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Psychologists' Experiences Conducting Suicide Risk Assessments: A Phenomenological Study
Expériences de psychologues menant des évaluations de risques de suicide : une étude phénoménologique

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ABSTRACT
Psychologists conduct suicide risk assessments (SRAs) regularly to identify and prevent clients' self-harm and risk of death, although little is known about their experiences of the process. In this phenomenological study, five registered psychologists (master's and doctoral level) were interviewed to explore the essence of their SRA experiences. Psychologists reported weaving tenets of assessment and therapy throughout their SRAs, relying on their clinical intuition, and investing deeply in their suicidal clients. Also, psychologists reported feeling significant anxiety working with suicidal clients, revealing the ways in which the fear of client suicide guides and motivates their SRA practices. While they have an empathic view of suicide, they believe in preventative intervention. They reported feeling pressure from clients and colleagues to conduct ethical and useful SRAs despite receiving what they consider to be insufficient and ineffectual graduate SRA training. Results from this study offer a qualitative foundation for future research on the ethics, training, and practice of SRA.

RÉSUMÉ
Les psychologues sont appelés à mener régulièrement des évaluations des risques de suicide (ÉRS) afin de déterminer et de prévenir les possibilités qu'un client s'inflige des blessures ou la mort; mais on en sait très peu sur leurs expériences lorsqu'ils effectuent une telle démarche. Dans le cadre de cette étude phénoménologique, on a interviewé cinq psychologues agréés (de niveau maîtrise ou doctorat) afin de fouiller l'essence de leurs expériences d'ÉRS. Les psychologues ont rapporté avoir incorporé des principes généraux de l'évaluation et de la thérapie tout au long de leur démarche d'ÉRS, en s'en remettant à leur intuition clinique et en s'investissant profondément auprès de leurs clients suicidaires. Ils ont aussi fait état d'une anxiété importante lors de ce travail auprès de clients suicidaires, tant que la peur du suicide du client guidant et motivant leurs pratiques d'ÉRS. Bien qu'ils aient une opinion empathique au sujet du suicide, ils croient en une intervention préventive. Ils ont

aussi rapporté ressentir une pression de la part des clients et des collègues pour qu'ils mènent des ÉRS éthiques et utiles, en dépit du fait qu'ils considèrent avoir reçu une formation universitaire insuffisante et inefficace en cette matière. Les résultats de cette étude présentent un fondement qualitatif pour de futures recherches sur l'éthique, la formation, et la pratique des ÉRS.

Suicide is a devastating and perplexing phenomenon. In 2012, the World Health Organization (WHO, 2012) estimated that 2,198 people die by suicide every day, with rates expected to double by 2020 (WHO, 2019). In the United States, the Centers for Disease Control and Prevention (2018) estimated that suicide rates have risen 30% since 1999, with nearly 45,000 lives lost in 2016. Globally, suicide is the third leading cause of death in 15- to 29-year-olds, with estimates that, for each adult death, 20 other adults attempt suicide (WHO, 2019). Fortunately, suicide is considered preventable, in part through a thorough suicide risk assessment (Schwartz-Lifshitz et al., 2012).

Suicide risk assessment (SRA) is considered a core competency for preventing suicide (Oquendo & Bernanke, 2017). SRA is the act of gathering data pertinent to a person's risk of suicide through a clinical interview and/or using a psychological measure. Empirical risk factors, the psychosocial environment, and the level of functioning are used to assess current risk levels (Silverman & Berman, 2014b). This suicide risk formulation is based on health professionals' judgment of the person's foreseeable risk to harm themselves. It requires comprehension of how risk factors, population demographics, base rates, and protective factors collectively influence the risk of death by suicide. The resulting formulation is used to provide nuanced and ideally individualized treatment for the person at risk of suicide.

SRA practice, however, is considered the most challenging and stressful responsibility for mental health professionals (Maris, 2019; Shea, 1999). It is, for example, highly anxiety-provoking due to a lack of time, the absence of or inadequate suicide management training, the belief that suicide is inevitable, and fear of litigation (Ellis & Patel, 2012; Reeves & Mintz, 2001). In addition, professionals risk experiencing counter-transference to suicide-related trauma (Cureton & Clemens, 2015), and nearly all psychologists list client suicide as their greatest clinical fear (Pope & Tabachnick, 1993). Despite these concerns, SRAs are considered necessary for ethical and effective professional practice. Detailed SRAs are highlighted as the minimum clinical responsibility in post-mortem suicide audits (Burgess et al., 2000).

Several studies have examined the experiences of other mental health professionals' SRA attitudes, beliefs, and practices. SRA experiences have been explored, for example, in psychiatric nurses (Aflague & Ferszt, 2010), psychiatric in-patient staff (Awenat et al., 2017), general practitioners (Michail & Tait, 2016), emergency department staff (Petrik et al., 2015), social workers (Regehr et al., 2016),

physicians in emergency departments (Roy et al., 2017), and psychiatrists (Waern et al., 2016). Practitioners in these studies report feeling anxiety and frustration with SRAs, experiencing loneliness and uncertainty when practising with a suicidal patient, lacking privacy, and being too busy to connect with their patients adequately. Although research has been conducted to explore how psychologists interact with suicidal clients (Osafo et al., 2012), there has been no qualitative inquiry into psychologists' SRA experiences.

The purpose of this qualitative study is to explore psychologists' experiences in conducting SRAs. This study's significance is threefold: it obtains a nuanced understanding of how psychologists conduct and experience SRAs, it elucidates the effect of suicide attitudes and beliefs on SRA practice, and it informs training programs by exploring how SRAs affect psychologists. Although we are aware of how psychologists are trained to practise ethical SRA (Liebling-Boccio & Jennings, 2013; Sommers-Flanagan & Shaw, 2017), we are unaware of how psychologists actually conduct the practice.

This study provides a brief, qualitative understanding of psychologists' SRA experiences, helping us understand how practices evolve after graduate training. This is critical, in light of the fact that best SRA practices have changed significantly over the last decade (Sommers-Flanagan & Shaw, 2017), particularly with a rise in client-centred and collaborative SRA (Schembari et al., 2016). Further, with the growing concern over the validity of information-focused SRA checklists and scales (Chan et al., 2016; Large et al., 2016; Sommers-Flanagan, 2018) and the call to stop using suicide risk factors to categorize clients (Bolton et al., 2012; Nielssen et al., 2017; Tucker et al., 2015), a review of how this knowledge has translated into the community is necessary. Knowing how psychologists experience SRAs may guide the development of training programs and help improve our understanding of how best to treat and view clients who struggle with suicidal ideation.

The primary research question of this phenomenological study is, *What are psychologists' experiences of conducting SRAs?* Three additional questions guided the study:

1. How do psychologists view suicidal clients?
2. How are psychologists affected by SRAs?
3. How do psychologists view their SRA training?

To address these questions, we used a phenomenological qualitative design; specifically, we used interpretative phenomenological analysis (IPA; Creswell et al., 2007; Smith et al., 2009). Broadly, phenomenology is the study of lived experiences (Creswell & Poth, 2017). Two approaches are used widely: interpretative and descriptive phenomenology. Although both are concerned with describing the essence of the experience, interpretative phenomenology focuses more on the interpretations the researcher makes on the meaning of the lived experiences. IPA specifically guides the examination of how people make sense

of these lived experiences, constantly comparing intra- and inter-participant data in a recursive fashion while attending to the details and depth of each experience (Smith et al., 2009).

Further, the underlying philosophical nature of IPA is that experiences are often unexamined by our conscious awareness. The phenomenon in question, SRA, is often enmeshed with complexities such that psychologists are not often afforded a chance to examine how or why they use the practice. For these reasons, we selected IPA to explore the essence of a collective phenomenon across multiple participants, such as psychologists' experiences of SRA.

Method

Participants

Five licensed psychologists participated in the study. They averaged 4.5 years of practice (SD = 3.7) and ranged in age from 27 to 46 years old (M = 37). Two participants are primarily in private practice while two identify as cognitive-behavioural therapists. Three participants practised with a master's-level education, whereas two practised with doctorates. All participants self-identified as European-Canadian/White. Table 1 summarizes participant demographics.

Procedure

Participant Recruitment

Participants were recruited through e-flyers sent to private and public practice sites across Alberta, Canada, and through postings on the Psychologists' Association of Alberta and the Canadian Psychological Association's research notice boards. In some provincial jurisdictions in Canada, psychologists can register with a master's-level education. These participants were included to account for the breadth of practising psychologists, as education likely influences SRA practices. Participants contacted the principal investigator through email and were assessed for appropriate inclusion. In order to be included in the study, participants needed (a) to be registered psychologists practising in Canada and (b) to have reported conducting 12 or more SRAs with clients per year. The university's ethics board approved the study. No compensation was provided to participants. Informed consent was obtained from all individual participants included in the study.

Interview

Interview questions (see Appendix A) were developed from existing literature in coherence with phenomenological designs and the study's research questions. The interview questions were designed to recall a participant's SRA experience and, once evoked, to explore the participant's reactions and interpretations of that experience. These semi-structured questions guided the phone interviews, which lasted, on average, 30 to 35 minutes.

Table 1
Participant Demographics

Participant Pseudonym	Age	Sex	Highest Degree Earned	Years Practised	Ethnicity	Primary Practice Setting	Theoretical Orientation
Olivia	32	F	M.Ed.	6	European Canadian/ White	Psychiatric Unit/ Hospital	Psychodynamic and Cognitive Behavioural
Emma	37	F	M.A./M.Sc.	0.5	European Canadian/ White	Private Practice	Integrative
Sophia	27	F	M.Sc.	2	European Canadian/ White	Private Practice	Cognitive Behavioural
Liam	46	M	Ph.D.	4	European Canadian/ White	Community Mental Health Centre	Process Experiential
Ben	43	M	Ph.D.	10	European Canadian/ White	University/College Counselling Centre	Cognitive Behavioural

Researcher as Instrument

In qualitative research, the researcher establishes intentional and conscious reflection of their own experience as significant to the interpretation and understanding of the data. The bracketing of the researcher's own experiences and biases throughout the qualitative inquiry helps the researcher concentrate on the participant's perceptions of the world (Heidegger, 1927/1962). It increases the credibility and transferability of the qualitative results (Morrow, 2005). The first author of this study, who conducted the interviews and the data analysis, has worked closely with chronically suicidal clients and has personal lived experience with suicide and SRA. To assist in bracketing these backgrounds and biases, a reflexive disposition was adopted. The first author completed memos before and after each interview and connected with like-minded peers and with other-minded peers to debrief findings. Nonetheless, the first author expected psychologists to report SRA practices that were stressful, ethically complex, and theoretically confusing, similar to his own and his peers' anecdotal experiences.

Data Analyses

In recognition of the research analyst's bias and of the double hermeneutic present in qualitative analyses, truth claims (or findings) are identified as subjective and tentative, although the process used to reach these claims is systematic, rigorous, and dialogical. Interviews were transcribed verbatim by the first author and reread twice with accompanying audio. Concurrent with additional memoing, transcripts were reviewed individually for semantic content and language. Then, transcripts were imported into Atlas.ti (Scientific Software, 2012) and analyzed for emergent themes. Categories were formed based on connections between themes.

Before moving to a new transcript, additional memos were completed to assist in bracketing. Once each transcript was analyzed, themes and categories were refined to reflect parallels and differences between participants better. Categories and themes were then connected to form superordinate themes that stretched across all five study participants. The result was nine superordinate themes that describe the overall experience of a psychologist conducting SRA. There were 943 quotes identified, and these accounted for 169 unique emergent themes. Table 2 shows a brief example of the data analysis process.

Despite attempts at bracketing, the process is only ever partially accomplished. The results were compared with the first author's memos to reflect on their development; essentially, a comparative triangulation process was undertaken (Creswell & Poth, 2017). The results were summarized and returned to participants to evaluate the coherence between the superordinate themes and the essence of their individual experience. This process, known as synthesized member checking (Birt et al., 2016), yielded three out of five responses, all of which confirmed the results as coherent with the essence of participants' experiences.

Table 2
Data Analysis Process Exemplars

Superordinate Theme	Category	Emergent Themes	Participant Quote
Weaving Assessment and Therapy	Harmonious Dichotomy of SRA	Therapy and assessment need each other to succeed	So that's where things like, the, you know, the protective factors, or how did you get out of the last time you felt really, really suicidal. Like when you look at the history and what stopped you then. Like, when they say what stopped them then, they start to already start thinking, "Well, maybe I can do that now, and I can pick up on that," right? So that's where the assessment really feeds into the therapy. (Liam)
	Emphasizing Client Rapport	Rapport builds a stronger SRA	I'm here to support. The more I know, the more I can help. And so you could tell with that, it's again that art of therapy, where it's, like, you have to ask those questions, but you have to do it in a really gentle and empathetic way, and meet the client where they're at, and their willingness to answer those questions, because they can be quite personal and private. (Sophia)
	Empathy in SRA	Rapport builds a stronger SRA	So that's why it's, like, you know, "I'm validating," like, "It's okay, I'm here, I'm not judging, I'm here to support. The more I know, the more I can help." (Olivia)
The Pressure of Responsible Caring	Reasons for Prioritizing Clients During SRA	Worry about properly assessing the risk	There was an instance where I did—where I was worried. Because I mean, this is a new person, and when you've got a spouse who's *that* concerned.… (Ben)
	SRA Is an Ethical Necessity	Worry about assessing the risk properly	Well, I definitely feel pressure from myself to, um, be able to help the client, and to do the suicide risk assessment properly, and to assess the risk properly. (Emma)
		Conflict between ethics and client care	I know that I've had conversations like at school about, well, "Do you need to? With someone suicidal do you actually need to intervene? Can it be ethical to not intervene?" (Emma)

Results

The analysis of participants' transcripts revealed nine superordinate themes: (a) Weaving Assessment and Therapy, (b) Relying on Clinical Intuition, (c) Investing in the Suicidal Client, (d) Empathic View of Suicidal Clients, (e) Suicide Is a Choice, but I Need to Intervene, (f) Fear of Client Suicide Drives SRA, (g) the Pressure of Responsible Caring, (h) SRA Is Setting-Dependent, and (i) Graduate SRA Training Is Inefficient and Insufficient. The results are summarized in Table 3.

Weaving Assessment and Therapy

The essential and most common experience in conducting SRA was feeling conflicted between combining two skill sets—assessment and therapy—and weaving them into one holistic SRA. The imagery of weaving was used by Emma: "I would weave techniques or tools that I thought might be helpful to build the relationship into the risk assessment, so I was kind of integrating them." Sophia, when discussing this dilemma, contextualized this integration as the "art of therapy," noting how blending therapeutic practices in assessment could "soften" the SRA. Liam went as far as to say that SRA cannot be conducted ethically without the integration of assessment and therapy, which he "firmly believe[s] are two different roles." He explained the differing roles:

> The experience is in part stressful because I'm popping back and forth between being an assessor, which is a gatherer of information, a formulator of a plan, a deliverer of a plan, making sure the plan occurs if the client is so distressed that they're going to harm themselves imminently. I have to be ready to assess, decide, and act. And that's not the role of a therapist. A therapist, in my orientation, is very much more of a non-directive, following, allow the client to discover their next steps.

Participants believed that the primary purpose of SRA is to assess, predict, and ensure client safety. When asked about why she conducts SRA, Emma explained that it is "for client safety," whereas Sophia said it is for "developing the safety plan." Ben emphasized that "the [SRA] steps help keep [the client] safe," which he sees as a necessary component to his "duty to protect."

However, Liam asserted that the therapeutic relationship was foundational to SRA: "The real part [of SRA] is trying to find that human hook with the person. And if I can't find that, then I'm really in trouble, because all that assessment stuff and safety planning stuff goes straight out the window." Olivia agreed, emphasizing the need for combined therapy and assessment in SRA: "I think that having enough therapeutic rapport with someone, and having a strong enough alliance, really, in my experience, contributes significantly to bring suicidality out on the table as something that we can talk about."

Table 3
Summary of Superordinate Theme Descriptions for Psychologists' Experiences Conducting Suicide Risk Assessment

Superordinate Theme	Superordinate Theme Description
Research Question 1: What Are Psychologists' Experiences of Conducting SRAs?	
Weaving Assessment and Therapy	Integrating the goals, practices, and world views of therapy and assessment into the SRA practice. Feeling obligated both to ensure client safety through assessment and to build connections through therapy. The two processes are semi-permeable to each other.
Relying on Clinical Intuition	Having a "gut feeling" about suicide risk and using this intuition to guide assessment and therapeutic practice.
Investing in the Suicidal Client	After hearing a suicide clue, feeling a need to invest in the client deeply and urgently. Includes higher professional resource allocation, worrying after session, and feeling exhausted.
Research Sub-Question 2: How Do Psychologists View Suicidal Clients?	
Positive View of Suicidal Clients	Being supportive of suicidal clients, including understanding suicide as a product of psychosocial distress while assessing for clinically significant factors, such as low affect and dysregulation.
Suicide Is a Choice, but I Need to Intervene	Belief suicide/suicidal ideation can be explained, but is likely due to overwhelming stress, ambivalence, or insufficient understanding of consequences.
Research Sub-Question 3: How Are Psychologists Affected by SRAs?	
Fear of Client Suicide Drives SRA	Uncertainty of proper SRA practice, inability to control client behaviour, and feeling responsible for client safety guide a fear-based SRA.
The Pressure of Responsible Caring	Due to perceived consequences of a poor SRA, feeling a need to be a perfect helper to the client and a perfectly ethical psychologist to supervisors, colleagues, and regulating bodies.
SRA Is Setting-Dependent	The goals, frequency, and clinician/client comfort with SRA changes depending on the practice setting.
Research Sub-Question 4: How Do Psychologists View Their SRA Training?	
Graduate SRA Training Is Inefficient and Insufficien	Graduate-level SRA training is not proportionate to the amount it is practised. Prior volunteer/practicum experiences are lasting formative SRA training experiences.

Overall, participants highlight client safety as the primary objective in SRA, with client support and rapport building as secondary. They perceived these practices as discordant and at times as sequential to each other rather than integrative. However, participants endorsed both approaches as integral to their SRA experience, with differing emphasis based on the clinical setting, the current client relationship, progress in therapy, and beliefs and attitudes toward suicide.

Relying on Clinical Intuition

Most participants referenced a "gut feeling" in their SRA practices whereby, although they used empirical means to predict suicide risk, they also relied heavily on how they felt about the seriousness of the risk. Olivia provided an example in which, although the SRA and other colleagues determined that the client was no longer suicidal, "it was [Olivia's] clinical intuition that [the client] wasn't just not suicidal anymore." Ben expands, discussing how he favours face-to-face interactions in SRA because it informs his clinical intuition:

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

Liam recalled an experience where he observed his supervisor conduct an SRA that determined that the client was fit to leave, despite the fact that he and his colleagues felt otherwise:

> None of us were morally comfortable with just sort of saying, "Well, good luck with all that." Not even at an ethical level, like at a moral level, like at a core value level. None of us felt good about her leaving. Not even the junior students. They all were, like, "This doesn't feel safe."

Although all the participants endorsed using empirically derived SRAs in their typical practice, this theme highlights how psychologists rely heavily on their intuitive assessment of their clients to guide their SRAs, often foregoing or de-emphasizing the actuarial SRA data.

Investing in the Suicidal Client

Participants invested deeply in their suicidal clients, worrying about them after sessions, scheduling emergency meetings, or working overtime to write detailed case notes and follow-ups. Sophia noted that with this investment came a feeling of urgency:

> Even just like an inkling that they might not want to be here, automatically I feel this pull to be, like, "Okay, I need to explore this further and see if there's a risk." Obviously, that sense of urgency as well, too.

Sophia continued, explaining the investment feeling as "springing into action," describing her transition from therapy to a "hurried" assessment. This sudden resource investment in the client is often followed by a feeling Olivia referred to as "going down the rabbit hole." Sophia explained this feeling, where once an SRA has begun, there is a well-trained and exhausting fixed action pattern:

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

Overall, participants experience a feeling of investing in the client at the advent of suicide risk, expending personal and professional resources inordinate to other clients. Because of this, psychologists worried about receiving another suicidal client, becoming anxious, agitated with SRAs and, exhausted overall.

Empathic View of Suicidal Clients

In contrast to the anxiety of receiving a suicidal client, all participants endorsed an empathetic approach to suicide. Olivia recounted an empathic moment in conceptualizing her client: "I'll admit I have parallel process of people where they tell me horrific things, the tortures, the abuses they lived through, and I think, 'No shit—I'd probably want to kill myself too.'" Sophia identified the empathic lens further: "And I think that anyone can get to a point in their life where they feel like life has become unbearable, and they can no longer cope with it." Liam highlights the environmental stressors of suicide: "Their loss, the isolation and loneliness, and that's the super catalyst on top of the already legitimately existing pain." Here, participants supported the belief that suicide can be justified, that underlying psychosocial concerns are causing suicidal distress, and that experiencing suicidal ideation was normative.

Suicide Is a Choice, but I Need to Intervene

When asked about their views on suicide, participants endorsed the idea that suicide can be rational. Olivia stated that "suicide makes sense," Emma endorsed

the idea that "[suicide] is something that people can choose," and Sophia asserted that "suicide is definitely a valid experience for someone to want to consider." However, this belief was quickly amended to include the understanding that suicide is the result of deep distress and despair, where the client sees suicide as their only remaining option to end the pain. Liam summarizes this position:

> Let's say if I de-escalate them, and they're totally de-escalated, and they're like, "Okay—I'm calm now, and now I very, very calmly decided and consulted and everything else, and I know I'm going to end my life on this day for these reasons," that becomes different for me. The client's autonomy becomes important to me at that point.

Ben echoed this belief, saying, "I will do what I reasonably can do to prevent someone from acting on thoughts of suicide, but I recognize that it's that person's choice." Emma continued, commenting, "I think [suicide] is something that people can choose, even though, as a professional, I would intervene." Participating psychologists believe suicide is not the solution to their clients' problems, and that, through psychotherapy, they may find alternatives to ending the pain caused by their problems.

Fear of Client Suicide Drives SRAs

Participants worried about client suicide, although it remains a preoccupying thought throughout their SRA practice. Emma reflected on this fear: "I always try to mentally prepare myself for the fact that I might lose a client to suicide," whereas Sophia called upon past losses to guide her current SRAs: "I feel like I'm even more cognizant or on edge, maybe a bit more prone to having more of a thorough risk assessment, because that fear of your client passing away has actually come true."

Participants explained that the fear induced by SRA arises from a lack of control over a client's behaviour and safety, as Olivia illustrated: "I don't really have any control over when people are discharged … and it can feel really powerless." Ben continued: "An hour after they walk out of my office, something might have happened that would have changed their risk level. You know, there's only so much a therapist can do." This lack of control is accentuated by the psychologists' implied ethical responsibility as a health authority. Identifying this stress, Emma noted that clients are "putting their trust in [the psychologist]. [The psychologist is] the professional." Liam echoed this responsibility:

> There are times when the therapist has to be turned off. [The] client is in so much distress that they actually need a hard plan, and that they are actually are in so much distress that you cannot contact them.

Deciding to intervene is at the centre of this fear, as external involvement in the client's therapy is often confrontational and conflictive with ethical principles. Emma explained her biggest fear: "The client doesn't want me to report it, so I have to call the police and then it turns into this big conflict." In summary, there is an underlying fear that guides SRAs, with intersecting conflicts of breaking client confidentiality, assuring client safety, avoiding client death, and acting as an ethical health authority.

The Pressure of Responsible Caring

A specific cause of the fear experienced by psychologists during SRAs is the mandate to balance competing interests when faced with a risk of client death by suicide. The most immediate pressure comes from the therapeutic dyad, explained Emma: "I feel pressure from my client to actually be helpful." Sophia tried to mitigate the pressure by cooperating with her clients: "I'm asking these [SRA questions] because I want to be able to help them." Despite this pressure, Sophia continued to recognize her responsibility to the client: "[SRA is] not going to be very productive, if you as a therapist are a nervous wreck and are exhibiting really nervous behaviour in front of [them]."

Participants also disclosed pressure from outside the therapy room, where their supervisors, colleagues, and ethics boards are paying attention to their SRA practices. Olivia understood this pressure, fearing the possibility of violating ethical standards—"I'm always conscious of 'Did I ask the right questions, did I ask them in the right way?'"—and acting in ways to dampen the pressure: "I'll document like crazy because, you know, cover-your-ass doctoring at this point." Emma spoke to the belief that SRA is an ethical obligation: "There is definitely a pressure to our profession and my ethics, you know, we have the [Canadian ethics] guidelines, and then we have [regulating body]. I have a professional responsibility." Ben noted the legal implications of SRA: "I think I'm [ethically] negligent if I'm not assessing for suicide in some form or fashion," on which Sophia expanded: "If we catch any sort of wind of a client having the impending threat, that's something you could be held liable for as a psychologist."

In managing this tension, the participants acknowledged the difficulty of getting the balance right. "I just do the best I can," Olivia reflected, whereas Emma spoke to her limits: "As long as you do the best you can, then that has to be enough." Responding to how they react to a suicide disclosure, Liam reflected that "something serious is happening and I've got to be the best therapist I can be right now."

Overall, participants expressed the experience of feeling pressure from their clients to be helpful and from their peers and regulating bodies to be ethical. Given the belief that SRAs protect psychologists from litigation, psychologists seek to practise their best SRAs, often causing strain and anxiety.

SRA Is Setting-Dependent

All participants identified the clinical setting as paramount in determining their SRA approach. Notably, psychologists who had practised or are practising in hospital or in-patient settings described being less worried about client suicide due to increased control and authority over their client's behaviour. As Olivia explained, "They go back to the unit and they're checked on every 15 minutes, or if I'm really concerned, I just talk to the nursing staff, and we get them on constant observation, and someone follows them around 24/7." Similarly, participants noted that clients in these settings are exhausted and saturated with SRAs, the recognition of which can be used therapeutically. Olivia expanded: "I'll even make deals with patients where I'm like, 'I know that you're still suicidal. I know that you get asked about it every five seconds. I'm not going to ask about it anymore.'" Liam added: "Some of these young adults have seen more suicide risk assessments than I've done. They've seen it and have been through it so many times. What am I going to add that's going to be any better, right?" Although core SRA practices and principles remain, psychologists identified that the setting determines how SRAs are approached and conceptualized.

Graduate SRA Training Is Inefficient and Insufficient

A reflection endorsed by most participants is that graduate-level SRA training was deemed more theoretical than practical and at times an afterthought to their training. When prompted about their SRA training, Emma said, "Oh, it's terrible." Olivia commented, "I think I could get more training," and Sophia replied, "My [SRA training] wasn't great." Liam asserted further that SRA training was not emphasized: "I got the sense that everybody sort of assumed that we all knew how to do a suicide risk assessment." When prompted about how they might change their training, participants endorsed experiential SRA training. As Sophia explained,

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

Other participants commented on the questionable foundations of their SRA practice. As Emma reflected, "I really feel that a lot of the knowledge I've gotten is from what supervisors do.… I obviously trust it because I use them." Ben, who has practised for over a decade, disclosed following his crisis call centre SRA training, albeit with a stronger therapeutic approach. When prompted about concurrent SRA training, participants disclosed not learning about novel SRA methods, saying there is little pressure to update and little emphasis on updating their SRA

standard of care. Participants called their SRA training subpar compared to other therapeutic practice standards, noting that SRA is not considered a competency that requires renewal.

Discussion

The purpose of this exploratory study was to obtain an understanding of the lived experiences of psychologists conducting SRAs. This was accomplished through the phenomenological analysis of semi-structured interviews with five (master's and doctoral level) practising Canadian psychologists. Results address the overarching research question *What are psychologists' experiences of conducting SRAs?* and provide insights into three sub-questions:

1. How do psychologists view suicidal clients?
2. How are psychologists affected by SRAs?
3. How do psychologists view their SRA training?

Research Question 1: What Are Psychologists' Experiences of Conducting SRAs?

The essence of psychologists' SRA experiences revolved consistently around the struggle of and ambivalence toward being both an assessor and a therapist while conducting SRAs. It was the balancing of these two roles that participants identified as the source of their anxieties, training difficulties, and ethical uncertainties. Participants explored these two separate yet intertwining processes: prioritizing risk factors and quickly gathering salient determinants of health while leveraging the therapeutic relationship to enact client change. Indeed, it is a challenging professional issue; assessing for risk factors without therapeutic intent may harm the therapeutic alliance, yet gathering client information increases the likelihood of a strong safety plan (Stanley & Brown, 2012). Conversely, approaches that uniquely emphasize client connection and the therapeutic alliance sometimes fail to prioritize the assessment of suicide, which may affect the quality and likelihood of a successful safety plan (Schembari et al., 2016).

As discovered in this study, some participants saw the practices as integrative. They used client connection as the basis for gathering assessment information, which has been emphasized as a suicide prevention strategy (Dunster-Page et al., 2017). The struggle between these two roles describes the essence of practising SRA as a psychologist. Ultimately, this struggle parallels differences between two assessment methods: information gathering and collaborative-therapeutic assessments (Finn & Tonsager, 1997).

Traditional SRA, influenced by the information gathering model of assessment, focuses on gathering risk factor information, often through a series of closed questions or checklists (Wu et al., 2019). Factors such as demographics, previous suicide attempts, mental health concerns, or substance use are prioritized

to assess the client's level of imminence, despite being poor predictors of suicide (Chan et al., 2016; Large & Ryan, 2014). Notably, no traditional SRA boasts sufficient sensitivity or specificity to be effective (Abarca et al., 2018; Roos et al., 2013; Simon, 2012). This is likely due to the low base rate of suicide, estimated at 0.0115% in Canada (Government of Canada, 2020), the high number of risk factors, and the fact that these factors do not distinguish between suicidal and non-suicidal individuals (Bolton et al., 2012). Given that there is no reasonable difference in treating someone at low or high risk of suicide (Large et al., 2016; Truscott, 2018), traditional SRAs are unhelpful to both clients and psychologists.

It is understandable that psychologists in this study struggled to weave assessment and therapy into one cohesive SRA practice, given that psychologists often are trained to complete these practices divergently (Finn & Tonsager, 1997; Poston & Hanson, 2010). All participants endorsed the belief that, in SRA, information must precede rapport building due to ethical and safety obligations and that assessment data is dissociated from the client. This information gathering framework is commonly found in clinicians who lack sufficient SRA training (Brown et al., 2015) or who are unaware of alternative assessment practices, which is consistent with data demonstrating that fewer than 5% of Canadian psychologists report familiarity with collaborative-therapeutic assessment (Jacobson et al., 2015). If psychologists are trained to practise information-gathering SRA that separates assessment and therapy, a precedent is set to view them as incongruent, increasing clinicians' difficulties with the practice and decreasing the likelihood of client collaboration.

Information-gathering SRA practices may soon be an artifact of a growing collaborative-therapeutic assessment and SRA field. For decades, the process of assessment and psychotherapy has become increasingly complementary through continued research on collaborative-therapeutic assessment (Finn & Tonsager, 1997), given that providing feedback and collaborating with the client during the assessment are well-established practices (Finn, 2007). Researchers and practitioners such as Jobes (2016) have developed collaborative-therapeutic assessment models of SRA that integrate the information-gathering approach to support client safety while emphasizing client collaboration as the primary therapeutic factor. For example, the Suicide Status Form (SSF-4; Jobes, 2016; Jobes & Drozd, 2004) uses scales and open questions focused on developing client awareness of their suicidality, primarily through clinician feedback and skill building.

The SSF-4 is core to a larger suicide treatment model: the Collaborative Assessment and Management of Suicide (CAMS; Jobes & Drozd, 2004), which is a manualized framework for understanding and remediating client-defined suicide drivers while providing a collaborative model of developing a stabilization plan. The practice of CAMS is well supported, with evidence demonstrating reductions of suicide behaviour in college students (Jobes & Jennings, 2011), outpatient community mental health (Comtois et al., 2011), military personnel

(Jobes et al., 2012), and psychiatric outpatients (Ellis et al., 2017). This model is consistent with client-centred approaches, as patients treated with CAMS reported receiving therapy as the most helpful component of the treatment model and discussing their suicide plan as the least helpful. The findings of the current study support these collaborative-therapeutic assessment changes to SRA, as psychologists themselves would benefit from an integrative SRA model of assessment and therapy that is coherent with their and the client's beliefs about treating suicidal ideation.

Research Sub-Question 1: How Do Psychologists View Suicidal Clients?

Participants have an empathic and highly supportive view of suicide and suicidal clients, which is consistent with other psychologists (Cwik et al., 2017; Gagnon & Hasking, 2012; Hammond & Deluty, 1992). Participants nuanced their beliefs with the caveat that, although suicide is rational and acceptable, they believe intervention is necessary. This belief reflects the pervasive world view of psychologists, as believing in client change is paramount to enacting therapy (Hill, 2014). Participants believed most suicides stem from excruciating psychosocial distress that occludes the perceived availability of options to relieve their pain, which is consistent with modern understandings of suicide (Sommers-Flanagan & Sommers-Flanagan, 2018). In holding this complex belief, psychologists in this study agreed that most clients can be treated through psychotherapy and see opportunities in their practice to help suicidal clients see choices other than suicide.

Understanding and discussing the suicide beliefs of psychologists and of psychotherapists in training is critical, given that these beliefs affect psychotherapy practice. In some cases, a negative or a neutral belief leads to a biased and stigmatizing SRA (McCabe et al., 2017). It is no surprise that recent guidelines and training opportunities include a dissection of psychotherapists' suicide beliefs as part of continuing education (Schmitz et al., 2012; Sommers-Flanagan, 2019), yet suicide beliefs are not prioritized in graduate-level SRA training (Liebling-Boccio & Jennings, 2013). Given that participants in this study endorsed humanistic and empathic beliefs about suicide, our current account of how SRA practices are affected by beliefs is narrow. It is increasingly vital that we develop a stronger understanding of how beliefs influence SRA practices and use the information to guide better SRA training and practices.

Research Sub-Question 2: How Are Psychologists Affected by SRAs?

When queried about how SRAs affect them, participants endorsed feelings of agitation, exhausting emotional arousal, and debilitating neuroticism, all leading to disproportional resource investments in their suicidal clients. Given the grim understanding that client suicide is inevitable within a psychologist's career (Chemtob et al., 1989) and that reactions from said client suicide are harmful

to the practitioner (Ellis & Patel, 2012), it is understandable that psychologists worry about these experiences. Two of the five participants who lost a client to suicide expressed sentiments similar to those of other psychologists such as guilt, betrayal, anxiety, and withdrawal (Skodlar & Welz, 2013). Participants confirmed that their SRA practices were guided by fear of client suicide, creating an internal locus of control toward client suicide, ultimately fostering a culture of self-efficacy in the face of an unpredictable phenomenon. The belief that psychologists can prevent suicide is aspirational and potentially damaging to their psyche, yet as a consequence, believing that nothing can be done is likely more harmful (Truscott, 2018).

Further, participants identified experiencing a culture of surveillance in their SRA practice, fearing being held liable for malpractice in the event of a client's death by suicide. Such fear is consistent with other health care workers' experiences when working with suicidal patients (Saigle & Racine, 2018), with some highlighting how the legal system does not endorse appropriate therapeutic care for those experiencing suicidal ideation (Fine & Sansone, 1990). Therefore, it is critical to educate psychologists and other mental health professionals about the predictability of and the known treatments to suicide in order to increase the understanding that, although there is hope that suicide can be prevented, there is sometimes little that can be done to avert it.

Research Sub-Question 3: How Do Psychologists View Their SRA Training?

All participants stated that their SRA training was either inadequate or antiquated. Four of the five participants reported that their SRA training was inordinate to the frequency of suicide in the field and that the training itself remained theoretical, preparing them poorly for practice.

Results from this study support graduate-level SRA training revitalization, especially as other data suggest that only half of the pre-doctoral psychology interns report any formal training in this area (Dexter-Mazza & Freeman, 2003). Although SRA training is endorsed by graduate-level programs (Liebling-Boccio & Jennings, 2013), there is little explicit expectation from regulating bodies that practitioners maintain SRA competency through additional postgraduate training (Silverman & Berman, 2014a). This is critical, as recent research (including our own) identifies problems with practising traditional SRA (Large et al., 2016). Considering that SRAs have changed dramatically within the last decade, such as advancements in theory, risk factors, and approaches (Sommers-Flanagan & Shaw, 2017), psychologists must be prepared to provide ethical, updated, and effective SRAs.

Limitations

A major limitation of this study rests on the sample's characteristics. Heterogeneous samples such as this do not favour the idiographic nature of qualitative studies, as we seek to saturate a group's phenomenological experience thoroughly. Three of the five participants are master's-level licensed psychologists, although they were in the late stages of completing their Ph.D.s at the time of the study. Master's level psychologist licensing is unique to Alberta's jurisdiction and to a few other Canadian provinces, and because of the educational differences, the themes described in this study may lack transferability. Further, the sample participants all self-identified as European-Canadian/White, limiting the study's representation of Canadian psychologists. As well, the sample size was small, which may have constrained the breadth of psychologists' SRA experiences. However, typical IPA studies such as this recommend three to six participants (Creswell & Poth, 2017; Smith et al., 2009). The collected data answered the research questions with what we believe to be enough depth (Braun & Clarke, 2019).

Another limitation is the possibility of a biased interpretation of the data analysis and results, given there was only one analyst of the transcripts. Although synthesized member checking (Birt et al., 2016) and triangulation (Creswell & Poth, 2017) were used to assist the credibility and confirmability of the results, the results may be borne from biased quote selection and analysis. This may have influenced how themes were developed and how research questions were answered.

Lastly, participants were recruited through self-selection, potentially biasing the results to be more suicide-informed than the average sample of psychologists. This may have specifically affected the humanistic understanding and support shown toward suicidal clients or how participants endorsed feelings of deep investment in their clients.

Directions for Future Research

These exploratory qualitative study results provide foundations for future empirical inquiries in psychologists' experiences of SRA. Given that the national and provincial characteristics of psychologists in Canada varied significantly from the sample in this study (Ronson et al., 2011), a research question emerges in generalizing and replicating this study on a larger and more diverse scale. A national mixed methods explanatory survey design could increase the transferability of these results, including collecting actuarial data on national SRA practices and beliefs (Hanson et al., 2005).

Furthermore, the results of this study could be examined across cultural backgrounds. Given that very little suicide research is conducted in countries outside of North America (Lopez-Castroman et al., 2015), SRA practices could be examined cross-culturally through qualitative or survey methods. This would be of notable impact, as ideas about death and suicide change dramatically across cultures, with

Western-centric philosophies seeing it as the ultimate end to meaning, whereas others, such as those of primarily collectivist cultures, view death with less anxiety due to communal in-group identities (Ma-Kellams & Blascovich, 2012).

Lastly, future qualitative studies can refine the data collected in this study, particularly regarding the intricacies of weaving assessment and therapy, the differences between practice settings, or how volunteer experiences before graduate training influence SRA practices. Although IPA was used for this study due to the phenomenological nature of the research questions, future studies could also examine SRA experiences through a naturalized setting as an ethnography (e.g., Aflague and Ferszt 2010), through an in-depth case study analysis (e.g., Skodlar and Welz 2013), or through a grounded theory approach (e.g., Glaser & Strauss, 1999).

Implications for Practice

Tentative though they are, this study's findings potentially have important practice implications. Firstly, psychologists should explore collaborative-therapeutic assessment approaches to SRA, such as CAMS (Jobes, 2016). This likely decreases the perceived difficulty of weaving assessment and therapy in SRA, but its novel approach to suicide prevention and prediction is consistent with contemporary research and calls to action (Sommers-Flanagan & Sommers-Flanagan, 2018; Tucker et al., 2015). Secondly, graduate-level SRA training should be redeveloped and revised to include experiential practice and intentional identification of suicide beliefs. If they used experiential techniques such as role plays and in vivo observations instead of theoretical techniques, new psychologists may feel less anxiety about doing SRAs after graduation (Shea & Barney, 2015).

Furthermore, investigating trainees' and practitioners' beliefs about suicide may increase comfort with existential matters such as suicide and prevent the development of stigmatizing SRA practices. Lastly, practitioners are encouraged to advocate for clear SRA practice guidelines in national and local regulating bodies, given that this study revealed that a large proportion of the fear induced by SRAs arose from the uncertainty about how to practise SRA and suicide management. Specifically, it is important to establish SRA as a practice competency, given that many psychologists, despite having more training than other health care providers in suicide assessment and management, struggle to stay updated on continuing research in the area (Schmitz et al., 2012).

Conclusion

Before conducting this study, we knew very little about psychologists' experiences of SRA. Although this qualitative exploratory study helped elucidate notable experiences such as weaving assessment and therapy, investing in the client, and balancing competing pressures, the psychologists' experiences are not fully understood. Aspects of the experience such as the actuarial usage of SRA scales

versus verbal assessments, the effects of suicidal beliefs affecting SRA practice, and in-depth analyses on how SRA training informs SRA practices all remain unanswered.

As one of the first inquiries into this area, this study provides a potentially useful framework from which to expand, critique, and understand better how psychologists experience the process of conducting SRA. As the rate of suicide increases globally, it is paramount that mental health practitioners recognize the weight, consequences, and therapeutic opportunities of SRA. Relatedly, they must also challenge prevailing beliefs about effective and ethically responsible SRA practices. Findings reported here suggest that alternatives to traditional approaches may be warranted and ultimately may be more beneficial to clients and psychologists.

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Appendix A: Semi-Structured Interview Protocol

Review consent form and confidentiality.

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

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