this is His way of testing your faith.
13. **Client:** I don’t know why I’m calling you. My family is financially well off, and my husband spends plenty of time with me, even though he has a successful law career. Even my kids have been doing well. They get good marks at school and have lots of free time activities with their friends. But nothing seems to interest me. Life is just a bore …

**Helper A:** Considering all you have going for you, your problems can’t be all that serious. Try to focus more on the positive aspects of your situation.

**Helper B:** So even though things seem to be going well at one level, life still seems pretty depressing, even if it’s hard to say exactly why.

14. **Client:** I have to hang up now. My mother’s coming home soon and I don’t want her to know I’ve been talking to you.

**Helper A:** Okay, but if you keep feeling suicidal, remember you can always call back.

**Helper B:** All right, but first I want you to promise me you won’t do anything to hurt yourself, until you call and talk to me. Will you repeat that promise?

15. **Client:** Is it really true, that many people feel this way? I thought I was the only one who had such dreadful, sinful ideas.

**Helper A:** No, there are many people who suffer from mental illness. But with appropriate treatment by a qualified physician, some of these patients can be cured.

**Helper B:** It is true. You’re not the only one who has suicidal thoughts. And you can be helped to get through this crisis, just as others have been.

16. **Client:** I’m so lonely, so tired. [Crying] There just isn’t anywhere left to turn.

**Helper A:** You seem so alone, so miserable. Have you been feeling suicidal?

**Helper B:** Come on now. Things can’t be all that bad.

17. **Client:** [Over telephone] It’s hard to talk here, with all these people.

**Helper A:** Would it help if I asked questions?

**Helper B:** Why don’t you call back some other time when you can talk more easily?

18. **Client:** I have a gun pointed at my head right now, and if you don’t help me, I’m going to pull the trigger!

**Helper A:** You seem to be somewhat upset.

**Helper B:** I want you to put down the gun so we can talk.

19. **Client:** Why should you care about me, anyway?

**Helper A:** I’ve been trained to care about people. That’s my job.

**Helper B:** Because I think your death would be a terrible waste, and it concerns me that things are so that you are considering suicide. You need help to get through this critical period.
20. **Client:** I really hate my father! He’s never show any love for me, just complete disregard.

**Helper A:** You must really be angry at him for not being there when you need him.

**Helper B:** You shouldn’t feel that way. After all, he is your father, and he deserves some respect.

21. **Client:** I don’t think there’s really anyone who cares whether I’m alive or dead.

**Helper A:** It sounds like you’re feeling pretty isolated.

**Helper B:** Why do you think that no one cares about you anymore?

22. **Client:** I tried going to a therapist once before, but it didn’t help … Nothing I do now will change anything.

**Helper A:** You’ve got to look on the bright side! There must be something you can do to make things better, isn’t there?

**Helper B:** Okay, so you’re feeling hopeless, like even a therapist couldn’t help you. But has anyone else been helpful before – maybe a friend, relative, teacher, or clergymen?

23. **Client:** My psychiatrist tells me I have an anxiety neurosis. Do you think that’s what’s wrong with me?

**Helper A:** I’d like to know what this means to you, in this present situation. How do you feel about your problem?

**Helper B:** I’m not sure I agree with that diagnosis. Maybe you should seek out some psychological testing, just to be certain.

24. **Client:** I can’t talk to anybody about my situation. Everyone is against me.

**Helper A:** That isn’t true. There are probably lots of people who care about you if you’d only give them a chance.

**Helper B:** It must be difficult to find help when it’s so hard to trust people.

25. **Client:** [Voice is slurred, unclear over telephone.]

**Helper A:** You sound so tired. Why don’t you get some sleep and call back in the morning?

**Helper B:** Your voice sounds so sleepy. Have you taken anything?

Neimeyer & Bonelle, 1997
Appendix G

End of Online Survey Link
Expression of Gratitude/Enter for Chance to Win Spa Treatment
Invitation to Interview

Thank you! Please read the following before you enter the draw for a chance to enter a draw to win a spa treatment.

Thank you! Would you like to participate in a personal interview?

Dear Psychologist,

Thank you for your participation in the surveys.

Perhaps you have more you would like to contribute to this research?

Do you have interest in additional interviewing to personally share your lived experiences of working as a psychologist in Saskatchewan?

If you feel that you can contribute valuable understanding about working with clients at risk of suicide, the impact of working through your own feelings of the death of a client by suicide, contributing factors that support your professional life as psychologist, or your sense of how you have developed satisfaction in your work as psychologist or elements that help in your fitness to practice, please contact the researcher to organize your interview.

The researcher, Renee Schmidt can be reached by mobile phone directly at 1(306)539-6820 or you may also contact her via email at schmid1r@uregina.ca

The researcher will discuss setting up a 90-minute interview at your convenience and at the location where you can speak comfortably. The researcher will travel to your location. In the interview you will share your experiences and knowledge for the development of the research about Saskatchewan psychologists’ quality of professional life and responsiveness to clients presenting with suicide-related ideation, communication, and behaviors. The interview will be audio recorded to allow for the researcher to review discussion provided in the interview. Participation in the interview is voluntary.

Consent forms and details of the interview can be discussed upon contact with the researcher.

With deep gratitude,

Renee J. Schmidt, Doctoral Student
Again, thank you for completing the survey!

If you feel that answering the survey has brought up thoughts and feelings that may require support or self-care, please take time to chat with a supportive person or participate in activities that help you to feel more relaxed.

Thank you for your participation!
Hurrah! I can enter a chance to win a spa treatment!

Now that the survey questions have been completed you may choose to enter a draw to win a spa treatment. The spa treatment is valued at $120. A spa treatment is just one means of taking care of your self!

Remember, the survey information you completed will not be linked to your email, your name, organization, or workplace specifically. No record of your participation in the data collection will be returned to your regulatory body (Saskatchewan College of Psychologists).

Your name and Email on the entry is not connected to the survey or demographics.

Your odds of winning a spa treatment are approximated to be 1 out of 250!

Would you like to enter the draw for spa services??

A. Great – I could use some self-care! I choose to enter my name in the draw now for a chance to win a spa treatment!

B. No, thank you, I do not wish to enter the draw for a chance to win a spa treatment.

(If response A were activated, this page would pop up)

Complete entry form details for a chance to win a Spa Treatment

Please indicate:

Name: ________________________________
Address: ________________________________
City/Town: ________________________________
Province: ________________________________
Postal Code: ________________________________
Email: ________________________________
Phone: ________________________________
(Upon completion of the entry form, this note would pop up)

Your name will be added to the draw!

Don’t forget…

If you wish to participate in additional personal interviewing you are welcome to contact the researcher, Renee Schmidt, at 1(306) 539-6820 or at schmid1r@uregina.ca to set up a 90-minute interview at a location of your choice.

Good luck on the draw for a spa service!!!

Thank you for you time, energy and sharing.

(If response B were activated, this page would pop up)

You did not enter the draw. Thank you for participating!

Don’t forget…

If you wish to participate in additional personal interviewing you are welcome to contact the researcher, Renee Schmidt, at 1(306) 539-6820 or at schmid1r@uregina.ca to set up a 90-minute interview at a location of your choice.

Thank you for you time, energy and sharing.
Appendix H

University
of Regina

Faculty of Graduate Studies

Consent Form

Interview

Study Title: *Psychologists’ quality of professional life as a determinant of responsiveness when working as suicide interventionist – A Saskatchewan perspective*

I have read the information in the invitation to participate in research letter forwarded through the Saskatchewan College of Psychologists.

I understand that the study being conducted by the primary researcher, Renee J. Schmidt (schmidt1r@uregina.ca or (306) 539.6820) is a part of the requirements for completion of a Ph.D. under the supervision of Dr. Heather Ryan, Faculty of Graduate Studies - University of Regina, (306) 585-4002.

I have had the opportunity to ask any questions related to this study by contacting the researcher via email, telephone, or in person as indicated in the invitation to participate letter and I have received satisfactory answers and details that I requested.

I am aware that I am providing my permission to use the interview discussion, descriptions and possibly my direct quotations about my experiences as a psychology practitioner in Saskatchewan – the information will be transcribed and utilized to inform the researcher’s dissertation. I am aware that the interview will be audio recorded. I am aware that no personal identifiers will be provided in the descriptions, in fact, pseudonyms may be used and personal/professional identifiers omitted to ensure anonymity.

I have been informed that I may withdraw my consent at any time without any negative consequence. To withdraw my consent during the interview, I can simply advise the researcher to discontinue my participation and end the interview – none of the collected information will be used. If, after the completion of my interview, I wish to withdraw my interview data, please contact the researcher no later than November 16, 2013 in order to ensure your data is withdrawn.

I understand that my participation in this study interview is entirely voluntary.
I have been informed that this project has been reviewed by and has received ethical clearance through the Research Ethics Board of the University of Regina on February 28, 2013.

I have been informed that if I had any concerns or questions resulting from my participation in this study, or regarding my rights as a participant, that my concerns may be addressed to the Research Ethics Board Committee at (306)585.4775 or research.ethics@uregina.ca. Out of town participants may call collect.

I acknowledge that I have read the aforementioned explanation of this research project, and I choose to participate in this study.

By completing and signing this form I am acknowledging free and informed consent, indicating that the researcher has permission to use the information and experiences discussed in the interview to inform her research.

To ensure truth in the research, the researcher will confer with you should there be concerns about transcription from the audio recordings and/or to establish confirmation of your interview. I acknowledge that I am in agreement with this follow up contact post-interview.

Participant’s signature ____________________________________________
Dated ____________________________________________________________

Researcher’s signature ____________________________________________
Dated ____________________________________________________________

A copy of this consent has been received by the participant _____ (participant’s initial).
Appendix I

Semi-Structured Interview Guide

1. Could you tell me a bit about your training, your work, and your practice?

2. What experiences influence your quality of professional life – feeling satisfaction or feeling fatigue within your work?

3. What have been your perceptions and experiences related to clients who present with suicide ideation, communication and behaviours?

4. Has there been personal or professional influence that resulted from the experience of work with client suicide?

5. What are your perceptions of supportive mechanisms for psychologists – such as supervision, personal therapy, engaging self-care, or organizational structures?

6. Considering your experiences, what might be helpful considerations for psychologists dealing with client death by suicide?

7. What is your perception of barriers to, or accessibility, for psychologists in activating support or help?
Appendix J

Emerging themes developed from each of the 12 open-ended questions from the web survey. Participant perceptions are placed into focused concepts/codes beyond initial coding. Frequencies of participant perceptions are also recorded.

Participants are either reflective of the entire survey respondents, n=61 or in questions dependent upon if the psychologist had experienced client suicide n=20.

The Effects of Self-Care

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Psychologists are more emotionally stable when self-care is engaged</td>
<td>49</td>
<td>• Increased emotional regulation, emotional balance, and self-regulation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Able to focus without becoming emotionally charged.</td>
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<tr>
<td></td>
<td></td>
<td>• Mind feels healthy. Thinking clearly.</td>
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<tr>
<td></td>
<td></td>
<td>• Not feeling overwhelmed. Reduction of anxiety.</td>
</tr>
<tr>
<td>Psychologists are more present and competent in their professional role with adequate self-care</td>
<td>47</td>
<td>• Clear thinking, decisions, clinical judgment, perspective and communication.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More focused on client, ready to listen, mindfully interacting, and aware if client needs.</td>
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<tr>
<td></td>
<td></td>
<td>• Renewed energy and interest at work.</td>
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<tr>
<td></td>
<td></td>
<td>• More able to serve clients and be objective.</td>
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<tr>
<td></td>
<td></td>
<td>• Able to leave personal life at home and professional life at work.</td>
</tr>
<tr>
<td>Increased self-awareness grows from self-care</td>
<td>26</td>
<td>• Self-aware, self-reflective, clear perspective, and spiritual awareness</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Boundaries established clearly between the professional and personal.</td>
</tr>
<tr>
<td>Health benefits come from self-care</td>
<td>19</td>
<td>• Less stress-related problems.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Physical health is more stable.</td>
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<tr>
<td></td>
<td></td>
<td>• Calmness noted - no anxiety, able to relax, sleeps easily</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Able to focus more easily.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased energy, feeling rejuvenated.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Lower blood pressure.</td>
</tr>
<tr>
<td>Improved personal relationships are a result of self-care</td>
<td>11</td>
<td>• More desire for social connections and outings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Improved relationships and sense of belonging.</td>
</tr>
</tbody>
</table>
### Benefits to Psychologists When Accessing Supports for Suicide-Ideated Clients

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=61)</th>
</tr>
</thead>
</table>
| Satisfaction increased because better clinical/therapeutic work was done for suicide-ideated client through accessing supports | 35        | - Best practice maintained.  
- Improved perspective in psychologist.  
- Second opinion - more collaboration, and consultation.  
- Clients learn to involve others and seek help.  
- Team improves work around suicide. |
| Increased client safety occurs by accessing supports and creates relief in psychologists | 34        | - Reduced risk of suicide allows psychologist to feel more assurance and less doubt.  
- More caregivers and resources help clients develop more independence, less dependence on psychologist caregiver. Team is stronger.  
- During crisis more helpers available.  
- Sustainable safety plan with more involved.  
- Suicide risk is complex on Reserves with isolation - more helpers involved helps safety. |
| Psychologists’ stress and sense of responsibility were less burdensome with supports being accessed | 28        | - Peace of mind – relief.  
- Less burden and/or sole responsibility.  
- Reduces client-dependence or over-reliance on psychologist.  
- Psychologist not isolated.  
- Shared workload. |
| With supports involved, self-care for psychologist increases                     | 16        | - Psychologist not isolated.  
- Strengthens psychologists because have help and more time.  
- More self-care time with a team involved. |
| Legal and ethical concerns were allayed when external supports were accessed       | 12        | - Fewer legal and ethical concerns.  
- Better clinical decision to involve more supports in community.  
- Dangerous to work alone around suicide.  
- Other caregivers can help when psychologist away – back up plans.  
- Psychologists cannot meet all client needs. |
### Professional Supports Accessed by Psychologist to Help Themselves Continue Suicide Work

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=61)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Strengthening</strong></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Colleagues are the biggest support | 46 | • Trusted colleagues understand and are supportive.  
• Peer discussion is helpful.  
• Team work is helpful  
• Colleagues create safety |
| A supervisor providing supportive discussion and debriefing is essential | 22 | • Support is helpful with a supervisor.  
• Talking through a case with understanding.  
• Debriefing with care |
| Consultation with a mentor is helpful | 14 | • Mentors who have experience with suicide are helpful.  
• Provisional psychologists benefit from a supervisor who is a mentoring. |
| Suicide-specific training strengthens psychologists’ suicide work | 13 | • Training strengthens suicide work.  
• Reading on the topic allows growth. |
| Personal counselling helps psychologists stay balanced | 6 | • Personal counselling and private therapists are helpful to remain balanced.  
• EAP programs are accessible and helpful |
| Self-care is important to continue suicide work | 6 | • Time for introspective thinking is caring.  
• Time for self-care.  
• Taking time for documentation of risk and safety plans helps.  
• Focusing on hopefulness in the work. |
| **Isolating** |           |                                                        |
| Organization/employers do not offer adequate help | 13 | • No help offered at employment.  
• Nothing is organized to be helpful to psychologist.  
• Supervisors are not helpful.  
• Talking takes up time and money.  
• Managers do not create supports.  
• Cannot ask time of other colleagues because they are too busy.  
• Organizational debriefings are not helpful. |
| Accessing mental health services or supports is stigmatized | 5 | • Colleagues and managers frowned upon accessing EAP.  
• Psychologists’ capabilities are questioned if counselling is sought. |
### Barriers that Prevent Psychologists from Accessing Help

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=61)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No external barriers to accessing help were identified. Internal barriers within the psychologist would block help seeking</td>
<td>17</td>
<td>Only if the psychologists, themselves, blocked getting help was there a barrier.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There were no comments, only a “no” or “none” statement</td>
</tr>
<tr>
<td>Barriers to accessing help were identified</td>
<td>44</td>
<td></td>
</tr>
<tr>
<td>Excessive workplace demands create inadequate time to seek necessary help</td>
<td>24</td>
<td>There are too many client cases to manage.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is not enough time allotted to manage the work ethically.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There are too few psychologists to manage the workload.</td>
</tr>
<tr>
<td>Lack of support from organization or employer is problematic</td>
<td>17</td>
<td>Supervisor and manager support is not readily accessible.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Collegial support and consultation is not supported by the employer/organization.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>There is inadequate funding for Employee Assistance Program benefits to offer adequate service to psychologists.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>The kind of therapeutic services provided by Employee Assistance Programs are not tailored to the needs of psychologists.</td>
</tr>
<tr>
<td>Confidentiality and non-biased support is a concern in a small psychological community</td>
<td>17</td>
<td>Dual relationships exist in therapist – colleague Unethical bias in service.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Confidentiality is a concern in a small community.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gossip is identified as problematic in the field of mental health.</td>
</tr>
<tr>
<td>Stigma and judgment is placed on psychologists’ help-seeking</td>
<td>17</td>
<td>Psychologists seeking help is not seen as professional.</td>
</tr>
</tbody>
</table>
|                                                                                |           | Psychologists have unrealistic expectations of those individuals in the psychology profession, as though they are not given to the same experiences of being human and having problems.
|                                                                                |           | Psychologists should not be helping others if they require help.                                                        |
| Help-seeking creates fears related to being seen as incompetent in practice     | 8         | Help seeking related to stress of work with client suicide would reveal a lack of competence.                            |
|                                                                                |           | Help seeking related to psychology practice and workload would reveal incompetence.                                      |
| There is unwilling to forfeit family time to pursue help-seeking                | 4         | Giving up family time is not an option therefore help-seeking is not prioritized.                                       |
| Lack of (awareness) resources                                                   | 4         | Lack of awareness of resources.                                                                                        |
|                                                                                |           | Rural isolation.                                                                                                        |
| Personality composition interferes with help-seeking                            | 3         | Psychologists whose pride gets in their way will not seek help.uality                                                  |
|                                                                                |           | Psychologists who are not good in team-situations will not seek team or collegial support.                              |
| Private practice limits collegial support                                       | 2         | Working alone limits interactions with colleagues to gain support.                                                    |
## Impact of Client Suicide

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes n=20</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Reactions</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Professional self-doubt</td>
<td>14</td>
<td>• Self-questioning – doubting.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Wondering what was missed or what more could have been done?</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Responsible for suicide – failure</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fearful of incorrect assessment</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Inadequate resource connections</td>
</tr>
<tr>
<td>Grief and long processing</td>
<td>14</td>
<td>• Grieving. Sorrow. Saddened.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• It took time to carefully process</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Heavy impact. Sobering.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Needed therapy</td>
</tr>
<tr>
<td>Shock, disbelief, distress</td>
<td>13</td>
<td>• Shocked/disbelief/In a daze</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Very distress, upset, devastated</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Visceral response</td>
</tr>
<tr>
<td>Hurt by manager’s lack of compassion</td>
<td>5</td>
<td>• Shocked and hurt by manager’s callous response.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Manager’s appear unconcerned for psychologist</td>
</tr>
<tr>
<td>Helpless and frustrated</td>
<td>4</td>
<td>• Helplessness and frustration</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Could not help despite efforts</td>
</tr>
<tr>
<td><strong>How news of suicide received</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Personal Connection/Community</td>
<td>11</td>
<td>• Family member of client. Small community. Word of mouth.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Moccasin telegraph</td>
</tr>
<tr>
<td>Workplace</td>
<td>5</td>
<td>• Employer advised of debriefing as way of telling of suicide</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Told of suicide in front of other colleagues</td>
</tr>
<tr>
<td>Media</td>
<td>4</td>
<td>• Newspaper or newscast</td>
</tr>
<tr>
<td>Coroner</td>
<td>3</td>
<td>• Called to confirm suicide.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Confirmed events and treatment prior to death</td>
</tr>
<tr>
<td>Professional helping community</td>
<td>2</td>
<td>• Other agency resources called to advise of suicide</td>
</tr>
</tbody>
</table>
### Emerging themes

#### Frequency

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=20)</th>
</tr>
</thead>
</table>
| Professional doubts came up - improving practice was a focus | 13 | • Despite second guessing professional judgment, did nothing.  
• Reviewed client case independently to increase awareness of what else to do to improve suicide work. Retrospectively realized that there was suicide risk  
• Aware cannot intervene with all suicide behavior |
| Connection with colleagues, healing and self-care allow release. | 15 | • Release feelings with loved ones and colleagues for release and to gain relief  
• Help and support are necessary  
• Colleagues who culturally appreciate First Nations understood  
• Spiritual/pastoral opportunities are necessary to process grief  
• Setting healthy boundaries around self needs is important |
| Operational debriefings alone do not offer support | 8 | • Operational debriefing caused second guessing  
• Business orientation is less supportive |
| Supervisors can be helpful and offer improved perspective | 1 | • After the debriefing psychologist can be relieved of guilt knowing they did their job well |

Note: 3 reported no supports were activated.  
17 reported support was activated (6 noted that there was work-related support)
### Work Environment Supports Post Client-Suicide

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizations offered no support</td>
<td>8</td>
<td>• Employer/organization offered no help or support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Managers were not helpful.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Organization protects the organization and has little investment in employees.</td>
</tr>
<tr>
<td>Colleagues offered themselves for support</td>
<td>7</td>
<td>• Colleagues who know and client and client culture share understanding.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Supported and cared for by colleagues they have similar experiences draw from.</td>
</tr>
<tr>
<td>Unconditional support and listening allows perspective and growth</td>
<td>5</td>
<td>• Feedback and understanding allowed perspective that psychologist did what they could and allowed for clinical growth for others.</td>
</tr>
<tr>
<td>Time off to attend the funeral allowed processing of grief</td>
<td>5</td>
<td>• Shared grief with others (colleagues, family, Elders)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Supported to take time to grieve.</td>
</tr>
<tr>
<td>Releasing feelings with colleagues without judgment was safe</td>
<td>4</td>
<td>• Shared experiences with colleague.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Just needed someone to listen and not judge.</td>
</tr>
<tr>
<td>Loss to suicide in mental health work is inevitable and comforting knowledge</td>
<td>2</td>
<td>• Comfort in the acceptance that there will be losses to suicide in the work with mental health populations.</td>
</tr>
<tr>
<td>Supervisor support allows perspective and growth</td>
<td>1</td>
<td>• Supervisor took time to listen and allowed psychologist to process the case, which helped to create improved perspective and growth.</td>
</tr>
<tr>
<td>Emerging themes</td>
<td>Frequency</td>
<td>Participant perception -Focused concepts/codes (12 of 20 who experienced client suicide)*</td>
</tr>
<tr>
<td>---------------------------------------------</td>
<td>-----------</td>
<td>-------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>What would have been helpful:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Supportive debrief</td>
<td>4</td>
<td>• Supervisors, mentor or manager to be present to debrief case effort and suicide in a caring and genuine way intending help.</td>
</tr>
</tbody>
</table>
| Emotional support                           | 6         | • Talk genuinely with manager or supervisor to allow an emotional release, gain support and validation of emotions.  
• Talk with another therapist whose client suicided to gain emotional support. |
| Recognition and validation of efforts        | 4         | • Talking through case and effort with manager or supervisor to recognize the efforts made with the client.  
• Have manager or supervisor validate the work that was done. |
| Recovery time                               | 4         | • Time off work after the client suicide to be away from work to recover, rest and reorient for work. |
| Direct talk with community about suicide    | 3         | • Informing communities about coping through adversity, by identifying how mental illness and addictions amplified suicide ideation to action.  
• Tell First Nations suicide higher |

Identification of responses and lack of responses that were not helpful and then restated as a need:

| Workplace was not focused on psychologists’ wellbeing  | 8         | • Workplace was unconcerned with psychologist’s emotions and health.  
• Organizational debrief was not helpful at a personal/individual level.  
• Numbers appeared more important to the organization than the psychologist.  
• Focus of employer was on politics of suicide not the psychologist’s feelings.  
• Psychologists were offered nothing from their employer. |
| Staying at work was not helpful. (Time off would have alleviated distress of workplace.) | 4         | • Time off was necessary as psychologist was distressed at workplace. |
| Psychologist not seeking support and training when needed. (Supports required through training, supervision, & freedom to ask for assistance) | 4         | • Inadequate identification of suicide signs and symptoms and although aware, did not seek support or training.  
• Was aware that help was needed but was afraid to ask for help. |

*Note: 5 participants acknowledged that they were uncertain of what would have been helpful to them, while 3 participants indicated that nothing would have been helpful.
### Change in Psychologists’ Practice as a Result of Client Suicide

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No changes identified</td>
<td>2</td>
<td>• One suicide out of hundreds of clients with ideation. No changes made.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• No change.</td>
</tr>
<tr>
<td>Changes identified</td>
<td>18</td>
<td></td>
</tr>
<tr>
<td>Increased seriousness in responsiveness</td>
<td>14</td>
<td>• Increased vigilance, cautiousness, diligence, seriousness and responsiveness.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Acute attention in assessment.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased assertiveness in safety planning.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More focused on immediate safety.</td>
</tr>
<tr>
<td>Ensuring that client resources are established</td>
<td>13</td>
<td>• Ensure supportive connections and external resources are made.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Suicide education of external resources established.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Psychologist cannot take on sole responsibility.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognition that psychologists need to involve others as they have limited time with client and little control.</td>
</tr>
<tr>
<td>Increased direct and specific suicide talk</td>
<td>13</td>
<td>• Increased engagement to talk directly, openly, and specifically about suicide and really listening to the responses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Asking directly about suicide or about risk elements.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Focus on individual not only assessment increases talk about suicide feelings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clarity about consequences of suicide.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Identify for client that suicide feelings and problem situations are temporary.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Direct talk about suicide with youth, families and Elders.</td>
</tr>
<tr>
<td>Self-monitor emotional state and health to maintain</td>
<td>9</td>
<td>• Keeping own emotions, anxiety and panic, in check so that can focus on client.</td>
</tr>
<tr>
<td>improved focus on client suicide work</td>
<td></td>
<td>• Use internal resources, such as spirituality, grounding, and mindfulness to keep in balance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Remove judgment from the discussion with the client to be effective.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognize that suicide feelings are common but if worked with do not necessarily result in clients’ suicide.</td>
</tr>
<tr>
<td>Psychologist resilience and competence increased</td>
<td>7</td>
<td>• Increased competence resulted from experience of client-suicide, as there was diligent reflection and self-examination.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Comfort and confidence has increased through suicide work and necessity.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Growth and change in practice occurred over years of experience.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Exceptional detail in suicide work has developed over time and losses.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased efficiency in recognizing suicide signs has developed over the years.</td>
</tr>
<tr>
<td>Suicide specific training is necessary</td>
<td>5</td>
<td>• Suicide specific training was needed to deal with future suicide work.</td>
</tr>
<tr>
<td>Consultation with colleagues/ supervisors engaged for</td>
<td>5</td>
<td>• Realized must inform manager of client suicide risk.</td>
</tr>
<tr>
<td>better outcomes for psychologist &amp; client</td>
<td></td>
<td>• Consultation and sharing with colleagues and supervisors is necessary.</td>
</tr>
<tr>
<td>Increased awareness that clients have choices</td>
<td>4</td>
<td>• Acceptance that clients have choices.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Clinicians have limits over how they can persuade clients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Liaise with other resources to support the client and establish whom the client feels comfortable with.</td>
</tr>
</tbody>
</table>
## Learned Strategies to Improve and Continue Suicide Work

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No learning</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>Learned strategies to improve and continue suicide work</td>
<td>19</td>
<td>• Overworking creates lack of focus and missed element of client risk and story about suicide.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Shame of not knowing must not influence collaboration.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Mindful of health and fatigue levels to ensure ethical practice.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Recognize impact of suicide risk on psychologist &amp; health.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• See psychologists as human, realizing and difficulties can create personal risk of suicide.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Maintain clear boundaries so that counter-transference does not influence practice.</td>
</tr>
<tr>
<td>Reflective self-monitoring maintains ethical practice</td>
<td>12</td>
<td>• Access support on one’s own as employer does not offer support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accept that employers are uninvolved and will not help.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Accept feelings and reactions as a psychologist and care for those feelings.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Take time to enjoy living, suicide work takes a toll.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Be gentle with one self, suicide work is fatiguing.</td>
</tr>
<tr>
<td>Suicide work is intense and the onus for self-care is on the psychologist</td>
<td>11</td>
<td>• More collegial support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• More team support.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Debriefing with colleagues or supervisors to ensure all client suicide risks were addressed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Never provide suicide work alone.</td>
</tr>
<tr>
<td>Collaboration is safer and protective for both the client and psychologist</td>
<td>9</td>
<td>• See clients as people not patients or clients.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Be mindful when with a client – be with them.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Do not rush.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Listen more with intentional awareness.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Be aware that psychologists cannot control client’s lives and choices.</td>
</tr>
<tr>
<td>Be mindful during client suicide work</td>
<td>7</td>
<td>• Establish external resources for client.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Use psychiatric consultation.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Have access to hospital admission.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Case conference more frequently.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Involve clients with their supports.</td>
</tr>
<tr>
<td>Grieve the client suicide</td>
<td>6</td>
<td>• Ensure training is ongoing through career.</td>
</tr>
<tr>
<td>Establish and connect with external client resources</td>
<td>6</td>
<td>• Know and follow best practice guidelines.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Know and practice thorough suicide risk assessment.</td>
</tr>
<tr>
<td>Suicide specific training for psychologist is necessary to know best practice and</td>
<td>5</td>
<td>• Create realistic treatment plans.</td>
</tr>
<tr>
<td>increase professional responsiveness</td>
<td></td>
<td>• Teach students the affect of client suicide to create preparation.</td>
</tr>
<tr>
<td>Avoid overwork of too many cases and too many suicide cases</td>
<td>5</td>
<td>• Caseloads are overwhelming.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Create limits on caseloads.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Fewer intense cases (i.e., suicide work related cases) per clinician.</td>
</tr>
<tr>
<td>Community suicide alertness and awareness training will support youth</td>
<td>1</td>
<td>• Adolescent and children training can be helpful to increase alertness and awareness for helping peers.</td>
</tr>
</tbody>
</table>
**Self-Identified Changes in Psychologists Resulting from Client Suicide**

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>No change</td>
<td>6</td>
<td></td>
</tr>
<tr>
<td>Changes observed</td>
<td>14</td>
<td>• Psychologists are less effective for clients if self-care is inadequate.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Psychologists were strengthened physically, emotionally and spiritually through self-care.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Self-care allows for balance.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Appreciation of life increased.</td>
</tr>
<tr>
<td>Self-care increased</td>
<td>11</td>
<td>• Clients’ needs and perspectives must be recognized.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Client time and interaction deserves complete attention and respect.</td>
</tr>
<tr>
<td>Clients must be valued</td>
<td>7</td>
<td>• Psychologists must understand that clients have a choice to suicide.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Psychologists are limited in what they can do.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Some suicides happen regardless of help and resources.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Psychologists cannot judge themselves too harshly if a client suicides.</td>
</tr>
<tr>
<td>More real in suicide work</td>
<td>6</td>
<td>• Psychologists need to take more time off work.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Work hours should be reduced.</td>
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<td></td>
<td></td>
<td>• Overtime is not useful.</td>
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<td></td>
<td></td>
<td>• More breaks are required in workday.</td>
</tr>
<tr>
<td>Balancing time is necessary at work when providing suicide work</td>
<td>4</td>
<td>• Asking more readily, directly and frequently is helpful.</td>
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<tr>
<td></td>
<td></td>
<td>• If in any doubt, directly ask about suicide.</td>
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<td></td>
<td></td>
<td>• Talking clearly about psychologists’ boundaries and mandates to respond are helpful to the psychologist and the client.</td>
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<tr>
<td></td>
<td></td>
<td>• Working at-risk environments has developed increased openness and awareness to talk about suicide.</td>
</tr>
<tr>
<td>More open talk about suicide</td>
<td>4</td>
<td>• Consultation with colleagues is more sought after.</td>
</tr>
<tr>
<td>Consultation is sought out</td>
<td>4</td>
<td>• Support is needed in suicide work but must seek own help.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Increased awareness that employers do not make any effort to provide adequate support to psychologists.</td>
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<tr>
<td></td>
<td></td>
<td>• Frustrated with lack of management and collegial support related to suicide work.</td>
</tr>
<tr>
<td>Psychologists seek own help</td>
<td>3</td>
<td>• Involving resources other than the psychologist relieves pressure on the psychologist.</td>
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<td></td>
<td></td>
<td>• Engagement of the client with enough resources allows the client to choose life.</td>
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<td></td>
<td></td>
<td>• Resources must be taught how to respond to the individual at risk of suicide.</td>
</tr>
<tr>
<td>External resources are more utilized</td>
<td>3</td>
<td>• Individual therapy was/is helpful when providing suicide work.</td>
</tr>
<tr>
<td>Therapy is useful</td>
<td>3</td>
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</tr>
</tbody>
</table>
## Changes Needed for Workplaces and Psychologists to Support Suicide Work and Create Growth in Psychologists’ Practice

<table>
<thead>
<tr>
<th>Emerging themes</th>
<th>Frequency</th>
<th>Participant perceptions – Focused concepts/codes (n=20)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recognition of the stress of suicide work</td>
<td>18</td>
<td>• Organizations, supervisors, and the psychologists need to recognize the stress/burden of suicide work and acknowledge need for psychologists to have help related to this work.</td>
</tr>
<tr>
<td>Organization implementation of support mechanisms related to suicide work</td>
<td>17</td>
<td>• Mandate to support care and self-care in psychologists.</td>
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<td></td>
<td></td>
<td>• Managers and supervisors would increase their effort to be present and helpful.</td>
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<td>• Shorter workweeks and more earned days off.</td>
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<td>• Create opportunity for informal collegial connections to increase comfort when there is need to access support from one another.</td>
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<tr>
<td>Collaboration of colleagues around suicide-related casework</td>
<td>17</td>
<td>• Increased teamwork.</td>
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<td></td>
<td></td>
<td>• Collegial discussion.</td>
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<td>• Peer supervision.</td>
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<td>• Case conferencing with client resources.</td>
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<td></td>
<td></td>
<td>• Private practitioners create collaborative connections.</td>
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<tr>
<td>Supervisory support and advocacy for the suicide work provided by psychologists is needed</td>
<td>14</td>
<td>• Supervision mandatory on suicide cases.</td>
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<tr>
<td></td>
<td></td>
<td>• Supervisors allot adequate time for supervision of psychologists.</td>
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<td></td>
<td>• Supervisors recognize the difficulty of suicide work and demonstrate genuine support.</td>
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<td></td>
<td>• Supervisors do not only align with organization debriefing process but also consider the needs of the psychologist.</td>
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<tr>
<td>Balanced work and caseloads are necessary around suicide work</td>
<td>8</td>
<td>• Psychologists cannot carry too many suicide-related cases – burn out can occur.</td>
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<tr>
<td></td>
<td></td>
<td>• A variety of case presentations are helpful.</td>
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<td></td>
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<td>• Lower numbers of cases to manage ethically.</td>
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<td></td>
<td></td>
<td>• More psychologists to manage client numbers.</td>
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<td></td>
<td></td>
<td>• Psychologists should determine if they want suicide work.</td>
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<tr>
<td>Suicide-specific training is needed</td>
<td>6</td>
<td>• More suicide-specific training is needed.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Culture-specific suicide training is needed.</td>
</tr>
<tr>
<td>Self-care must be considered when providing suicide work</td>
<td>4</td>
<td>• Psychologists must recognize personal needs for increased self-care when providing suicide work.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Engagement in personal therapy is helpful when providing suicide work.</td>
</tr>
<tr>
<td>Lean initiatives are not considerate of the psychologists’ needs around ethical suicide work and balancing client needs</td>
<td>4</td>
<td>• Psychologists are humans and not machines.</td>
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<tr>
<td></td>
<td></td>
<td>• Needs of psychologist must be considered.</td>
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<td></td>
<td></td>
<td>• Ethical client care starts with a well psychologist.</td>
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<td></td>
<td></td>
<td>• Mandated numbers on caseloads are not a reflection of client needs.</td>
</tr>
</tbody>
</table>