THE LIVED EXPERIENCES OF COUNSELING PROFESSIONALS CONDUCTING SUICIDE RISK ASSESSMENTS FOR YOUTH: A PHENOMENOLOGICAL APPROACH

Christine Abassary

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THE LIVED EXPERIENCES OF COUNSELING PROFESSIONALS CONDUCTING SUICIDE RISK ASSESSMENTS FOR YOUTH: A PHENOMENOLOGICAL APPROACH

By

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DISSERTATION

Submitted in Partial Fulfillment of the Requirements for the Degree of

Doctor of Philosophy
Counselor Education

The University of New Mexico
Albuquerque, New Mexico

May, 2016
Dedication

I dedicate this dissertation to the voiceless youth and their families that have suffered silently in despair. Also, to the fearless counseling professionals that give their all to address the needs of their clients on the brink of suicide. Many counseling professionals will never know the final outcome of their service to others. I also dedicate this dissertation to the people of Malawi, Africa I had the pleasure of living amongst for two years who endlessly demonstrated the true meaning of resilience in the face of personal tragedy. Particularly, to Mr. Munthali who is no longer here with us yet, will always remain in my heart.

I am grateful to my advisor Dr. Deborah Rifenbary for her dedication to students and challenging me to search for deeper understandings of a complex and meaningful topic.

I would like to especially thank my dedicated and loving husband Hassan and his family that have supported me each step of the way. His wisdom and grace has been my steadfast companion. In this life we have journeyed together and I am grateful to my mother who has taught me to always stand confidently and to never give up despite the many hardships and triumphs she encountered. I am also particularly thankful to have gained a lifetime mentor and colleague Dr. Reshma Kamal who has gently guided me with enduring care and compassion.
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Furthermore, special thanks to Dr. Torrez who believed in my experience and supported my work as a Research assistant in Teacher Education, Educational Leadership and Policy. I am also grateful to Dr. Seniye’ who inspired me to look inward and from the heart versus a solely clinical perspective. Last, Mr. Mark Cornett, Mr. Jim Sayers, Mr. Vinton Zunie, Karessa Silversmith, the Graduate Professional Association and all my colleagues who have been exemplar role models for their dedication to students. I have been honored to be a member of the New Mexico Returned Peace Corps Association that has renewed my spirit through the many friendships I have encountered.

I am particularly thankful to my brother Patrick and sister-in-law Jennifer for giving me the recent gift of becoming an aunt to my precious nephew Desmond and lovely niece Genevieve. It is my sincere hope that they will grow up in a kinder and gentler world.
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ABSTRACT

This study explored the lived experiences of counseling professionals conducting suicide risk assessments for youth kindergarten through 12th grade receiving a suicide risk assessment recommendation. A qualitative phenomenological approach was utilized to capture the perceptions of the participants in this study. Fifteen (15) in depth, semi-structured interviews and a focus group with seven (7) returning participants were the primary sources of data for this study. Five (5) themes emerged: Care, Supervisory Relationship, Challenges, Symptoms of Vicarious Trauma and Transcendent Growth Experiences. Implications for the counseling profession may encompass enhanced organizational development, supervision, training and clinical preparation for counseling professionals providing a vital service to youth and their families.

Keywords: Counseling professionals, empathy, posttraumatic growth, suicide risk assessment, supervision, and vicarious trauma.
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Chapter 1: Introduction

This study examined the lived experiences of counseling professionals when conducting suicide risk assessments for youth. Counseling professionals are challenged with a myriad of traumatic experiences when working with their clients and particularly, when conducting suicide risk assessments for youth. Calhoun and Tedeschi (2006) describe trauma as, “trauma, crisis, major stressor, and related terms as essentially synonymous expressions to describe circumstances that significantly challenge or invalidate important components of the individual’s assumptive world (p.3).” The individual’s ability to understand, control and predict her/his life is associated with how the individual assesses the trauma (Joseph & Linley, 2008). Gilliland and James (2013) liken trauma to a disease that may be profound at the time and having lasting scars through adulthood. Depending on the trauma, distinct or ongoing, different psychological problems may develop for youth. Some of the symptoms that may result from trauma include PTSD like symptoms, developing defensive coping strategies, denial, psychological numbing, dissociation, identification with the aggressor, and developmental issues such as the ability to organize mental processes and suicidal tendencies (Gilliland & James, 2013). According to Banks (2006) traumatic events may be highly subjective including natural disasters, severe accidents, and death of a loved one; however, these occurrences may be less impactful than relational trauma. Relational trauma has been described as trauma suffered at the hands of another person including, sexual abuse, neglect, domestic violence, and terrorism (Banks, 2006). Banks (2006) asserted that regardless of the trauma experienced, some individuals who become traumatized question their desire to be alive. Suicide and the impact of trauma comprise
a variety of social issues that are complex and from an ecological perspective impact the individual, family, community, and society at large (Bronfenbrenner, 1979). Nearly a third of all practicing counseling professionals will encounter client suicide and almost two-thirds can expect a client to attempt (Schwarz & Rogers, 2004). Shields and Kiser (2003) found that a high percentage of counseling professionals believe that they are unprepared to work with or anticipate violent behavior in clients despite the high probability that they will encounter them. According to Brown (1987) work with suicidal clients is intense and demanding and some find reasons not to take on referrals when a client is known to be suicidal. Counseling professionals have reported feelings of guilt, sadness, anger, and increased fear in working with at-risk clients for years after the event (Lafayette & Stern, 2004).

Particularly, when working with youth who are facing crises, the counseling professional is taxed to be present and available while providing for the client’s immediate and long-term emotional well-being. Similar to trauma, crisis in psychological terms has been defined as “…a perception or experience of an event or situation as an intolerable difficulty that exceeds the person’s current resources and coping mechanisms (Gilliland & James, 2013, p. 3).” Anecdotal reports suggest that working with youth may be more distressing than working with adults (Beaton & Murphy, 1995; Dyregrov & Mitchell, 1992). McAdams and Foster (2002) asserted that counseling professionals who have experienced a client suicide have found it stressful and for many it has made an impact on their long-term career and personal life. McAdams and Foster (1999) found counseling professionals feelings of loss after a suicide commensurate with those of losing a parent. Counseling students or trainees may
be more likely to feel that they have failed as a professional versus more experienced counseling professionals (Brown, 1987). Over time, experienced counseling professionals may come to realize that despite everything they do to prevent suicide, in some cases suicide is out of their control to prevent. Research has demonstrated that pre-crisis education can reduce the risk of negative outcomes in client risk particularly for novice counseling professionals (McAdams & Foster, 2000). Counseling professionals that were adequately prepared with training aimed at heightened awareness of their own limitations and sensitization to experience of critical incidents found pre-crisis education helpful in guiding their professional practices (McAdams & Foster, 2002). In summary, the impact of assessing clients and particularly youth for suicide risk may have implications that severely impact the counseling professional. There is substantial literature specific to domestic and sexual violence concerning counseling professionals working in crisis settings. Studies examining counseling professionals conducting suicide risk for youth are remiss in the literature.

**Researcher Background**

My decision to become a counselor engaging with youth and families developed from my experiences working in community health and prevention. My community health background extends to working as a US Peace Corps Maternal Child Health Officer in Malawi, Africa and a Health Education Coordinator in Zuni, NM for youth. In both of these positions, I witnessed trauma as well as the amazing resilience of individuals and communities who faced tragedy and loss on an ongoing basis. I became particularly interested in working with the issue of suicide for school youth kindergarten through twelfth grade as an intern during my doctoral studies. After receiving a suicide
risk assessment clients initially evaluated for suicide received on-going counseling. I also learned that the majority of cases that obtained a same-day suicide risk assessment at my internship site never attempted nor would complete a suicide. I found the assessment could serve as a crucial intervention step and an on-going support for the client and her/his family members. The experience of working with youth and families led to my desire to contribute to the counseling profession by examining the counseling professionals experience and particularly, how individual perspectives, coping mechanisms, and support could potentially lead to better practices.

When I began the study, I was initially interested in suicide prevention for youth. With a community health background, I quickly learned that the antecedents, incidence, and prevalence of suicide is a complex research dilemma. Equally important as a counselor intern conducting suicide risk for youth and their families, I learned the value of the supervisory relationship, maintaining supportive relationships with coworkers, family and friends as well as practicing routine self-care. After realizing that suicide is a rarity when an assessment is performed, I moved away from examining the problem of suicide and began looking at the prevention component that the assessment can provide. By connecting to a client in a moment of despair and finding the opportunity to conjointly create new opportunities for client growth I began to look at suicide risk assessments with less apprehension. Furthermore, after hearing many agonizing accounts, I also became cognizant of the amazing resilience of my clients. I witnessed the phenomenal recovery and effect of a suicide risk assessment impacting the individual and her/his family for increased quality of life over the long-term in that brief time span. By focusing on the counseling professionals’ lived experiences I hope to emphasize an
important intervention piece whereby the counseling professional can be a pivotal 
instrument concerning the complex problem of suicide and recovery.

I strongly believe that the research a person gravitates towards reflects one’s own 
values on some dimension. My paradigm or worldview is most closely tied to social 
constructivism. As a human being and particularly as a counselor, I believe it is crucial 
to look at each relationship as a unique experience, retaining judgment and fully engaging 
with my clients, family and peers. I acknowledge that because of my own unique 
experiences I cannot remove all biases, yet I seek through constructivism to live in the 
present, taking in all that an individual contributes to the experience. In conducting this 
research, I aimed to explore how a counseling professional’s lived experiences may be 
compromised as well as enhanced by providing front-line assistance and on-going 
support for youth at-risk for suicide. I believe these experiences are highly personal in 
nature and as a researcher I sought to illuminate them.

**Problem Statement**

A suicide risk assessment requires the counseling professional to look at 
everything that is negatively affecting the individual, including family, school, peer 
relationships, history of abuse, and trauma. On the other hand, the counseling 
professional is also assessing the influence of protective factors like family and school 
connectedness (Kaminski, Puddy, Hall, Cashman, Crosby, & Ortega, 2010). Counseling 
professionals will need to make an immediate decision to ensure the safety of their clients 
and follow-up with interventions that may or may not be in place. For example, the client 
may not have after-school care and may be unsupervised until the caregivers return home 
from work. The assessment will provide for clients immediate safety and also offer
recommendations for continued therapy and care in most cases. There is an absence in training preparation, certification, supervision, and ethical guidelines commiserate with intervention, post-crisis recovery, and practice standards (McAdams & Keener, 2008). Over the years, the focus on crisis-based counseling has increased (James, 2008) with the most recent revisions furthering the need to the Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) standards. With increasing requirements for counselor preparedness in crisis response, there are minimal guidelines to assist counseling professionals in best practices and specifically, even less in post-crisis recovery (McAdams & Keener, 2008). With the field of professional counseling having established a wellness paradigm which situates itself within a holistic, prevention-based model it is often contradictory that counseling professionals find themselves negotiating crisis as a normal aspect of their occupation (Myers & Sweeney, 2008; Gladding & Newsome, 2010).

One of the most challenging roles a counseling professional will encounter is assessing suicide risk (Granello, 2010). According to Rogers and colleagues, 71 % of counseling professionals will at some juncture work with an individual who has made a suicide attempt (Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001). McAdams and Foster (2000) asserted nearly 23% of counseling professionals have been faced with a client suicide. Wachter, Minton, and Clemens (2008) argued that many school counseling professionals feel unprepared for a crisis and only a few participate in clinical supervision. With the rising incidence in suicidal behavior, it is essential that counseling professionals have access to the most appropriate and effective treatment information (Rogers et al., 2001).
This research aimed to inform counseling professionals who conduct suicide risk assessments for youth. This research aspires to assist counseling professionals more meaningfully in their endeavors.

**Vicarious Trauma and Posttraumatic Growth**

According to the literature, one phenomenon a counseling professional may experience is vicarious trauma (VT). McCann and Pearlman (1990) define VT as, “Profound psychological effects that can be disruptive and painful for the helper and can persist for months or years after the work with traumatized persons” (p. 133). VT is a relatively new paradigm used to describe a host of symptoms that may encompass burnout, countertransference, compassion or emotional fatigue, post-traumatic stress disorder (PTSD) or secondary work stress, and trauma. First described by McCann and Pearlman (1990), VT may include many internal processes for the counseling professional that may have profound psychological effects as a result of working with trauma victims over the long term. Pearlman and Saakvitne (1995) have defined VT as, “the cumulative transformation in the inner experience of the therapist that comes about as a result of empathic engagement with the client’s traumatic material” (p.31). The most disturbing aspect of VT if left unaddressed is that VT can permanently alter one’s worldview. Bober and Regehr (2005) emphasized that counseling professionals are increasingly providing services primarily focused on memories of trauma and ensuing traumatic symptomatology. Given the unique needs of the individual, counseling professionals contend with a host of crises and must respond to these needs effectively by demonstrating a deep understanding of what their clients may be facing. Furthermore, counseling professionals while not losing sight of longer-term goals and commitments,
must express genuine care and concern, while ensuring the basic safety of their client’s. Figley (2002) stated, “The very act of being compassionate and empathic extracts a cost in most circumstances. In our effort to view the world from the perspective of suffering, we suffer” (p. 1434). In sum, VT is a fairly recent iteration in the literature describing the effects of witnessing client trauma that can in some circumstances lead to an altered worldview.

Figley (1995) described symptoms of the therapist experiencing VT as *compassion fatigue* including: unwanted recollections, dreams, re-experiencing the traumatic event with the client, distancing from the clients’ traumatic event, psychological numbing, avoidance of certain activities, detachment or estrangement from others, persistent arousal resulting in sleep disturbances, irritability and outbursts of anger, difficulty concentrating and hypervigilance. It is important to recognize that these symptoms of VT may impact the effectiveness of the counseling professional. The urgency and helplessness on the part of the client can provoke major countertransference (Slonim & Hodges, 2000). McCann and Pearlman (1990) asserted that, “countertransference traditionally has referred to the activation of a therapist’s unresolved conflicts or concerns (p.134).” Furthermore, Pearlman and Saakvitne (1995) explained a counselor may experience signs of depression, anxiety, and PTSD similar to her/his client, become a powerless witness to the destructive behavior of her/his client, experience cynicism, despair and loss of hope. Although there is an overlap concerning symptomology with *posttraumatic stress (PTSD)* or *secondary related work stress*, and sometimes termed *compassion fatigue* resulting from work stress, VT focuses on the cognitive schemas or core beliefs of the counseling professional and the way they change
with empathic engagement (Bober & Regehr, 2005; Jenkins & Baird, 2002). *Secondary related work stress* refers to the comparable PTSD symptoms found within the Diagnostic and Statistical Manual (DSM-V) of the American Psychiatric Association (2013) and has been moved from Anxiety disorders to its own category found within trauma and stress related disorders. The new classification includes the avoidance and persistent negative alterations in cognitions and mood, retaining most of DSM-IV numbing symptoms and reconceptualized symptoms of persistent negative emotional states. The second cluster includes alterations in arousal and reactivity and retains most of DSM IV arousal symptoms with more irritable, aggressive, and reckless, self-destructive behavior outlined. For example, despite the fact that the counseling professional never experiences the traumatic event firsthand, a counselor who hears traumatic material from her/his client may still suffer symptoms equivalent to PTSD. Secondary work related stress is used in this context representing symptoms akin to PTSD except the symptoms are arising vicariously from the client’s accounts and not from the actual trauma. *Burnout*, an earlier and further developed construct in the literature refers to people who work intensely with others’ problems (Jenkins & Baird, 2002). Schaufeli and Peeters (2000) defined burnout as:

> Persistent negative, work related state of mind in ‘normal’ individuals that is primarily characterized by exhaustion, which is accompanied by distress, a sense of reduced effectiveness, decreased motivation, and the development of dysfunctional attitudes and behaviors at work (p. 21).

Burnout can be conceptualized as a defensive response to prolonged occupational exposure that results in psychological strain and inadequate support (Jenkins & Baird,
Without any supportive safeguards in place to counteract the negative effects of chronic stress, it is inevitable that burnout will occur to counseling professionals exposed to trauma.

In contrast to the damaging effects of VT, vicarious exposure to trauma may also have positive outcomes known as posttraumatic growth (Arnold, Calhoun, Tedeschi, & Cann, 2005). Sexton (1999) argued that being a part of the healing process can also be transforming, inspiring and rewarding for the counseling professional. Cohen (2009) described the concept of the *Wounded Healer* as a risky opportunity for growth. The experience of posttraumatic growth has been found to be adaptive and also to counterbalance the negative aspects of vicarious trauma (Brockhouse, Msetfi, Cohen, and Joseph, 2011). Arnold et al. (2005) defined vicarious posttraumatic growth as, “psychological growth following vicarious brushes with trauma” (p. 243). According to Calhoun and Tedeschi (2013), clients who suffer from traumatic events such as the death of a loved one, cancer, and other life-threatening events may come out with a healthier attitude towards life, spiritual transcendence, strength and appreciation of living each day to their fullest potential. Similarly, counseling professionals may experience personal meaning after working with resilient individuals who have experienced difficult life events including heightened sensitivity, compassion, insight, tolerance and empathy (Arnold et al., 2005). By listening to clients with respect for their strength and courage, counseling professionals can experience positive changes elevated by the moderating effects of a sense of coherence, organizational support and empathy (Brockhouse et al., 2011; Linley, Joseph, Cooper, Harris, & Meyer, 2003; Tedeschi & Calhoun, 2004). In summary, although less is empirically known about the phenomena of posttraumatic
growth, a counseling professional may nevertheless experience growth by hearing stories of resilience after her/his client’s subsequent confrontations with trauma.

**Assigning Meaning to Experience**

Drawing from a constructivist lens and how one assigns meaning to her/his experiences, the counseling professionals lived experiences were investigated. Constructivism is a dynamic process that looks at the subjective meaning of individuals who are impacted by history, culture, and experiences (Creswell, 2013). The shared meanings become connected, and the researcher participates through the engagement with her/his participant. These experiences can never truly be objective or post-positivistic according to constructivism (Creswell, 2013). According to Iliffe and Steed (2000), constructivism is based on the theory that the individual constructs her/his reality with ever changing mental frameworks or cognitive schemas. Consistent cognitive schemas, including beliefs are necessary to feel safe in the world (Fiske & Taylor, 1984). McCann and Pearlman (1990), using a constructivist foundation, identified seven basic psychological needs including: intimacy, esteem, power, dependency/trust, safety, independence, and frame of reference or an individual’s attributions of what is likely to occur. Dunkley and Whelan (2006a) posited that with both intrinsic and extrinsic factors, VT can be located within a constructivist theory. Trauma has been observed to disrupt these schemas (Iliffe & Steed, 2000).

In conclusion, counseling professionals’ lived experiences of conducting suicide risk assessments for youth was the main focus of this study. When encountering a complex problem such as suicide risk assessments for youth, inexperienced counseling professionals may be faced with complexities beyond their level of experience.
Experienced counseling professionals may also come away with difficulties outside their available resources. VT has been phenomena demonstrated in the literature when resources are unavailable to the counseling professional. Although fewer studies have been conducted, the experience of posttraumatic growth has been found to be alternatively beneficial and protects the counseling professional from VT. The experience of VT and/or alternatively posttraumatic growth was be considered in relationship to conducting suicide risk assessments for youth. Although the literature informs the study, experience is personal and consequently, the voices of counseling professionals ultimately informed the study.

**Youth Suicide**

The Centers for Disease Control and Prevention stated approximately 4,600 for youth aged 10 to 24 years old die by suicide nationally (CDC, 2013). This is the third leading cause of death for 10- to 24-year-olds (CDC, 2013). Albrecht, Fitzpatrick, and Scrimshaw (2000) explain that sociological determinants of health, such as ethnicity, race and poverty, may contribute to health disparities. Disparities may exist due to the inherent stressors associated with being poor, and as a person of color, living in the United States (Albrecht et al., 2000).

This study was conducted in the southwest portion of the U.S. and population estimates by race and ethnicity indicate higher proportions of American Indians and Hispanics reside in these areas (U.S. Census Bureau, 2014). According to U.S. Census Bureau (2011), nationally Arizona ranked second at 19.2% for people living below poverty, New Mexico ranked third at 19.1%, and Mississippi first with 21.3%. Both national and local data suggest that Native youth are at a greater risk for suicide.
completion. According to the (CDC, 2006) suicide accounts for nearly one in five deaths among American Indian (AI) /Alaskan Native (AN) groups. The considerably higher incidence of suicide among Native Americans emphasizes a health disparity when compared to other ethnic groups. It is reported that adolescent Latina females have a higher incidence of suicide attempts when compared to their African-American and White peers (Kuhlberg, Oenba, & Zayas, 2010). Garcia and Saewyc (2007) explain rates of anxiety, depression and suicidal ideation are high among Latino adolescents many of whom are also recent immigrants. Furthermore, in rural and underserved communities coupled with a lack of accessible mental health services youth suicide rates are reported to be two to ten times higher than analogous groups (Brown, Wyman, Brinales, Gibbons, 2007). Due to the landscape of its population it could be argued that the southwest, in combination with sociological determinants of health such as poverty, ethnicity, and lack of accessibility to mental health services, may put youth at a higher risk for health issues including suicide.

Rutter (2006) stated differences in gender compound the understanding of suicide. For example, females tend to display more suicidal ideation while males complete suicide more often. According to the CDC (2011a), nationally Latina adolescent girls had the highest rates of suicidal ideation (21%) and attempts (14%) compared with their peers. The New Mexico Youth Risk and Resiliency Survey (2011) reported girls persistent feelings of sadness, thoughts about suicide, and attempts were higher than boys in most cases (Green & Peñaloza, 2014). For instance, 12.3% of high school girls versus 5.0% of high school boys attempted suicide. Green & Peñaloza, (2014) stated 25.2% of middle school girls as opposed to 14.9% of boys ever thought about killing themselves. It is
important to add nationally those that identify as lesbian, gay or bisexual have higher rates of attempts and completed suicides than the general population (Rutter, 2006). Also, schools may be ill prepared for addressing the needs of lesbian, gay, bisexual, transgender or questioning youth (LGBTQ) students (Mahdi, Jevertson, Schrader, Nelson, & Ramos, 2013). In sum, being female and/ or having a LGBTQ orientation may put youth at greater risk for suicide.

Pisani, Wyman, Petrova, Schmeelk-Cone, Goldston, Xia, and Gould (2013) asserted emotional regulation difficulties were correlated with increased risk for suicidal risk above depressive symptoms and demographic factors. In youth with severe abuse and trauma, the evidence is significant (Perry, 2002). Perry (2002) studying brain development and childhood trauma, found that through nurturing relationships the human brain can develop effective coping strategies. In increasingly isolating environments where families are no longer cohesive and communities are becoming fractured, youth are increasingly vulnerable and unable to develop successful coping mechanisms (Perry, 2002). Effective coping strategies and emotional regulation are important for assessing suicide risk in youth.

In conclusion, Rutter and Behrendt (2004) emphasized the majority of research has focused on correlating data with demographic variables; however, this does not explain why certain youth may be at risk for suicide. For instance, despite LGBTQ youth being at a higher incidence of suicidal attempts sexual orientation alone did not predict risk (Rutter, 2006). In addition, numerous studies correlate suicide risk to substance abuse problems, psychiatric disorders, family disruption/stress, antisocial behavior, or family suicide history; however, research continually neglects intervention strategies
Suicide is a complex problem with many antecedents contributing to suicidal behavior that may be preventable given appropriate interventions.

**Assessing Suicide Risk for Youth**

According to the CDC (2009) mortality from youth suicide is only a piece of the puzzle. Risk behaviors for suicide include those associated with unintentional injury, violence, cyber bullying, sadness and suicidal ideation, tobacco use, alcohol use, drug use, and sexual activity (CDC, 2011b). In addition to surveying risk factors that lead to suicide, protective factors are also evaluated when counseling professionals are assessing for risk. Protective factors are measures of the positive and supportive relationships, experiences, activities, resources and values that foster healthy youth development (CDC, 2016). Protective factors and related traits including connectedness found within caring and supportive relationships in the family, school, community, and with peers are related to safeguarding youth from suicide (Bariola, Hughes, & Gullone, 2011; Hunter, Katz, Shortt, Davis, Leve, & Allen, & Sheeber, 2011; Call & Mortimer, 2001). Call and Mortimer (2001) explain constructive use of time in school, and outside of school through interest-based clubs, teams, religious and secular community organizations promote healthy development in youth. For instance, despite the higher incidence of suicide among Native Americans those with higher cultural/spiritual affiliations actually decreased the prevalence of suicide compared to those with lower affiliations (Lizardi & Gearing, 2010). In summary, identifying protective factors are equally important to risk factors in prevention efforts for suicide risk assessments for youth.
Purpose of the Study

Conducting suicide risk assessments for youth is involved and requires the counseling professional to assess the client for suicide lethality on many dimensions. Research specific to suicidology in youth is limited. Suicide assessment also poses additional layers of difficulty with a lack of standardized assessments and the developmental considerations needed for youth. Vicarious trauma is a complex construct and research is insufficient concerning the effects on counseling professionals conducting suicide risk assessments for youth. Many of the studies to date have focused on VT in relationship to sexual abuse and domestic violence. Even less research is available concerning the construct of posttraumatic growth and its ability to safeguard counseling professionals from the detrimental effects of prolonged exposure to working with clients in crisis.

The purpose of this phenomenological study was to discover how the lived experiences of counseling professionals are reflected in conducting suicide risk assessments for youth. Education, training, and the supervisory relationship can ultimately impact the lived experiences leading to more successful client and counseling professional outcomes. Personal life experiences, support, and coping can also sustain the counseling professional’s effectiveness. By examining the counseling professionals’ lived experiences, the resulting findings have the potential to contribute to the enhancement of practices that allow counseling professionals to continue in assessing suicide risk for youth and maintaining a healthy and balanced approach to this work.
Significance of the Study

Carl Rogers (1961) stated, “Counselors can support an individual’s personal growth and freedom only to the extent that counselors maintain their own.” In the assessment of suicide risk for youth, it is essential that the counseling professional be well trained and therapeutically present to her/his clients. In a complex assessment including many variables, the counseling professional will make a decision that affects the immediate safety for her/his client and care over the long term. In the development of training and practices to provide for client safety, it is equally important to explore professional practices that develop a counseling professional’s effectiveness. The study explored the lived experiences of counseling professionals conducting suicide risk assessments for youth in addition to what may be considered toxic in the case of VT and/or alternatively, expansive by posttraumatic growth.

Research Questions

For the present study two overarching central questions are included:

1.) What are the lived experiences of counseling professionals conducting suicide risk assessments for youth?

2.) What are the circumstances in this counseling professional’s life that contributed to conducting suicide risk assessments?

The subsequent interview questions (Appendix A) have been developed as a result of the literature review and will also be present in the coding of the themes.
Definitions of Terms

- **Burnout**: Results from work related stress over the long-term in the absence of support (Jenkins & Baird, 2002).

- **Compassion Fatigue**: Symptoms akin to PTSD resulting from the act of compassion and empathy towards a client while hearing her/his traumatic material (Figley, 2002).

- **Posttraumatic Growth (PTG)**: Emphasizing the positive psychological outcomes resulting from trauma and the transformative nature of potentially harmful experiences (Calhoun, Tedeschi, & Cann, 2005).

- **Posttraumatic Stress Disorder (PTSD)**: Symptoms of re-experiencing trauma such as intrusive images, sleep disturbance resulting from a traumatic event (DSM V, 2013).

- **Secondary Work Related Stress**: Symptoms akin to PTSD resulting from hearing a client’s traumatic material rather than experiencing it firsthand (Bober & Regehr, 2005; Jenkins & Baird, 2002).

- **Trauma**: Crucial meanings are challenged in the individual assumptive world as a result of the traumatic event (Calhoun & Tedeschi, 2006).

- **Vicarious Trauma (VT)**: Results from hearing a client’s traumatic material and may have negative psychological outcomes for the counselor such as a disruption of her/his worldview (McCann & Pearlman, 1990). The symptoms may resemble those of PTSD and include changes in frame of reference, identity, sense of safety, ability to trust, self-esteem and sense of control (Bloom, 2003).
Limitations of the Study

In choosing this study, I am taking an axiological approach, acknowledging that my own experience and biases are present in my work as a researcher and how I relate to my participants (Creswell, 2013). Furthermore, my own interpretation of the participants’ experience is value-laden because of my background having worked as a counselor assessing suicide risk for youth.

The trustworthiness and creditability of this study is an epistemological issue that the researcher must defend asking the question, “Has the data reached the level of depth for the researcher to truly understand the experience of the counseling professionals participating in this study?” In relationship to reliability, the methodology is defined and repeatable and does not profess to make claims to the population at large. The study aspires to inform in similar situations that may support counseling professionals in conducting suicide risk assessment for youth and performing to their best standards of the professional counseling practice. For practitioners who experience suicidology and trauma in their work this study may also render salient themes.

In summary, I believe this dissertation is important in order to guide counseling professionals more meaningfully through their endeavors. In acknowledging the inherent bias, I also retain the hope that my experience and the lived experiences of counseling professionals encountering suicidolgy in youth can create a deeper understanding of the complexity of assessing suicide lethality and risk in youth, the subject of vicarious trauma, and in some instances ensuing posttraumatic growth.
Chapter II: Literature Review

This review includes published research and literature from 1951 to 2016 related to the experience of conducting suicide risk assessments of youth. The first section includes an overview and discussion of suicide risk assessment, supervision, and ultimately counseling professional impact. Although not related to the present study, the impact of client suicide on counseling professionals is included, as it is relevant to the subject of suicide risk assessments. The literature regarding counseling professionals’ experiences of conducting suicide risk assessments specifically among youth of all ages is not exclusive. The next two sections offer a look at the phenomenon of vicarious trauma (VT), posttraumatic growth and empathy. The review concludes with examining counseling professionals’ experiences of VT, posttraumatic growth and use of empathy in a variety of settings. Finally, cultural implications regarding suicide are discussed.

The review is not restricted to counseling professionals and included case workers, clinicians, mental health workers, nurses, psychiatrists, psychologists, and social workers. The experience of VT and posttraumatic growth is explored as a phenomenon and is not limited to youth and suicide risk assessments alone. Other counseling contexts included abuse/neglect, sexual violence, domestic violence, natural disaster, war related PTSD, and several other contexts in this review.

Suicide Risk Assessment

According to Granello (2010) suicide risk assessment may be one of the most complex challenges a counselor will encounter. Westefeld, Range, Rogers, Maples, Bromley and Alcorn, (2000) affirmed that suicide risk assessment is more viable than prevention efforts alone. Reeves, Bowl, Wheeler, and Guthrie, (2004) explained that
within the contract of confidentiality undertaken by counseling professionals lies the responsibility of care to competently assess for suicidology. Many of the risk assessments found within psychiatry, psychology, and social work do not easily align with a humanistic counseling paradigm (Reeves et al., 2004). Granello (2010) affirmed that the broader guiding principles for assessing suicide are remiss in the literature. Oftentimes, counseling professionals rely on standard suicide risk assessments. Granello (2010, p. 364-368) recommended twelve Core Principles that should guide a suicide risk assessment:

1. Suicide Risk Assessment of Each Person is Unique
2. Suicide Risk Assessment is Complex and Challenging
3. Suicide Risk Assessment is an Ongoing Process
4. Suicide Risk Assessment Errs on the Side of Caution
5. Suicide Risk Assessment is Collaborative
6. Suicide Risk Assessment Relies on Clinical Judgment
7. Suicide Risk Assessment Takes All Threats, Warning Signs, and Risk Factors Seriously
8. Suicide Risk Assessment Asks the Tough Questions
9. Suicide Risk Assessment is Treatment
10. Suicide Risk Assessment Tries to Uncover the Underlying Message
11. Suicide Risk Assessment is done in a Cultural Context
12. Suicide Risk Assessment is Documented

Roberts and Yeager (2005) suggested utilizing a decision tree leading to a determination to rate a client as: a.) Imminent risk b.) Moderate risk and c.) Low risk for suicide. The
assessment would include conducting an in-depth interview, biopsychosocial and lethality/danger assessment. For instance, a person with a specific suicide plan, impaired judgment/or psychosis, access to lethal means, chemical dependency, and poor social support would be classified as *Imminent suicide risk* and arrangement to transfer the client to a psychiatric facility would follow. A *Low risk* may include no clear intent. A *Moderate risk* would encompass the level of intent with no access to lethal means. Both low and moderate ratings comprise having a supportive network and a willingness to follow treatment recommendations (Roberts & Yeager, 2005). Recent research has outlined certain signals that are important when considering suicide risk such as history of a prior suicide attempt, having a specific plan to commit suicide or harm oneself, recent cutting off communication with friends and/or family, and giving away prized possessions (Schwartz & Rogers, 2004).

Although many models of suicide risk assessment can be found, the most accepted theoretical models according to Westefeld et al. (2000) incorporate biological, psychological, and environmental empirically researched correlates with suicidal behaviors. For example, the Overlap model foreshadows the greater prevalence between five risk factors and varying domains regarding whether or not one is likely to commit suicide (Blumenthal & Kupfer, 1990). The five domains include: a.) social support, b.) biological vulnerability, c.) psychiatric disorders d.) personality factors including depression and impulsivity, and e.) family history and genetics. Theoretically, the more risk factors overlap the higher the risk for suicide (Blumenthal & Kupfer, 1990). The Three Element Model concentrates on the amalgamation of predisposing risk factors, family history, social environment, personality, life situation, and availability of suicide
mechanisms, such as firearms (Jacobs, 1999). The various characteristics combine in unique ways to lead to suicide and suicide behaviors (Jacobs, 1999). The Trajectory Model explores the interactive influence of risk factors that may trigger suicidal ideation (Stillion, McDowell, & May, 1989). Stillion et al. (1989) maintained that in addition to these factors a “last straw” event would move a person more towards suicidal behavior. The Cubic Model represents three factors believed to move a person to the belief that suicide is the only alternative (Shneidman, 1987). The three axis of the Cubic Model according to Shneidman (1987) are represented by press, pain and perturbation. Press represents the external events that cause the person to react, pain is produced by unfulfilled psychological needs and perturbation is a state of being upset that could have many individual sources (Shneidman, 1987).

Westefeld et al. (2000) indicated established personality tests such as the Minnesota Multiphasic Personality Inventory (MMPI-2 Hathaway & McKinley, 1989), the Hopelessness scale (Beck, Weissman, Lester, & Trexler, 1974), as well as many suicide questionnaires may also be utilized to assess suicide risk. According to Rogers, (1994) the Suicide Assessment Checklist (SAC) with good reliability and internal consistency was devised from a comprehensive literature review to be utilized for a standardized component of a comprehensive risk assessment and documentation strategy for counseling professionals. Reeves et al. (2004) contended that many suicide risk assessment tools are available, yet this is largely an inexact science. Leenaars (2004) added that we may understand what comprises risk; however, ultimately we cannot predict who will attempt suicide and who will succeed on the basis of empirical findings alone. Reeves et al. (2004) examining clinical discourse found few counseling
professionals mentioned the word suicide explicitly. Furthermore, how the counseling professional assesses suicide may also depend on how one views suicide morally. For example, if the counseling professional believes an elementary school student is incapable of suicide, she/he may brush aside warning signs and opportunities for intervention (Schwartz & Rogers, 2004). Outcomes of an assessment may be influenced by how suicide awareness was offered during core training, how counseling professionals conceptualize confidentiality, feelings of fear concerning working with suicidal clients and feelings of incompetency or even anger at the expression of suicidal ideation (Reeves et al., 2004). Reeves et al. (2004) added that although counseling professionals are not typically diagnosticians, they play a crucial role in maintaining hope versus confirming despair. Clearly, suicidal assessment is multidimensional and requires decisions on many levels that ultimately impact client safety.

According to Barrio (2007), suicide risk assessments pose added complexities for children due to varying developmental considerations. Many assessments are designed for adolescents. Barrio (2007) further recommended altering questions to fit age appropriate levels. Certain factors may put children at greater risk for suicide including biological risk factors such as impulsivity, psychological factors such as inferiority, cognitive factors including concrete thinking, environmental factors such as chaotic or inflexible family structures, abuse, neglect, and precipitant events like loss or threatened loss (Barrio, 2007). Schwartz and Rogers (2004) maintained that there are many myths about suicide particularly with very young children under 6 years old, including that they cannot conceptualize the finality of death, are incapable of committing suicide, and mentioning suicide may lead to suicidal behavior. For instance, those counseling
professionals that may not be able to form a mental picture of a child ending one’s life may neglect follow-up and a safety plan. Recently, the DSM-V (2013) has become more developmentally sensitive including lowered thresholds for children and adolescents. For example, the DSM-V (2013) includes a separate criteria under PTSD for children 6 years and younger. For young children, suicidal rates are relatively low, and general lack of awareness can make assessment of younger children one of the most challenging diagnostic tasks (Wise & Spengler, 1997).

Murray and Wright (2006) emphasized that suicide risk assessment is difficult when adolescents struggling with stressors and life events utilize self-harming behavior as a way to communicate or cope. The American Association for Suicidology (2006) estimated for youth aged 15-24 years old approximately 100-200 attempts are made for every completed suicide. It has been established that adolescence does mark a time of particular biopsychosocial and developmental processes (Santock, 1998). Given that this time marks changes to a relatively functional adolescent growing up in a healthy environment for less fortunate youth this time can bring added challenges (Murray & Wright, 2006). Ben-Zur (2003) speculated for underprivileged adolescents this period is often characterized by challenging behavior and rebellion. Research regarding the youth perspective on suicide risk assessment is limited often because parents are unwilling to reopen the issue of suicide with the fear that discussing suicide will lead to suicidal tendencies (Murray & Wright, 2006). Murray and Wright, (2006) provide a glimpse into the youth perspective of suicide risk assessments in a qualitative research design using a phenomenological interviewing approach. The researcher interviewed adolescents concerning their experience of the suicide risk assessment (Murray & Wright, 2006). The
results included in-depth interviews from three adolescents and six parents. The major findings developed from the youth perspective included: (a) initially the clients spoke of fear, apprehension, shame, and the importance of having one therapist to establish trust, (b) after the initial assessment the participants found the assessment helpful, reduced anxieties, helped “getting things under control,” and changing their thinking, and behavior, (c) perceptions changed from giving up to a sense of hope, (d) connection to the counseling professionals who cared for them and the importance of the relationship were key, (e) active listening (versus lecturing or advice) and a non-judgmental approach worked best, (f) viewing the context of the individual’s situation that may be contributing to the behavior such as socio-economic conditions within neighborhood and family are important, and (g) cooperation is enhanced when adolescents felt they were heard and respected (Murray & Wright, 2006, p. 159-161). In this limited study the participants found a family systems and person centered approach worked best for the adolescents interviewed (Murray & Wright, 2006).

In summary, suicide risk assessment involves many context dependent considerations, and with each individual assessment a new criteria for understanding client’s needs may arise. There are no universal guidelines for suicide risk assessment. Particularly when dealing with youth, developmental and social conditions factor into a decision that ultimately impacts client well-being.

**Supervision**

McGlothlin, Rainey, and Kindsvatter (2005) asserted that supervision is essential for the well-being of counseling professionals working with suicidal clients. Tracey, Ellickson and Sherry (1989) emphasized expert and novice counseling professionals alike
preferred highly structured supervision when working with suicidal ideation. McGlothlin et al. (2005) developed the Cube Model of supervision to assist supervisees based on the level of experience in her/his conceptualization and implementation with suicide lethality and risk. The Cube Model integrates Stoltenberg, McNeill and Delworth (1998) and the Developmental Model to determine the supervisees’ level of experience and what he/she may need. The model also encompasses Bernard’s (1979) Discrimination model to include the role of the supervisor as teacher, consultant and counselor. Client lethality is also represented as Low, Moderate, and High as the third dimension to the model (McGlothlin et al., 2005). According to McGlothlin et al., (2005, p. 45) the three aspects supervisors consider when engaged in suicide assessments with trainees are:

1. Level of development of the supervisee.
2. Role the supervisor will employ for the situation: teacher, counselor, and/or consultant.
3. Level of client lethality.

The Cube Model includes: (a) explores the complexity and context of the situation to increase effectiveness in the counseling role while determining lethality and risk, (b) considers the supervisees’ development, and (c) employs the role best suited for the supervisor/supervisee relationship (McGlothlin et al., 2005).
Figure 1. Cube Model

Adapted from Cube Model. McGlothlin, Rainey, & Kindsvatter (2005)

For instance, how a client’s level of lethality impacts counseling trainees may be different from that of a professional counselor. Even with low lethality it would be important to assess whether the supervisee is asking the right questions to determine if, in fact, that client is presenting as low lethality or if crucial observations are going undetected due to lack of experience (McGlothlin et al., 2005). In the case of a novice counselor, the Cube Model would employ the teacher role to inform or instruct versus a consultant role to guide a more seasoned professional (Bernard, 1979). However, the Cube Model is fluid, and an experienced counselor may also require the counselor, or teacher role depending on the impact the suicidal client has on the counselor. The role a supervisor takes to ensure client safety while also being responsible for the training of the supervisee may differ depending on client lethality and level of experience. According to McGlothlin et al. (2005) the Cube Model does not prescribe, yet seeks to contextualize the complexities between supervisors, supervisees, and clients.
Counseling professionals and supervisors play a vital role both after and during a suicide risk assessment that includes decision-making, as well as reflection on best practices. Westefeld et al., (2000) added that suicide risk assessment includes intervention, prevention, and postvention. Intervention is not limited to the assessment and includes arranging medical appointments, social support and possibly follow-up counseling (Westefeld et al., 2000). According to Westefeld et al., (2000) prevention includes educational programs. Finally, postvention activities are conducted after a suicide has occurred. These activities are performed to reduce the effect of what is termed as an emotional contagion and ultimately help the community to heal (Westefeld et al., 2000). Finally, the act of supervising counseling professionals through suicide risk assessment is multidimensional. In summary, in order to promote sustainability, supervision must also address the counseling professional’s well-being negotiating a potentially highly stressful situation.

Emotional Impact of Suicide and Suicide Risk Assessments

With every assessment lies the understanding that the assessment may not lead to prevention. Brown (1987) described that inexperienced counseling professionals in training are oftentimes the ones conducting suicide risk assessments with the understanding that when they complete their training they will not have to engage in this type of work. McGlothlin et al. (2005) stated that in counseling settings, suicidal ideation is one of the most common forms of crisis and also leads to the highest amount of stress for counseling professionals. Brown (1987) explained that the impact of suicide on a child is equivalent to that of a counselor trainee; both being never easily understood. Brown (1987) articulated that it is difficult to always be successfully empathic while
glimpsing into the world of the client. The counseling professional may be weighing the difference of a threat or actual suicide, feeling anxious or concerned over making an error, and needing to make a decision that may affect the client’s immediate safety and well-being (Brown, 1987). McAdams and Foster (2000) assert supervision is essential for the well-being of counseling trainees.

Especially for trainees, a client suicide may be impactful because trainees are deeply invested in being helpful (Brown, 1987). Some supervisors liken trainees who work with suicidal clients akin to being an emergency room doctor and it may be an unavoidable aspect of entering the counseling profession. Yet, trainees may lack adequate skills to assist severely suicidal clients (Brown, 1987). According to Roberts, Monferrari, and Yeager (2008) in most cases the law assumes suicide is preventable, and many counseling professionals may face malpractice lawsuits because of a lack of understanding of the legal aspects of malpractice accompanying suicide. To make matters worse, Juhnke and Granello (2005) acknowledged that many counseling professionals suffer abandonment by their professional colleagues when a suicide occurs. Feelings of loss, doubts about professional competence, fear about being blamed by clients or families, irrational feelings of anger, betrayal and disappointment including existential grief are supported in the literature (Juhnke & Granello, 2005). McAdams and Foster (2002), in a study of 66 professional counselor respondents concerning frequency and impact on client suicide, revealed participants rated supervisory support as most helpful to them in their recovery. This was followed by personal support, contact with family after suicide, and education and training. Juhnke and Granello (2005) suggested developing a pre suicidal preparation plan to protect the emotional needs of the
counseling professional including building a professional support network, fostering mutual growth, and personal counseling for established counseling professionals and trainees. Kleespies, Penk, and Forsyth (1993) found that trainees who experienced a client suicide suffered greater feelings of shock, disbelief, failure, sadness, self-blame, guilt, shame, and depression than those that did not. McAdams and Keener (2008) found precrisis education and rehearsal was a prerequisite for competent intervention, coping with crisis impact, and moving forward in the counselor’s personal and professional life. In a national survey McAdams and Foster (2000) surveyed 376 professional counselors and found that 23% had experienced client suicide in their care, and 24% were student counseling professionals at the time of suicide. These counseling professionals experienced a moderate to moderately high impact on their well-being. Relevant findings were that counseling professionals in the study reported intrusive negative thoughts concerning the suicide, counseling professionals were impacted more than psychologists or psychiatrists, and the intensity and persistence of stress was greater for student trainees. Novice counseling professionals may suffer more impact from working with suicidal clients although seasoned professionals may be equally affected. With the likelihood of experiencing a suicidal client education, training, and further research regarding effective supervision are fundamental.

Many decisional evaluations take place by the counseling professional working with a suicidal client. Suicidal assessments are manifold and require complex assessment including biological, psychological, and environmental. There are no standardized guidelines for suicidal assessment and it requires individual competence and judgment. Suicidal assessment for youth may include additional complexities when considering
developmentally appropriate assessment tools. Supervision places importance on determining suicidal lethality and risk and protecting client safety; however, it may be remiss in following up with counselor impact. Furthermore, unlike traditional counseling, assessing for suicidology adds a third dimension to the supervisory relationship when considering level of client lethality and risk. Education, training and particularly, supervision may be an important key for working with suicidal clients especially in the aftermath of a suicide. Counseling trainees may be unprepared and lack the emotional resources to confront client suicide. In summary, given the prevalence that a counseling professional may ultimately face a suicidal client the necessary educational preparedness, training, and supervision are indispensable.

**Vicarious Trauma**

Some individuals, particularly counseling professionals, experience vicarious trauma (VT) indirectly by listening to their clients shocking accounts of being the primary target of a horrific event (Pearlman & Saakvitne, 1995). Bloom (2003) explained the emotional *catharsis*, that the client brings to therapy requires the caregiver to contain the trauma or *emotional contagion* in limited and prescribed ways. Further, because the trauma is contained rather than expressed, the counseling professional is then guarded against revealing her/his own hyperarousal, fear, anger and grief. The counseling professional’s reactions can render a noxious physiological and psychological state. (Bloom, 2003). McLean, Wade, and Encel (2003) found that for counseling professionals, experiencing trauma through their clients symptoms were equivalent to post-trauma symptoms including sleep disturbance, intrusive images, and disruption to core schema about safety in the world, trust, intimacy and control. Hearing a client’s
account of that trauma can lead to changes in personal and professional identity (McCann & Pearlman, 1990). Bloom (2003) stated that VT is a normal reaction to “abnormal stress.” VT can have negative psychological consequences for a counseling professional if unmitigated (McLean et al., 2003). One of the most disturbing aspects of VT occurs when therapist bias happens due to an altered worldview (Dill, 2007). For example, a counseling professional working in juvenile detention centers may begin to assume all youth are suicidal and/or violent, which may or may not be the case. Secondary traumatic stress, the consequent emotions resulting from the knowledge of a traumatizing event and the desire to help the person experiencing it may arise and can be based on a person’s life experience (Dill, 2007). For instance, if a client has been sexually violated, the knowledge of the experience could trigger the counselor’s past traumas and the desire to alleviate the client’s pain (Dill, 2007). In their model of psychodynamic life narrative in crisis supervision, Slonim and Hodges (2000) relate current emotional reactions of the counseling professional to the context of her/his life history that may elicit the rescuing response for her/his client.

Neumann and Gamble (1995) recommended counteracting the ambivalence counseling professionals feel about sharing their feelings by intently promoting a supportive, accepting and non-judgmental work culture. This can be achieved in a variety of ways, including clinical supervision or consultation, case conferences, peer process groups, personal psychotherapy, trauma therapy training, professional development and organizational team meetings (Neumann & Gamble, 1995). Pearlman and Saakvitne (1995) recommended utilizing outside consultants to provide objectivity when
organizational dynamics are an issue. Four aspects necessary for successful supervision include (Pearlman & Saakvitne, 1995):

1. A strong theoretical grounding in trauma therapy.
2. Attention to both conscious and unconscious aspects of treatment.
3. A mutually respectful interpersonal environment.
4. An educational component that directly addresses VT.

Both seasoned professionals and student trainees alike reported that a formalized procedure for reviewing the experience is helpful in post-crisis recovery (Kleespies, Penk, & Forsyth, 1993).

Culver, McKinney and Paradise (2011) in a mixed methods study design examined mental health workers serving victims of Hurricane Katrina. A solicitation email was sent to 33 agency directors in the region requesting participation from their clinicians. Thirty directors agreed to participate. It was estimated each director supervised between two and 10 counseling professionals yielding a region-wide population of 200 participants (Culver et al., 2011). The first portion of the study utilized the Vicarious Traumatization Questionnaire (VTQ) developed from content-based conceptual literature review on VT (Culver et al., 2011). Clinicians included counseling professionals, social workers, and individuals from a variety of other disciplines. Culver et al. (2011) reported that clients who experienced the hurricane and were also exposed to additional traumatic events including domestic violence, sexual abuse, loss and physical assault required more agency resources and time. Descriptive statistics were obtained using Pearson’s r to examine relationships between key variables. From the sample, 96% reported working with 1 to 20 trauma victims weekly. The most
common types of trauma were domestic violence, childhood sexual abuse, physical assault, and natural disaster. The counseling professionals who worked with trauma victims reported negative psychological symptoms, including anxiety (n=19; 73%), suspiciousness (n=16; 62%), and increased vulnerability (n=12; 46%). Furthermore, participants reported (sense of safety (n=17; 71%) and frame of reference (n=12; 50%) were disrupted working with trauma victims. Esteem was least disrupted (n=2; 8%). A significant association between participants working with trauma victims and perceptions of self (r=.436, p< .05 that was significantly correlated with experiencing negative psychological effects (r=.671, p< .01). The VTQ revealed VT was a common problem for counseling professionals (Culver et al., 2011). In the second part of the study five agency directors were interviewed concerning the effects on personal and professional functioning of mental health providers. The themes that developed confirmed prior findings and led to more in-depth analysis including: (a) trauma is a common problem reported by clients in mental health agencies, (b) there are various types of trauma presented by clients, (c) trauma victims are the most challenging clients, (d) experience and training of clinicians are factors in treatment effectiveness, (e) coping and support for mental health providers are necessary to treat trauma victims, (f) time, resources, and funding of agencies are strained, and (g) clinicians perceptions of others and worldview are effected (Culver et al., 2011).

In a study measuring therapists’ psychological well-being and exposure to trauma Pearlman and Mac Ian (1995) found those who had personal exposure to trauma reported higher vicarious traumatization. Therapists in this study with a trauma history expressed higher negative effects including disrupted cognitive schemas about themselves and their
clients (Pearlman & Mac Ian, 1995). Similarly, Dunkley and Whelan (2006b) conducted a study examining VT and the influence of coping style, supervision, and personal trauma history experienced by 62 telephone counseling professionals. Participants reported at least one PTSD symptom and having a history of trauma was positively correlated (Dunkley & Whelan, 2006b). Furthermore, Dunkley and Whelan (2006b) found lower levels of disruption of beliefs associated with having a strong supervision alliance. Coping was related to dealing with the problem of VT and non-productive coping or ignoring the problem was related to disruptions in cognitive beliefs (Dunkley & Whelan, 2006b). Jenkins, Mitchell, Baird, Whitfield, and Meyer (2011) in a study that examined content analysis of 101 sexual assault and domestic violence, counselor’s recollections working with trauma victims reported personal changes, secondary trauma, vicarious trauma and burnout. Using seven measures including open-ended questions and the Traumatic Symptom Inventory (TSI) Belief Scale, the researchers found counseling professionals motivated by interpersonal trauma reported both more symptoms of VT as well as positive changes including dealing with their own trauma (Jenkins et al., 2011). The counseling professionals’ successful confrontation of their own trauma resulted in increased resilience and altruism towards their clients (Jenkins et al., 2011). Those counseling professionals reporting negative changes were motivated by a higher purpose and personal meaning. Jenkins et al. (2011) contended that individuals with highly optimistic expectations may become easily disillusioned with trauma work. Results are inconsistent concerning the experience of VT being reliably higher or detrimental to the therapeutic relationship concerning counseling professionals with past histories of trauma.
In a qualitative study examining working with perpetrators and survivors of domestic violence (DV) 18 counseling professionals (13 female and 5 male) were interviewed with the main criterion being that they worked therapeutically with high caseloads (Iliffe & Steed, 2000). Based on VT, burnout, and countertransference literature, the purpose of the study was to explore the impact on counseling professionals working with DV. The counseling professionals participated in semi-structured interviews with questions encouraging an open dialogue in order to gain rich descriptive data of the lived experiences of trauma of counseling professionals. The analysis to describe the data was termed interpretative phenomenological analysis (Smith, Harré, & Langenhove 1995). Themes were grouped into categories which included: (a) initial impact of DV counseling, personal impact of hearing traumatic material, (b) changes to cognitive schemas, (c) challenging aspects to DV counseling, and (d) burnout, and coping strategies (Iliffe & Steed, 2000). In regards to the initial impact of DV counseling, most participants reported a loss of confidence recognizing the need for more specialized training. All reported taking on more responsibility when they first started working with DV clients and difficulty remaining neutral with male perpetrators as well as the recognition and loss of respect for clients that may return to the DV relationship. Most notable findings were changes to cognitive schemas with more than half the female and male participants reporting feeling less secure in the world as a result of DV counseling. Some of these concerns were related to being threatened by male perpetrators although most participants reported changes in their worldview. For example, participants reported being more acutely aware of power and control issues in their environment.
Some believed they were more realistic while others felt their perceptions of males became more distorted (Iliffe & Steed, 2000).

Likewise, McLean et al. (2003) in a quantitative study of 116 counseling professionals primarily working with trauma victims including 85 females (73%) and 31 males (27%) found their beliefs about their work and their clients impacted their psychological adjustment. Utilizing the Traumatic Stress Institute (TSI) Revision M belief scale measuring postulated outcomes of VT including disruptions in cognitive schemas related to the need for safety, trust, control, esteem and intimacy, findings revealed unhelpful beliefs about therapy and their clients contributed to both VT and burnout. Last, in addition to beliefs, recent significant stress, higher clinical caseload and less clinical experience may all lead to negative consequences such as VT, burnout, and emotional exhaustion (McLean et al., 2003). Correspondingly, in a mixed methods study examining the effects of working with sexual violence survivors among women psychologists, 525 questionnaires were sent out and 220 were returned for a 42% response rate (Schauben & Frazier, 1995). Quantitative measures revealed practitioners who had a higher percentage of survivors in their caseload experienced more VT (Schauben & Frazier, 1995). The qualitative section of the study examined both difficult and enjoyable aspects of working with survivors. Four out of seven categories of challenging aspects of working with survivors were discovered and mentioned by 50% of the sample. The most common negative aspects of working with survivors included concerns regarding therapy management, maintaining boundaries and setting limits, client’s terminating prematurely, difficulty establishing trust, and the lengthy process (Schauben & Frazier, 1995). Baird and Jenkins (2003) investigated occupational hazards
of therapy with trauma victims looking at secondary traumatic stress or compassion fatigue, and burnout with 101 trauma sexual assault and domestic violence counseling professionals. The study concluded that more experienced and educated counseling professionals had fewer symptoms of VT and emotional exhaustion than their younger counterparts (Baird & Jenkins, 2003). Bloom (2003) suggested that being a more experienced counseling professional may not always lessen VT, particularly when experience is linked to carrying a heavier caseload of trauma victims and healthy boundaries have been ignored (Bloom, 2003). Significant findings suggest the need for more training, treatment and agency support systems for counseling professionals working with trauma victims (Baird & Jenkins, 2003). Although research focuses on the impact of trauma on novice counseling professionals experienced counseling professionals, may not be immune to VT.

Dunkley and Whelan (2006a) argued that research is deficient in the study of VT although VT has long been recognized in the profession. There is an increased awareness of trauma affecting counseling professionals and the need for self-care; however, there are few measurements of the effectiveness of self-care to alleviate counselor stress (Bober, Regher, & Zhou, 2006). The Coping Strategies Inventory (CSI) was utilized to measure self-care in trauma counseling professionals from various disciplines including social work. Bober et al. (2006) found that self-care and organizational support were correlated to effective coping strategies. Dunkley and Whelan (2006a) reasoned that developing coping strategies for counseling professionals and improving the quality of supervision is recommended for future research. The empathic engagement that is necessary for trauma work may serve as a double edged sword leaving the therapist
deplete of the emotional engagement that is necessary for the therapeutic relationship to develop and for healing to begin (Sexton, 1999). The confidentiality necessary in the work of counseling professionals (ACA, 2014) may cause them to isolate their emotional reactions because they cannot share personal client material with others outside the profession (Skovholt, 2001). Warren, Morgan, Morris, and Morris (2010) asserted that compartmentalizing feelings results in an emotional blindness to the self. It may be necessary for counseling professionals to recognize the effect their clients are having on their emotional well-being in order to counter the detrimental effects of VT.

Pearlman and Saakvitne (1995) asserted that acknowledging that VT is real and an accepted normal response to hearing their client’s traumatic experiences is the first step in counteracting its effects. Warren et al. (2010) recommended self-care practices, such as creative writing, to reach a cathartic release of these sometimes damaging emotions. Others have suggested self-awareness and mindfulness (Greason & Cashwell, 2009; Lum, 2002; Rothaupt & Morgan, 2007). Bober & Regeher (2005) found beliefs about the effectiveness of coping strategies including dedicated leisure time, self-care and supervision did not correlate to time devoted to these activities. Even fewer qualitative studies have looked in depth as to how counseling professionals are fortified in their work. In a qualitative study including six peer nominated master therapists Harrison and Westwood (2009, p. 203) asked, “How do you manage and sustain your personal and professional well-being, given the challenges of your work with seriously traumatized clients?” Harrison and Westwood (p. 207) found nine major salient themes including:

1. Countering isolation (in professional, personal and spiritual realms)
2. Developing mindful self-awareness
3. Consciously expanding perspective to embrace complexity
4. Active optimism
5. Holistic self-care
6. Maintaining clear boundaries
7. Exquisite empathy
8. Professional satisfaction
9. Creating meaning of a counseling professionals work

Myers and Sweeney (2008) summarized the wellness paradigm as including physical, intellectual, emotional, spiritual, and relational wellness. Venart, Vassos, and Pitcher-Heft (2007) affirmed that lack of self-awareness can lead to habitually participating in escapist activities such as mindlessly watching television, surfing the internet, and engaging in negative behaviors including drinking and gambling. McCann and Pearlman (1990) noted that counseling professionals might have a need to verbalize feelings and at the same time also want to shield others from the trauma they hold. In a qualitative study measuring coping strategies among nurses that assist rape victims, all had developed ways to cope after hard cases regardless of whether they experienced VT or burnout (Maier, 2011). Maier (2011) described coping mechanisms to be talking or reaching out to family members, colleagues, coordinators or rape victim advocates and detectives, contributing in meetings where the focus is on problems after difficult cases, and discovering relaxing activities. In short, counseling professionals may find it necessary in working with trauma victims to develop coping strategies.

VT unrecognized may increase boundary violations and the inability to maintain the therapeutic relationship (Neumann & Gamble, 1995; Pearlman & Saakvitne, 1995).
Danieli (1988) working with holocaust survivors found recurrent themes for therapists such as guilt, rage, dread and horror, grief and mourning, shame, inability to contain intense emotions, and using defenses such as numbing, avoidance and denial. Although countertransference may be seen as a necessary element in all therapies, the strong emotional reactions developed in the therapeutic relationship may also serve to sever the therapeutic stance (Wilson & Lindy, 1994). According to Dill (2007), emotional fatigue can occur by providing emotional safeguarding to those at risk as well as to supervisees that can lead to a disintegration of one’s own emotional coping capacity over time.

Sexton (1999) affirmed the empathic engagement with the trauma survivor may be a key ingredient for effective therapy; however, it also leaves the therapist at risk for VT. Those suffering VT may also have eroded empathic abilities resulting in incomplete therapy, and eventually in high staff turnover (Sexton, 1999). Individuals in the helping professions are at risk of compassion fatigue as a result of the pervasive need to be present and empathic to clients (Dill, 2007). The erosion of empathic skills can also leave professionals at risk for minimizing client risk or denying underlying feelings (Figley, 2002). This is a major concern for any professional who might work in crisis-based situations. McLean et al. (2003) asserted that it is likely that VT may have commonalities in a range of disorders. More research is needed to identify specific variables. In addition, VT anecdotally has been reported to be more impactful when working with children (Beaton & Murphy, 1995; Dyregrov & Mitchell, 1992).

Studies looking at factors that influence VT, including lived experiences, personal trauma history and coping style are scant (Dunkley & Whelan, 2006a). The costs of the emphasis on alleviating the pain for the victims of trauma have resulted in newer
literature focusing on the care of the counseling professional (Bober & Regehr, 2005). Beaton and Murphy (1995) and Dyregrov and Mitchell (1992) have stressed more research is needed in relationship to children and the experience of VT. Future investigation should also look at factors increasing a counseling professional’s resilience (Dunkley & Whelan, 2006a).

Posttraumatic Growth

Cohen (2009) recently affirmed that the social-cognitive-biomedical positive psychology movement has led to a new iteration termed posttraumatic growth. Posttraumatic growth is used to describe the positive aspects of those experiencing trauma (Cohen, 2009). With no specific explanatory models, the moderating effects of support for counseling professionals leading to vicarious posttraumatic growth is a relatively new research paradigm (Brockhouse et al., 2011). However, posttraumatic growth studies and/or the concept of resilience can be traced back to Anna Freud (Cohen, 2009). In terms of posttraumatic growth, it may also be important to mention landmark findings for client resilience because by witnessing client growth counseling professionals have also reported their own personal growth.

Studies examining client resilience were illuminated by Werner (1982), who studied a cohort of 700 children from Kauai, Hawaii from birth to age 32. Werner found about 10 percent of those experiencing adverse childhood events were resilient adults who were better able to cope with adversity with a sense of optimism, confidence, self-efficacy, and an internal locus of control. The Werner (1982) study illuminated the need for more studies focusing on resilience of individuals in the face of difficult life circumstances. The focus in the past tended to be on dysfunctional often termed
pathological outcomes for clients. Cohen (2009) described trauma as a risky opportunity for growth that may affirm values, growth, social engagement, and purpose for the traumatized individual. Furthermore, trauma can coexist with reflective capabilities, insight, empathy, and a tolerance for ambiguity (Cohen, 2009). Rotter’s (1966) theory that individuals believe that their well-being or even survival can be controlled by actions that they control versus external locus of control enforced by others, fate or luck may lead to a more optimistic appraisal than expected for a difficult circumstances. Although we cannot predict how individuals will react to trauma and make assumptions concerning whole cultural groups, some groups who have experienced trauma on a large scale have demonstrated amazing resilience of the human spirit.

Based on the strength perspective, counseling professionals working with battered women and family violence participated in a qualitative study of work induced secondary trauma (Bell, 2003). Utilizing grounded theory, the strength perspective emphasized strategies and counselor resources that prevented secondary work trauma. The following inner counseling professional resources were revealed: (a) a sense of competence about their coping, (b) obtaining objective motivation for their work, (c) resolving their own personal traumas, (d) drawing on earlier models of coping, and (e) having safeguarding emotional beliefs lessened symptoms of secondary trauma or PTSD, compassion fatigue and VT (Bell, 2003). Furthermore, only 10 percent of the counseling professionals interviewed felt that their work had an adverse impact on them making them more negative towards others (Bell, 2003). In a mixed methods study the qualitative portion of the study looked at the effects of VT on sexual abuse counseling professionals and psychotherapists. Almost 45% reported: (a) watching clients grow and change was the
most enjoyable aspect of their work, (b) they liked being part of the healing process, (c) witnessing client resilience and their own growth and change, (d) the importance of the work, and (e) being appreciated by clients and being the change in the world (Schauben & Frazier, 1995). In sum, it is equally important to look at how counseling professionals are sustained in their work versus adversely affected.

Recently, Brockhouse et al. (2011) examined the mitigating factors of counselor coherence, organizational support, empathy and their impact on alleviating vicarious exposure to trauma. Brockhouse et al. (2011) found that compared to other factors, a therapist’s empathy with her/his client was the strongest predictor of growth. A sense of coherence in the Brockhouse et al. (2011) study negatively affected vicarious posttraumatic growth, and organizational support only predicted moderate growth. When faced with trauma and incomprehensible situations, being coherent caused a counselor to question her/his own sense of meaning. If organizational support is out of one’s control, according to Lazarus (1985) the appraisal of stress may be less optimistic. However, consistent with his findings that having an internal locus of control, such as “my ability to offer empathy to my client” may lead to positive outcomes for the counseling professional and lessen VT (Lazarus, 1985).

**Empathy**

According to Rogers (1951) empathy is the art of understanding, reflected in perspective taking, standing in another’s shoes, openness, tolerance, uncritical judgment, and unconditional positive regard. Furthermore, empathy entails the belief that clients have the resources within to self-direct their behavior and by creating an open and caring environment clients will change and grow constructively towards *self-actualization*
(Rogers, 1951). Jordan (1989) described empathy as a complicated affective and cognitive experience whereby the therapist joins with the client and in that moment pulls the client out of isolation by understanding her/his experience. Marotta (2003) described the use of *unflinching empathy* to treat refugee survivors of torture particularly when dealing with multicultural oppression and fear concerning treatment. Banks (2006) acknowledged that the psychodynamic framework in some therapies maintains that neutrality and objectivity from the counseling professional is essential. For those experiencing childhood abuse this stance can retraumatize the client versus alleviating the pain (Banks, 2006). Many counseling professionals have been warned not to get too intimately involved with the client and/or her/his issues because the counseling professional may also lose grounding in the case of VT. Yet, there seems to be enough evidence that empathy may be a key component for treating the individual suffering from trauma; however, too much empathy in the case of *compassion fatigue* could lead to VT. According to Banks (2006) empathy is necessary in Relational Cultural Therapy (RCT) to increase *growth fostering relationships*, decreasing isolation, and restoring the individual. Creating a new non-violating relationship built on mutual respect, vulnerability, honesty, and empathy without a power differential leads to healing (Banks, 2006, Jordan, 2001). Finally, a counseling professional’s belief in her/his client’s growth, use of empathy and theoretical orientation may play a role in the development of the new iteration of posttraumatic growth.

**Cultural Implications**

Lustig and Koester (1999) asserts culture and communication can be understood in terms of a continuum between Hall’s high and low- context cultures. Whereas, high-
context cultures communicate more intuitively recognizing implied meanings based on internalized beliefs and rely less on explicit messages, low-context cultures including western cultures depend more on overt communication. According to Lustig and Koester (1999) examples of high-context cultures include Japanese, African-American, Mexican and Latino; high-context comprise German, Swedish, European, American and English. Although it is difficult to make assumptions concerning cultural patterns of communication, intercultural competence can be increased by understanding where one as an individual falls along the continuum (Lustig & Koester, 1999).

According to Stebnicki (2007) traditional Native Americans believe that each time one heals someone she/he gives away a piece of oneself. Furthermore, that by giving something away an individual will need to remedy this by performing required healing (Stebnicki, 2007). Lizardi and Gearing (2010) add that Native Americans as a group believe that death is part of the cycle of life. Furthermore, Native Americans may avoid the focus on death and place more emphasis on the present life (Lizardi & Gearing, 2010). Therefore, if a counseling professional were working with a Native American client these inherent beliefs may not be expressed explicitly as in High-context cultural affiliation yet, these implicit meanings may ultimately impact the communication between the client and counseling professional. An additional consideration is power distance may be greater in High-context cultures and the actions of authorities would not be questioned or challenged (Lustig & Koester, 1999). By not explicitly communicating on the part of the client, the counseling professional may assume a client with High-context cultural affiliation is erroneously uninvolved versus the implied silence or respect for authority the client is attempting to relay. Tensions may also exist between parents/
caregivers when youth are struggling with integrating developmental strivings for identity that are reinforced in the individualistic mainstream American culture versus a High-context collective culture valuing family involvement (Cauce & Domenech-Rodriquez, 2002; Lustig & Koester, 1999). It is important to recognize the role of family a value termed familism in Latino cultures, may also protect youth’s emotional and behavioral health (Kuhlberg, Peña, & Zayas, 2010). Kuhlberg et al. (2010) contend that family involvement is important for addressing culturally competent suicide prevention. In sum, many factors including cultural communication may impact suicide risk assessments for youth.

**Summary**

Conclusions from the literature reveal the following observations. Suicide risk assessments, supervision, and the impact on counseling professionals including client suicide can be complex and profound. In addition, themes and correlational studies concerning the experience of VT and posttraumatic growth provide a glimpse into experiences of counseling professionals working with traumatic material. Suicide risk assessments may be one of the most challenging aspects of counseling because they include many considerations necessary to make a decision that can immediately affect a client’s safety and well-being. With a lack of standardized assessments, suicide risk assessment poses complex questions and may be more difficult to assess in children due to developmental considerations. Supervision is essential not only to assess client safety but also to address the impact of a suicide risk assessment particularly with new or inexperienced counseling professionals. Even though the literature focuses more on issues with inexperienced counseling professionals, experienced counseling professionals
also require supervision when dealing with suicidal clients. Ultimately, the experience of conducting suicide risk assessments, and in some cases client suicide can be devastating to a counseling professional. Structured support is necessary for dealing with ongoing concerns of conducting suicide risk assessments and the impact on the counseling professional.

Research concerning suicide risk assessments for youth and the experience of VT and posttraumatic growth are remiss in the literature. Quantitative measures of VT occur mainly in sexual violence and domestic violence literature yet findings remain inconsistent. Qualitative inquiry is also limited to counseling in contexts such as sexual and domestic violence. A counseling professional’s years of experience may affect her/his beliefs/perceptions and counselor trainees may struggle more with VT. Studies were inconsistent concerning a counseling professional’s past trauma history affecting her/his ability to cope and provide for effective client care when facing trauma. Not surprisingly, those with higher caseloads of trauma victims may experience VT at a higher incidence. Counseling professional’s beliefs about her/his clients and the effectiveness of therapy may impact the experience of VT. A counseling professional’s ability to self-regulate and engage in self-care may be helpful in preventing VT; however, measurements or ways to describe self-care are deficient. VT is real and should be acknowledged widely because a counseling professional’s worldview may become affected. Supervision not only addresses the immediate needs of the client but is also necessary to meaningfully combat VT for the counseling professional. Research involving posttraumatic growth as a new iteration may help to provide ideas for counselor effectiveness when working with crisis and trauma. Specifically, empathy and
recognizing internal locus of control may serve to shield the counseling professional against VT. Cultural beliefs may impact how suicide is perceived among differing groups and effect communication between clients and counseling professionals. In summary, in order for the counseling profession to develop and routinely respond to suicide, supervision, training, education, and understanding of support/self-care are pivotal.
Chapter 3: Methodology

This chapter outlines the methodology utilized in this study. The study design, procedure and setting are outlined. The counseling professional’s demographic information is provided in addition to the suicide risk assessment procedures. The data collection and analysis conclude the chapter.

Qualitative Research

Qualitative research, according to Gay, Mills, and Airasian (2009), seeks to understand the way things are and why, in relationship to how the participants understand, contextualize, or perceive them to exist. Qualitative research begins with an assumption, worldview, perhaps a theoretical lens, and a research problem searching for the particular meaning that the individual or group ascribe to a phenomenon (Creswell, 2013). Qualitative research utilizes the collection of data sensitive to the people under study in their natural setting and data that induces the participant’s voice to establish themes (Creswell, 2013). Creswell (2013) added that the minutia of qualitative inquiry is the framework one chooses to view a particular phenomenon. Akin to using similar language or having a similar worldview in qualitative inquiry, the researcher then chooses to use her/his own accent. For the purposes of this study, a phenomenological methodological approach described by Hays and Singh (2012) to emphasize the participants’ lived experiences as it is revealed through consciousness or discovering and describing meaning is applied. According to Wertz (2005), phenomenology is fundamentally scientific including the incorporation of a methodology that is systematic, critical, general and potentially intersubjective that requires critical thinking, creativity, and reflective decision-making. According to Creswell, (2013, p. 44-47) common
qualities are present in qualitative research including: (a) recognizing the importance of the human experience, (b) focusing on wholeness rather than object, (c) searching for meanings rather than measurement, (d) obtaining first person descriptions through conversations or interviews, (e) emphasizing the data of experience as the most important to understanding, (f) forming problems or research questions representing the personal commitment of the researcher, and (g) viewing the experience as integrative. Creswell, (2013) explained that it may be a challenge to put aside all assumptions when entering into phenomenological research due to the process of research. For example, dissertation research entails conducting a literature review prior to the study. Further, that careful selection of the research participants is necessary to describe the phenomena (Creswell, 2013). Also, Creswell (2013) described different types of phenomenology such as, hermeneutical phenomenology with the interpretation of lived experiences of individuals in texts versus transcendental psychological phenomenology with more emphasis on the actual lived experiences. Grbich (2013) emphasized phenomenology is utilized when little is known about the phenomena, and when there is little in-depth data concerning the lived experiences. For instance, domestic violence, high-risk activities, near death experiences are all topics to consider for phenomenology (Grbich, 2013).

Phenomenology

According to Moustakas (1994), in phenomenological research, the concept of intentionality, noema and noesis distinguishes the methodology from other forms of qualitative inquiry. First, intentionality directs consciousness toward something real, imaginary or nonexistent. Specifically, the noema in its simplest terms ascribes meaning to what one sees, touches, thinks, or feels. Moustakas (1994) asserts the noesis describes
how one would assign meaning to *noema* through the recollection of memories. Grbich (2013) explained phenomenology involves in depth exploring of experiences or texts to clarify the essence or meaning of the individual.

It is important to include a brief history of phenomenology as it is related to the development of this study. As a concept, Kant introduced phenomenology in the mid 1700’s although Edmund Husserl (1859-1938) was credited as the founder through his work seeking to understand post World War I and the social crisis that followed (Creswell, 2013; Hays & Singh, 2012). Phenomenology has a strong philosophical component beyond procedures and Heidegger, Sartre, and Merleau-Ponty can be credited for expanding phenomenology and creating contrasting points of view (Creswell, 2013). Most, however would agree that phenomenology values the connection between self and world and the subjective meaning of the participants (Hays & Singh, 2012). Creswell (2013, p. 77-78) emphasized four philosophical perspectives in phenomenology. These include:

1. A change from positivism or “scientism” and a return to the Greek search for wisdom.
2. The usage of “epoche” or the suspension of judgment termed by Husserl.
3. Reality is based on how one views an object or the *intentionality of consciousness* designated by Husserl as the dual Cartesian or mind body nature of both subjects and objects interconnected.
4. The Cartesian nature also contains the reality of an object as it is only perceived within the meaning of the individual.
The relationship between persons and situations in phenomenology provides knowledge of psychological “essences” or meaning given an individual’s imaginative variation (Wertz, 2005). These essences are woven together from the group to form composite descriptions of the shared meaning of the individuals experiencing the phenomena (Creswell, 2013). As phenomenology develops in the field of psychology, Wertz (2005) explained its utilization represents a protest against dehumanization in mental health. Phenomenology rather places emphasis on the first person experience, freedom, and the client-therapist relationship. In Europe, phenomenology can be credited to many including Viktor Frankl and his extraordinary work *Man’s Search for Meaning* (1946) describing his experience in Nazi death camps. While experiencing the most dehumanizing conditions, Frankl (1946) provided an illustration of how while retaining a rich spiritual connection and hope for the future one can find meaning in the very act of being alive. Some noteworthy practitioners that contributed to phenomenology coming to fruition in the U.S. around the 1930’s includes Adrian Van Kaam, Kurt Kaffka, Erwin Straus, and Irving Yalom (Wertz, 2005). Irving Yalom (1983) specifically emphasized the power of the group process in counseling and the focus of the here and now or more concretely the individual experience in the group. The philosophical nature of understanding individual’s common experience of a phenomenon is aligned with the counseling paradigm (Hays & Wood, 2011). Hays and Wood (2011) asserted phenomenology has a strong congruence with counseling because accessing the client’s experience is a natural part of the counseling relationship. Furthermore, with a strong philosophical foundation it is ideal for understanding how individuals view a common experience (Hays & Wood, 2011). For the purposes of this study Moustakas (1994)
transcendental or psychological phenomenology was employed because it emphasizes the lived experiences of the participants rather than that of the researcher.

According to Hays and Wood (2011) qualitative research is dominated by four paradigms: social constructivism, critical theory, feminism, and queer theory. The paradigm or lens for the purposes of this study is social constructivism. Gergen (2011) affirmed that the understanding of the world is a social process drawing on earlier theorists and philosophers from the constructivist movement such as Vygotsky, Spinoza, Kant, and Nietzsche where knowledge depends on processes. In contrast, logical empiricists such as Locke, Hume, Mills and various others view the world more succinctly where knowledge is a linear mental representation of the world (Gergen, 2011). Phenomenology paradigmatic assumptions are primarily constructivist reflecting multiple participant perspective realities that are contextually relevant (Hays & Wood, 2011).

**Research Design**

In this study, the counseling professionals’ experience of conducting suicide risk assessments for youth was explored utilizing a phenomenological approach, seeking the understanding of the lived experiences of counseling professionals conducting suicide risk assessments for youth. Creswell (2013) defined a phenomenological study as one that “describes the meaning for several individuals of their lived experiences of a concept or phenomenon” (p. 76). A composite of these shared experiences was developed to eventually describe the phenomena (Creswell, 2013). To describe the process of gathering phenomenological data Padgett (2004) used the term *burrowing inward* to understand the depth of the participants’ lived experiences. The researcher applied
bracketing, the approach chosen to suspend all judgment from the term *epoche* attributed to the Greeks. By suspending judgment, the data is permitted to emerge in relationship to the phenomena without researcher interference (Creswell, 2013; Hays & Singh, 2012). Initially, the researcher immerses herself/himself in the data, also *bracketing* herself/himself from any assumptions or researcher bias about the study. By immersing oneself in the data and at the same time reserving judgment, the researcher remains fluid and open to the participants’ reality (Hays & Singh, 2012). In addition, the researcher’s paradigm or lens is constructivism that follows the belief, as Guba and Lincoln (1988) asserted, that the research should be emergent, context dependent and utilize an inductive analysis. Textural descriptions include verbatim examples and the perceiver is the final judge of the validity of the phenomena by assessing the object from differing angles and by eliminating prior judgments in a free and open process (Moustakas, 1994). Constant-comparison asserted by Lincoln and Guba (1985) was utilized to develop the textural descriptions. Finally, through the use of *imaginative variation* or intuitive differentiation of the infinite multiplicities of actual possible interpretations the essence of the experience is created to eventually form the structural descriptions (Husserl & Gibson, 1931). Adapted from Moustakas (1994) Figure 2 represents a description of the process of phenomenological research.
Figure 2. The Process of Phenomenological Research

<table>
<thead>
<tr>
<th>Epoche</th>
<th>Horizontalization</th>
<th>Textural</th>
<th>Structural</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tabla rasa</td>
<td>Listing every possible expression</td>
<td>Invariant meaning units</td>
<td>Definitions of deeper meanings</td>
</tr>
<tr>
<td>Burrowing inward</td>
<td>Eliminating expressions that do not contain the experience</td>
<td>Imaginative variation</td>
<td>Textural-Structural Descriptions</td>
</tr>
<tr>
<td>Bracketing</td>
<td></td>
<td>Construct for each participant</td>
<td>Composite of themes</td>
</tr>
<tr>
<td>Suspending judgment</td>
<td></td>
<td>Illustrative verbatim</td>
<td></td>
</tr>
<tr>
<td>Noema-Noesis</td>
<td></td>
<td>examples</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Developing tensions</td>
<td></td>
</tr>
</tbody>
</table>

**Procedure**

**Setting.** Included in the mission for Vistas is the belief that people are inherently resilient and capable of change. In addition to this person-centered approach, a family systemic philosophy of treatment is achieved by treating not only youth but in many cases their parents and caregivers. To address the mental health needs of the district and other parts of the state, Vistas was founded over 10 years ago. The adjoining institute started at the same time to promote professional practices throughout the community and training for counseling professionals in the following areas: parenting, communication, bullying, leadership, trauma, and life skills. In addition, a co-director and staff coordinate training and direct an internship program that provides pro-bono suicide risk assessments and on-going therapy for youth and their parents during the school year. Vistas services include office, home-based and school based services. Vistas is a for-profit agency yet, the majority of youth and their families are considered low-income by the state and
covered under Medicaid insurance. Some private insurances are also accepted although utilized much less frequently for services.

Vistas is the main contracted agency to provide same-day suicide risk assessments for youth through an established school district. If the client is not planning to end her/his life at that immediate juncture other agencies and mental health facilities that conduct suicide risk assessments for youth may or may not be able to provide follow-up treatment or even rate a client with high suicidal risk. Both contracted counseling professionals and interns provide same day suicide risk assessment for youth and their families. Interns provide pro-bono services for suicide risk assessments and therapy during the school year for those clients who are uninsured and/or unable to pay. School-based services include providing on-going therapy for those students referred to Vistas by their school counselor in most cases and many that continue to receive services after a suicide risk assessment. Clients may receive continuing services at a participating school site with a contracted Vistas counselor assigned to that school or at an office-based location.

Vistas maintains a high caliber of educated and licensed staff. Furthermore, Vistas provides routine supervision and training for staff. Coming from many diverse backgrounds and theoretical orientations counseling professionals and staff are chosen to meet the best needs of the clients they serve. Self-care is also encouraged and included in the mission statement as important for counseling professionals to maintain. Counseling professionals are provided immediate supervision during a suicide risk assessment primarily to determine the level of suicide risk. Counseling professionals are offered no cost routine supervision depending on their caseload that is weekly in most
circumstances, and trainings are also provided at no or low cost. Some training pertinent to a counseling professional’s treatment and care may also be reimbursable. This study took place at Vistas where suicide risk assessments for youth are conducted.

**Participants.** In phenomenological research, Polkinghorne (1989) recommends approximately 5 to 25 participants who have all experienced the phenomena in this case conducting suicide risk assessments (as cited in Valle & Halling, 1989). Furthermore, Wertz (2005) contends until the research goals are achieved the researcher may include additional participants until saturation or redundancy in findings is apparent. Approximately, twenty (20) counseling professionals were asked to participate in the study and fifteen ultimately met the criteria and agreed to participate.

The participants in this study were counseling professionals who have conducted suicide risk assessment for youth K-12 at least three times during the past year when this study was conducted. The term “counseling professionals” in this study may include: Licensed Mental Health Counseling professionals (LMHC), Licensed Professional Counseling professionals (LPCC), Licensed Social Workers (MSW), and Marriage, Child and Family Therapists (LMFT). Interns provide a majority of the front-line suicide risk assessments for uninsured clients. Interns completing their master’s degree requirements from a variety of educational institutions while working towards licensure in counseling, social work, and marriage, child, and family therapy are also included and termed counseling professionals. The unit of analysis is the lived experiences of counseling professionals conducting suicide risk assessments and therefore, purposely sampled from those professionals providing this service.
The sample was chosen by setting clear criteria of counseling professionals who have been engaged in assessing suicide risk for youth during the past year. Given the frequency of assessment, one year was set to capture all levels of counseling professionals i.e. novice to expert in this sample. For example, novice counseling professionals may be actively engaged in suicide risk assessment while seasoned professional may be less active currently yet, still able to recollect their lived experiences. Purposeful sampling according to Gay et al. (2009) can also be referred to as judgment sampling, where the researcher uses her/his experience and knowledge of the population to select the sample and also believes the sample to be representative of the population under study. Furthermore, setting clear criteria for purposeful sampling is the main defense for this method (Gay et al., 2009). The sample was chosen from a wide variety of individuals from diverse backgrounds.

To determine how many counseling professionals may be actively accessing suicide risk for youth, the number of participants for interviews was determined by speaking with the suicide risk assessment coordinator. At any given time, a few counseling professionals may be regularly conducting assessments, some sporadically throughout the month and other seasoned professionals even less throughout the year. Adding to those counseling professionals who may choose to conduct suicide risk assessments, new counseling professionals and interns are typically hired at the beginning of the school year and during winter term break. Counseling professionals who participated in the individual interviews were contacted to return for a focus group to discuss the same questions asked during individual interviews.
The study utilized a purposeful sample of fifteen (15) participants that had conducted a suicide risk assessment for youth K-12th grade within the past year. The fifteen (15) participant’s experience was extrapolated through individual interviews and a focus group with seven (7) returning participants. A focus group was conducted to serve as a member checking instrument and triangulate the data. Triangulation of the data according to Gay et al. (2009) is the process of using multiple methods of data collection strategies to provide a broad picture of what is being studied as well as to crosscheck information.

Demographics.

Fifteen (15) counseling professionals agreed to participate (see Table 1). There were thirteen (13) women and two (2) men. Seven (7) participants identified as Caucasian/ White, Four (4) participants identified as Hispanic/ Latina/ Latino, two (2) as mixed Hispanic/ Latina and Caucasian/ White, one (1) as African American, and one (1) identified as Mexican American. The participant’s age ranged from 25-50+ and the average age was 34 years old. Nine (9) participants were between 25-30 years old, three (3) were between 31-40 years old, and three (3) participants were 50 years and older.

The participants reported working between 6 months to 6.5 years (M=2.88) conducting SA’s for youth. Counseling professionals performed approximately 5 to 280 (M=66) SA’s for youth in one year. In Table 1, all of the participants were given pseudonyms that were utilized in the discussion to protect their confidentiality.
Table 1. Participants’ Demographic and Professional Information

<table>
<thead>
<tr>
<th>Participant</th>
<th>Age</th>
<th>Gender</th>
<th>Race/ Ethnicity</th>
<th>Years/ mth. Suicide Assessment (SA)</th>
<th>Number of SA’s Past year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lisa #1</td>
<td>25-30</td>
<td>F</td>
<td>Caucasian/ White</td>
<td>3</td>
<td>40</td>
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<tr>
<td>Maria #2</td>
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<td>F</td>
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</tr>
<tr>
<td>Carlos #4</td>
<td></td>
<td>M</td>
<td>Hispanic/ Latino</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Clint #12</td>
<td></td>
<td>M</td>
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</tr>
<tr>
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<td>Mexican American</td>
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<td>87</td>
</tr>
<tr>
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<td>Caucasian/ White</td>
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<td>96</td>
</tr>
<tr>
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<td>87</td>
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<tr>
<td>Linda #8</td>
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<td>Caucasian/ White</td>
<td>.6</td>
<td>96</td>
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<tr>
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<tr>
<td>Jane #13</td>
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<td>F</td>
<td>Hispanic/ Latina</td>
<td>3</td>
<td>13</td>
</tr>
<tr>
<td>Nora #14</td>
<td></td>
<td>F</td>
<td>Caucasian/ White</td>
<td>6.5</td>
<td>36</td>
</tr>
<tr>
<td>Total</td>
<td></td>
<td></td>
<td></td>
<td>43.3</td>
<td>996</td>
</tr>
<tr>
<td>Average (M)</td>
<td></td>
<td></td>
<td></td>
<td>2.88</td>
<td>66</td>
</tr>
<tr>
<td>Bold=Focus Group Participant</td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>
Table 2 represents the participants level of practice, education, licensure and theoretical orientation. There were seven (7) participants with a Master’s in Counseling (MA), four (4) with a Master’s in Marriage and Family therapy (MFT), one (1) with a Master’s in Social Work (MSW), and three (3) with one or more Bachelor (BA) degrees. The remaining three (3) participants were interns with Bachelor degrees; two (2) were pursuing their Master’s in counseling and one (1) in social work. Two (2) Marriage and Family therapists were also pursuing their doctorates.

Level of practice was determined by a counseling professional’s years of experience conducting SA’s for youth and their role within the agency. Participant’s level of practice for the purposes of this study are labeled as Intern (I), New (N), Mid-level (M/b) beginner or (M/a) advanced, and Advanced (A/l) low or (A/h) high. There were three (3) Interns (I) performing SA’s. There were two (2) licensed counseling professionals with less than one year of experience conducting SA’s and were considered new (N). There were a total of seven (7) Mid-level counseling professionals that had five years or less experience; four (4) were Mid-level (M/a) advanced that conducted supervision of SA’s and three (3) (M/b) beginner that did not conduct supervision. There were three (3) Advanced counseling professionals that had over five years’ experience; two (2) conducted supervision (A/h) high and one (1) (A/l) low that did not conduct supervision.

There were fourteen (14) counseling professionals that identified with a particular theoretical orientation associated with their counseling practice and one (1) participant that did not identify. There were four (4) Humanistic, client-centered or Gestalt participants, four (4) Cognitive behavioral/ affective, brief or solution focused
participants, two (2) with a combination of CBT/ Humanistic, three (3) Marriage family and child/ family systems, and one (1) Psychodynamic participant.

Table 2. Participants’ Experience and Education

<table>
<thead>
<tr>
<th>Participant</th>
<th>Level of Practice</th>
<th>Education</th>
<th>Currently Pursuing</th>
<th>Licensure or/ Intern</th>
<th>Theoretical Orientation</th>
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<tr>
<td>1</td>
<td>M/a</td>
<td>MA MFT</td>
<td>PhD</td>
<td>LMFT</td>
<td>CBT/Solution focused/ Brief</td>
</tr>
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<tr>
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<td></td>
<td>LMFT</td>
<td>Family systems adolescents</td>
</tr>
<tr>
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<tr>
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<td>15</td>
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</tbody>
</table>

The Suicide Risk Assessment Procedure

Counseling professionals contracted through Vistas provide front-line same day suicide risk assessments during the school year. When a student verbalizes, tells another person or writes an intention to harm oneself or end one’s life, Vistas receives the call
from the school counselor, school nurse, principal or administrator for a required same day suicide risk assessment. A parent and or caregiver must also attend the session in one of the Vistas offices scheduled with a counseling professional within that same day. If a parent or caregiver is unwilling to escort the student to Vistas, social services may be notified. Next day assessments are considered crisis assessments and may also include school violence. Discussions between client and professionals at Vistas are confidential. Possible exceptions to releasing confidential information include but are not limited to the following situations: Imminent danger or threat to self or others, abuse or neglect of a child or vulnerable adult, legal matters which information is subpoenaed by law, and information requested by the insurance carrier responsible for providing mental health coverage and payment. Typically, the student and her/his parents and caregivers will meet for 45-90 minutes depending on the individual case and in some situations longer. Counseling professionals may meet with the individual, family or in most cases both parties separately and then together to determine the suicide risk. The counseling professional will also meet with her/his supervisors to review the case and determine the level of suicide risk during the assessment.

During the assessment a counseling professional will assess the reasons that led to the event, legal and custody concerns, protective factors, personal/family history, past suicidal behaviour, means, plan attempt, level of intent, risk taking behaviours/impulsivity, and the overall mental health of the client. The assessment ends with a low, medium, or high rating in combination with a safety plan and follow-up recommendations. In some cases, high ratings may be referred to immediate emergency mental health assessment at a psychiatric facility. Some assessments may include a
follow-up psychological evaluation, individual/family counseling, school counselor appointment, or medical evaluation depending on individual circumstances and the evaluation. Many clients and families elect follow-up counseling and have their choice of services including Vistas. A call to the school counselor and a next day follow-up with the client/caregiver is also conducted in many cases.

**Data collection**

The primary source of data collection for this study were in-depth semi-structured interviews. Wertz (2005) explained that when the phenomenon of interest is complex in structure, and the participants are unlikely to spontaneously offer responses, open-ended questions are recommended. Wertz (2005) emphasized that the most outstanding quality of phenomenological data is concreteness which is descriptions reflecting the lived experiences rather than any hypotheses, opinions, explanations, interpretations, inferences, or generalizations regarding the phenomena. This phenomenological, qualitative study explored the lived experiences of counseling professionals conducting suicide risk assessments (SA’s) for youth. Vistas maintains a confidential password protected email site only accessible to Vistas interns, contractors, and employees. A confidential email was sent to potential participants (Appendix D). After the interview date, the email communication was deleted. A flyer was posted at the worksite for voluntary participation (Appendix D). Participants were asked to contact the researcher directly by email/phone if interested in voluntary participation in a study. If the counseling professionals agreed to participate an interview was scheduled and their consent process was included at the beginning of the interview. Interviews occurred at Vistas in a scheduled private interview room with noise blockers placed outside of that
room to insure the confidentiality of the counseling professionals. If recording the
interview was not acceptable to any participant and yet she/he still wanted to participate
in the study, counseling professionals were given the option during consent to have notes
taken in place of recordings. All of the counseling professionals agreed to recorded
interviews. Each of the counseling professionals met individually with the researcher to
describe the study, answer any initial questions, and consent to participate in the study.
The fifteen questions asked during the individual interviews were semi-structured and
open-ended. Twelve questions were the basis of gathering data. The first three were used
as supplemental information for the demographics questionnaire and the remaining
formed the basis of the findings. To fully understand the phenomena of counseling
professionals conducting SA’s for youth the following interview questions were
presented during the individual interviews (Appendix A).

The interviewees were invited back to participate in a Focus group. The original
interview questions were asked in a group format encouraging discussion among
members. The focus group took one and a half hours and was recorded. For the focus
group, there is a potential risk that information shared in the focus group might be
disclosed by a member of that focus group to another audience. The possibility is out of
the researcher’s control. However, counseling professionals were encouraged to keep
whatever was shared within the group for purposes of the research study being
conducted. Audio recorded, semi-structured open-ended interviews were conducted to
examine the individual participants’ experience about conducting SA’s for youth.
Individual interviews lasted approximately thirty (30) to sixty (60) minutes in length.
The focus group lasted approximately ninety (90) minutes. After completion, the
audiotapes were professionally transcribed. Once transcribed, the researcher reviewed the transcription for accuracy. Audio-recorded interviews and the focus group were assigned numerical codes/pseudonyms and transcribed and deleted within one-month after the interviews took place. The transcription was maintained on a password-protected file and permanently deleted after an acceptable period determined by the Institutional Review Board (IRB). All efforts were made to remove any identifiable information from the resulting composite information. A link to counseling professionals was for the sole purpose of contacting participants to set up interviews and deleted at study closure. All efforts were made to remove any identifiable information from the composite information resulting from data analysis.

Figure 3. Data Process

**Researcher as Instrument.** The researcher was the primary instrument utilized to gather data. According to Creswell (2013), in qualitative research the researcher is the main instrument to collect data, examine documents, observe behavior and interview participants.
From September 2011 to May 2012 the researcher conducted suicide risk assessments for youth at Vistas on a weekly basis, working as an intern. During the spring of 2012, the researcher maintained a caseload of approximately five to ten clients a week and conducted a few suicide risk assessments monthly being on-call. Currently, the researcher maintains a caseload of less than five clients weekly focused on youth and their families. The researcher is employed as a regular independent contracted therapist for Vistas and does not participate in suicide risk assessments. The researcher attends regular supervision and occasionally participates in trainings by Vistas.

In summary, dominant themes from the literature review were the basis for the interview (Appendix A) and demographic questionnaire (Appendix B). Open-ended interview questions were utilized to gather data from the participants and minimize researcher bias. Furthermore, from a constructivist paradigm the data was emergent, and the focus was on the present.

**Data analysis.**

Utilizing Moustakas (1994) modification of van Kaam’s (1959, 1966) phenomenological data analysis the preliminary grouping of data was termed horizontalization. Horizontalization is a process of listing every possible expression relevant to the data and identification of nonrepetitive themes or nonoverlapping statements in the participant’s transcripts. Moustakas (1994) explained that expressions that do not contain the experience necessary for understanding the phenomenon or if it is impossible to abstract or label resulting themes they should be eliminated. Hays and Wood (2011) and Creswell (2013) explained *textural description* is formed by clustering the depth of the invariant meaning units for each participant as a way to describe what
happened in relationship to the phenomena. Moustakas (1994) describes the process of transcendental-phenomenological reduction: “each experience is considered in singularity, in and for itself” (p. 34). Initially, nineteen (20) meaning units were developed from the transcripts and collapsed into five (5) themes. Hays and Singh (2012) added verbatim examples should be provided resulting from the core themes, as well as a construct for each participant. *Imaginative variation* is applied to identify the invariant themes (Patton 2015). Patton (2015) relates analyzing invariant themes to moving around a statue and viewing it from differing angles. Axial coding, similar to grounded theory, is applied to seek the multiple meanings and tensions in the textual descriptions to eventually create a structural representation of the data (Hays & Singh, 2012).

For each individual interview, statements were divided into meaning units through horizontalization utilizing *in vivo* and open coding. Codes were merged into thematic categories and then were interrelated to the Focus group discussion to provide in-depth textual-structural descriptions. A *structural description* is created for the group to explain how the experience happened reflecting on the context or setting of where the phenomena occurred (Creswell, 2013). Patton (2015) illustrates that the structural description is the “bones” that depict the deeper meanings of what the group experienced. Moustakas, (1994) explained a visual model or list may be provided to represent the textual-structural descriptions. A composite representing the group was developed to describe the essence of the experiences and are outlined in the analysis and findings.
Trustworthiness and Creditability

According to Husserl and Gibson (1931) my existence and the other’s existence are intertwined and corepresented in intentional communication. Husserl explains there is access to every human being within the self. Qualitative research is described in terms of trustworthiness, authenticity and quality (Lincoln and Guba, 1985). According to Maxwell, (2013) there is no known ultimate “objective truth.” Constructivist rationale upholds there are no meaningful truths outside the constructions of individuals. It is the researcher’s sole task to determine if participant involvement has reached a level of understanding consistent with the research questions. Further, the research should entertain implausible or rival hypotheses (Maxwell, 2013). For example, if it were found that the counseling professionals in this study had no feeling, be it positive or negative, associated with conducting suicide risk assessments for youth disconfirming would be presented (Patton, 2015). To add to the authenticity and rigor of the study meeting with a fellow doctoral student who served as a critical friend to peer debrief was included to discuss rival hypotheses and introduce multiple meanings that may resonate with individuals outside the study (Creswell, 2013).

Another threat to trustworthiness and creditability according to Maxwell (2013) is researcher bias. By stating the researcher’s background and experiences in relationship to this phenomenon, the researcher seeks to eliminate this bias. Furthermore, by bracketing my own assumptions and allowing the data to emerge from the interviews themselves the researcher eliminated existing theories, goals and preconceptions according to Maxwell (2012) that neatly fit study expectations. The second problem according to Maxwell (2012) is reactivity from the participants that may shape how they
respond in an interview. In order to address this potential for bias, confidentiality was built into the study and was protected by every possible effort. However, as a colleague and doctoral student the researcher may not have been able to control how much the counseling professionals provided open and honest responses or were affected by the researcher’s presence. Wertz (2005) suggested an attitude of wonder that is highly empathic to counteract potential bias. As a licensed mental health counselor (LMHC) the researcher’s training concerning listening, engagement through genuine empathic understanding and interviewing skills may have enhanced the comfort level of the counseling professionals participating in this study rather than detracting from the research. Maxwell (2012) suggested several checks that can improve the trustworthiness, authenticity and quality of qualitative research. For the purposes of this study long-term involvement, rich data and searching for negative or disconfirming evidence, peer debriefing and triangulation of the data was included.
Chapter Four: Analysis

Introduction

This research sought to understand the phenomena or lived experiences of counseling professionals conducting suicide assessments (SA) for youth. This chapter outlines the significant themes that emerged from the individual interviews and the Focus group. The main findings are outlined in this chapter. The Counseling Professionals section provided an individual construct of each interviewed participant followed by a composite of themes. The next section summarized the findings of the Focus group. The reduction and the process known as Imaginative Variation contributes to a synthesis of all possible meanings forming the structural definitions and core themes (Husserl & Gibson, 1931). The final section provided a structural portrait of the individual interviews and the Focus group. Hays and Singh (2012) describe the process as a metaphorical “sieve.”

Figure 4. Core Theme Development

![Core Theme Development Diagram](image-url)
The Counseling Professionals

Participant 1: Lisa

“I think that there’s an opportunity to instill hope in people because they’re at a level of crisis.”

-Lisa

After being involved in crisis work for several years Lisa has been conducting suicide assessments (SA’s) for youth for a few years and has recently begun supervision as a Mid-level (M/a) advanced practitioner for Vistas. Lisa considers herself a Cognitive behavioral therapist (CBT)/ brief solution focused counselor. Lisa is a Marriage and Family Therapist (MFT) also pursuing a doctorate. Lisa began SA’s based on the demonstrated need by Vistas in the schools. Lisa considers her training related to trauma work with youth as an asset.

Lisa feels supported by colleagues, friends, family and the organization as a whole, and engages in her own therapy as needed. Lisa reports collegial support is another important aspect of her self-care. “Just having a back room that has a table where everybody sits together and talks about stuff. It’s basically like supervision without a leader” (Interview #1, January, 2015). Lisa mentioned her family and friends as an aspect of her support. “I would say that my husband is a support that I’ve utilized but also he’s just supportive in general so I lean on him” (Interview #1, January, 2015). Lisa also engages in therapy to address self-care, “I see my counselor off and on when I feel like life’s getting way too stressful” (Interview #1, January, 2015).
Lisa does not receive routine supervision, however, believes she can speak to a supervisor as needed. Lisa stated,

Rather than people pushing you to do more or to take on more or to disregard whatever feeling—I don’t know if other people do that—but our agency is so great about—when I call (supervisor) in tears maybe because something was going on that was really stressful, she’ll be like, “You, can you just take the whole day off?” You know—really supporting my self-care and nurturing myself.

(Interview #1, January, 2015).

Lisa considers one of her greatest challenges to be hearing traumatic material and the related emotional toll. “The greatest challenges are, I would say, emotional, exhaustion and tired, but—and just hearing people want to kill themselves. That’s the saddest thing on earth—consistently to hear about kids that want to kill themselves” (Interview, January, 2015). Furthermore, Lisa considers parents and high risk suicide assessments challenging, “I had one kid where we had to call child protective services because of—he wasn’t going to take his son. He had the most specific plan of any kid I’ve ever heard” (Interview #1, January, 2015).

Lisa mentioned some symptoms of VT related to SA’s such as anxiety of not knowing what was coming through the door and high risk assessments over making an accurate assessment rating, “There’s still anxiety there when they say it and really assessing, “Did I do the right thing?” (Interview #1, January, 2015). Lisa described compassion fatigue:

I definitely have symptoms of compassion fatigue—I’m exhausted. Especially as I described with some of the challenges, but you can’t give people things. You
just want to give them something to make it better, and you can’t. It’s so
exhausting sometimes just to not be able to do anything. Or be doing a lot, and
then nothing gets better (Interview #1, January, 2015).

Furthermore, work related or secondary stress resulted from hearing a shocking account of how a client would commit suicide and subsequently, taking a test where she performed less than optimally. “When I had taken the test and failed it, I realized what an impact that thing (SA) had had that morning or that afternoon that I had done” (Interview #1, January, 2015). Lisa mentioned the possibility of burnout related to the ability of being able to speak freely about suicide. Lisa stated,

Burnout—I don’t know if this would fall under that category, but one of the things I’ve noticed is I can talk about, “Oh, this person wanted to kill themselves,” and not like I’m not nonchalant about it. I do care, but I say it so much about suicide, suicide, suicide—that I feel like it’s almost—not that I’m immune to it. I never want to be immune to it (Interview #1, January, 2015).

Lisa mentions some past trauma related to being raised in a single-parent family that may trigger her in her work:

My mom was a single mom. She raised (a number of children), and she works dang hard. I would say any assessment that has that kind of component to it really speaks to my heart and makes me feel even more like I wish I could do more in like—I don’t know. (Interview #1, January, 2015).

Lisa describes her past trauma as emotional versus physical and that it does not hinder her ability to assess suicide. Rather her past experience creates an opportunity for more compassion and understanding of her client needs.
Lisa points to a greater awareness of how to assess for suicide and what to look for as a transcendent aspect of this work for instance, “It’s always alarming, but I feel like because I’ve done it for so long, I’m more equipped to deal with it and know what to say or how to assess for it” (Interview #1, January, 2015). Although parents were mentioned as a challenge, Lisa also stated, “I feel like a lot of parents can be really thankful. Thankful to me for being in there and allowing their kid to open up” (Interview #1, January, 2015). As far as opportunities in this work when referring to a suicide risk assessment Lisa said, “…though this was maybe a rough time to be here, I feel like this is a catalyst for getting help that you need and so sometimes it takes this (SA)and tell them that they’re really brave for saying it” (Interview #1, January, 2015). The ability to provide resources is important:

If kids are struggling in school and they’re being bullied and the teachers aren’t doing anything—parents reaching out so I’m able to tell them about that community resource. Or if they’re struggling with food or whatever—being able to tell them about some of the programs and—I don’t know. There’s a lot of opportunities I think to tell people about things that they wouldn’t have otherwise known about (Interview #1, January, 2015).

As a relatively new supervisor Lisa feels supported by colleagues, the organization as a whole, and engages in her own therapy. Although Lisa does not participate in routine supervision she believes she can call on her supervisors to process SA’s and describes being supported in her self-care. Lisa mentioned parents and high risk assessments as a challenge. Primarily, Lisa reported some symptoms of VT such as, anxiety and compassion fatigue associated with high-risk assessments. Lisa mentioned
some past trauma, yet believes it does not affect her work negatively. Lisa believes providing resources is an important aspect of this work. Despite the challenges of assessing suicide in youth Lisa views the suicide risk assessment as an opportunity to instill hope and provide resources in a short time-frame.

Participant 2: Maria

“That’s been a challenge just trying to have the faith that the parents will take it seriously and do their part once the client leaves here.” -Maria

After working on a crisis hotline during her master’s degree training, Maria has been conducting SA’s for youth for approximately one year and is considered a Mid-level (M/b) beginner working with Vistas. Maria prefers Cognitive Behavioral Therapy (CBT) and is a Licensed Mental Health Counselor (LMHC). Maria began shadowing SA’s when she began working for Vistas and has enjoyed continuing to conduct suicide assessments to supplement her regular client load.

Maria is supported by colleagues, the organization, and practices her own personal self-care. In relationship to the organization Maria stated:

I think this organization is very, very good at being supportive and having that environment of a collaboration, where you feel like you can go to anyone, talk to a colleague, supervisors, even ones that are not your supervisor. It makes you feel like you are definitely not alone in anything. If you have any questions or need support, a second opinion, then that definitely contributes to alleviating any stress associated with the job (Interview #2, January, 2015).

Maria mentions several physical outlets that have contributed to her self-care. Maria stated, “I do yoga, as well, and that’s a form of meditation. I’m really into mindfulness.
Think all those things help me to de-stress, relax, and provide a positive outlet, too” (Interview #2, January, 2015).

Maria receives both immediate and routine supervision. When describing immediate supervision following a suicide risk assessment Maria states, “It’s really, really important to get that collaboration for me, and have a second eye of just looking over everything, and another opinion, just especially for safety reasons and hospitalization and risk level” (Interview #2, January, 2015). Maria described routine supervision:

I definitely receive it every week, and it has been very, very crucial in alleviating stress, and just support, mainly. I’m very lucky to have my supervisors extremely supportive (of her work). This definitely helps with burnout, stress, everything related to different clients, and expertise (Interview #2, January, 2015).

Maria speaks of high risk assessments as a challenge when working with parents. Maria said,

Okay. I guess the challenges would be when they are very high-risk. A lot of the times with parents, I’ve had challenges in both extremes; sometimes when the parents are very surprised, and it’s very hard on them to try to help support the parents or explain it to them; and on the other spectrum, when they don’t seem to be taking it very seriously or understand a lot about suicide or their children’s—the extent to the risk level (Interview #2, January, 2015).

Maria does not mention having any specific symptoms of VT related to conducting SA’s particularly, because she limits the number of assessments, “I don’t think so. Maybe doing more of these (SA’s) per week I think; with about four (SA’s) per
week, it’s that the compassion fatigue or anything, it’s not—like I said, I can separate that going home” (Interview #2, January, 2015). Although Maria does not mention any specific symptoms of VT including anxiety, work related stress, compassion fatigue or burnout Maria states, “Maybe the only thing would be when I see certain symptoms or stories that remind me of someone close to me or a family member that—experiencing the same type of thing can cause stress” (Interview, January, 2015).

Maria explains her awareness has increased about the issue of suicide, parenting and transcendent growth experiences including witnessing client growth. For example, “I guess it has taught me a lot more about this population, and helps me to deal with my current clients that I have that are suicidal or self-harming” (Interview #2, January, 2015). In regards to parenting, “You see how those issues are so much more influential than what can be seen at face value into what they’re feeling, and feeling supported especially, or having any compassion at home” (Interview #2, January, 2015). In relationship to transcendent growth experiences Maria mentions being able to follow-up with her assessments and continue therapy with a few clients:

…I took them on as clients, and now it’s just completely different just to see the progress that they’ve made since that initial assessment, coming in for that (SA), and just the level of progress from that depressed mood and never having any—not having ideation to this day, and just becoming—significantly improving in all those symptoms. That’s been very positive just to track that, which you can’t do with all the assessments. (Interview, January, 2015).

Overall, as a new counseling professional Maria appears confident about assessing for suicide risk particularly with the built in agency supports. Maria believes having a
healthy routine contributes to her self-care. Maria views the supervision she receives as a crucial aspect of feeling supported and relieving stress. Maria includes parents and high risk assessments as challenges. Maria did not report symptoms of VT because she associates not having many SA’s with the absence of symptoms. Maria also has experienced some parents that exceeded her expectations and the ability to follow-up with clients rewarding.

**Participant 3: Glenda**

“I feel like I’m learning more than about suicide assessments. I’m really learning about children’s lives, and what really helps them, and what really hinders them.” –Glenda

Glenda is an intern with some prior training in SA’s from her mentor in a medical setting. Glenda has just begun conducting SA’s and works from a psychodynamic perspective. Glenda is pursuing a masters in social work while completing her internship with Vistas. Glenda became interested in SA’s when a family member attempted suicide and was drawn to the internship program where she learned she would be conducting SA’s.

Glenda feels generally supported by her colleagues, family, and the organization. Glenda engages in her own personal self-care to alleviate stress. In relationship to collegial support Glenda said,

Occasionally, in the staff room, I might talk something over with another therapist. That’s one of the great things about Vistas, especially this particular office, is there are always therapists sitting around, and they’re always willing to talk, and teach, and just share. I love that (Interview #3, January, 2015).
Glenda engages in several practices that contribute to self-care. Overall Glenda said, “I’m pretty adept at self-care” (Interview #3, January, 2015).

Glenda believes she is supported by her routine supervisor although, has had a few instances where she felt unsupported during an immediate suicide risk assessment. “I felt that I had made a very relevant clinical observation that was important, and she really negated it. I’ve learned to pick my supervisors very carefully because I have supervisors here who really respect me…” (Interview #3, January, 2015). In general Glenda feels her routine supervision is valuable:

She’s willing to listen. I feel like she’s really a mentor in this process. That really makes it enjoyable because I feel like I really learn. If she comes in with me afterwards, to present the recommendations, and I talk to the family, and if—maybe there’s something she would like to add, so she’ll add it. Then, another day, if I’m in a—with a similar—in a similar situation, where the same thing needs to be said, I can incorporate that into what I’m doing (Interview #3, January, 2015).

In relationship to the SA’s, Glenda views one of her challenges in terms of the parents, “Sometimes I can just see that the parents are not parenting as optimally as I would like them to be, and I can see how this is really contributing to their child’s distress” (Interview #3, January, 2015).

Glenda who does not believe she has experienced many symptoms of VT related to SA’s except in regards to high-risk assessments states, “I really only had one, probably the hospitalization one, that was really stressful. Yes. Afterwards, I was more tired, just a little more drained…” (Interview #3, January, 2015).
Although examples of less than optimal parenting were mentioned, Glenda alternatively stated,

I see some who just don’t really seem to care that much, but I see a lot who really, really do, and who really work hard to be good parents, and who take the recommendations really seriously. That’s been very inspiring, and heartening, and encouraging (Interview #3, January, 2015).

Glenda speaks about the awareness about SA’s she has gained, “It takes maybe an hour, but I feel like I really get a very good overall picture of the kid’s life and the challenges in it, but also a very strong sense of their strengths” (Interview #3, January, 2015).

As an intern Glenda feels supported by colleagues, family, the organization, and engages in her own personal self-care. Although Glenda had described a few instances where immediate supervision was unhelpful, the majority of her supervision experiences with her routine supervisor have been beneficial. Glenda could only recall symptoms of VT in one instance, associated with high-risk ratings and the experience with a supervisor that did not validate her assessment rating. Despite some of the high-risk ratings associated with parents being negative, Glenda also described transcendent growth experiences with parents. In sum, Glenda enjoys connecting to the lives of clients and families.

**Participant 4: Carlos**

Letting go a little—a lot actually, of that experience and that connection that was just made, then transitioning back to connecting with people in my personal life, without letting what happened at work interfere. –Carlos
Carlos is a mid-level (M/b) beginner counselor that had been engaged in crisis work for a few years and entered SA’s through his internship. Carlos has been a contracted counselor through Vistas for two years. Carlos identifies with a Gestalt/Humanistic counseling orientation and is a Licensed Mental Health Counselor (LMHC). Since Carlos completed his internship through Vistas he has chosen to minimally participate in conducting SA’s while carrying a full client load. Carlos regularly attends agency trainings and participates in programs related to trauma work.

Carlos is supported by colleagues, the organization, family, and values the importance of personal self-care. For example, “I feel supported by a lot of my colleagues here. When we have a minute we're able to run situations past each other.” (Interview #4, January, 2015). Carlos mentioned the importance of family to his self-care. Carlos said, “Let's see—I have (number) young kids and I find that just being playful and light with them is a lot of self-care for me, too” (Interview #4, January, 2015). In relationship to self-care Carlos said, “I've also implemented much more of an organized routine for myself, so I don't forget things like meals and getting some exercise, getting to bed at the right time” (Interview #4, January, 2015).

Immediate supervision while conducting a suicide risk assessment has been valuable. Carlos stated,

Then having someone who is really present and give some feedback and is asking about all these details, just helping me get back in the right—maybe just in a better frame of mind to go back in and give that recommendation. Just look at things from as many angles as possible, too. I felt that like—it played a role in helping me feel more oriented and then I’m just learning—or I have learned too,
different things to look out for the next time and ways to keep doing better at the assessment. (Interview #4, January, 2015).

Carlos who receives routine supervision said,

I think it does alleviate my stress because sometimes there's just some complicated situation that I need some direction. I realize I don't know everything or how to completely address every single type of symptom that's being presented. In that way, having some additional feedback or even getting some kind of validation or—I sense some appreciation from the supervisors, too—at the work that I'm doing. I guess in those ways I feel like it alleviates some stress. (Interview #4, January, 2015).

Carlos describes his challenges in the role of conducting SA’s, “I think sometimes staying in my role as a professional and not coming out of that boundary for any reason. Still trying to connect with the client, yet gather the information...” (Interview #4, January, 2015).

Carlos mentions symptoms of VT including anxiety related to a high risk suicide risk assessment, “I've definitely experienced anxiety after a very intense assessment—like on a drive home or something like that, having to just shift gears so to speak from work mode back to personal life” (Interview, January, 2015). Furthermore, “Yeah, definitely anxiety, like a fast heart beat—maybe a fatigued feeling in my thinking. Especially if I had two (SA) that day or something like that. Almost like feeling a little disoriented or something for a minute” (Interview #4, January, 2015). Carlos speaks to compassion fatigue and burnout in terms of, “Where I don't feel like following through with scheduling things. In that way I think my motivation has gotten a little bit affected.
That's really all—I don't feel like I'm cynical or anything like that” (Interview #4, January, 2015).

Carlos describes how his awareness has increased as a result of conducting SA’s, “Well I think that my perception of youth, families and therapy is changed in the way that—I feel like my perception of the need has been amplified by doing these assessments” (Interview, January, 2015). Carlos describes being able to provide resources as a transcendent growth experience, “Connect them to counseling or other kinds of resources that they need, if they need hospitalization or something like that. Being a part of that system” (Interview #4, January, 2015).

As a relatively new counseling professional Carlos feels supported by his colleagues, family and values routine personal self-care. Carlos participates in routine and immediate supervision. Carlos appreciates the feedback he receives from his supervisors particularly when processing client interactions and his resulting thoughts and feelings. Carlos is challenged by high-risk assessments and has experienced some anxiety. Carlos’s awareness of the problems families face has increased as result of conducting SA’s. Carlos views providing resources and connecting to clients as a transcendent aspect of this work although, at times challenging to maintain a healthy balance.

**Participant 5: Daisy**

Having that other person involved in the decision or just reinforcing your decision or questioning your decision, which gives you the opportunity to go back to that family and say, ‘After talking to one of my colleagues, maybe we should be looking in this area. –Daisy
Daisy is an Advanced (A/h) high counselor who has been conducting SA’s for youth over five years when she began as an intern with Vistas. Daisy never stopped providing SA’s after she discovered it was an interest. Daisy considers herself a family systems counselor specializing in adolescence and is licensed as a Marriage and Family Therapist (MFT). In addition to continuing education credits (CEU’s) Daisy considers her training related to trauma work with children to be an asset.

Daisy is supported by colleagues, and the organization as a whole. Most of Daisy’s self-care is directed towards her colleagues and the organization, “For the most part, my self-care specifically around dealing with this issue like suicide assessments and crisis assessments are just the ability to process with other therapists here in the office or with the Director” (Interview #5, January, 2015). Daisy describes her self-care as awareness and is somewhat challenged with routine self-care. Daisy said,

Self-care is one of my tricky areas, but I do—I’m as needed—again, talking to other colleagues about stressors that I’m having or barriers that I’m up against, I’ve accessed my own individual therapy at certain periods of time since I started this career just for professional supervision at that level. Not ongoing but as needed. (Interview #5, January, 2015).

Daisy receives supervision as when deemed necessary. For example, when referring to immediate suicide risk assessment supervision, “…it’s not something that you do and then you just keep inside and don’t—there’s somebody here that you can talk to and get it out and process with a little bit” (Interview #5, January, 2015). In addition, Daisy will call the on-call supervisor to receive immediate supervision during SA’s:
Another perspective, saying it out loud to somebody else, again, if your senses were tingling or if something felt off or you’re just not quite sure or don’t know what the best resource would be, the idea that we as one person can just do it all and be the expert or whatever is ridiculous, especially when you’re dealing with adolescents” (Interview #5, January, 2015).

Daisy considers her challenges as high-risk assessments, “Those are the ones I think stick with me, and those are the ones where sometimes I’ll even take the mom’s number home with me at night or call first thing in the morning…” (Interview #5, January, 2015). Furthermore, when referring to whether or not a client would be admitted to the hospital “We send him to the hospital. They may or may not have gotten—there’s just enough question marks in there, that’s stressful for me” (Interview #5, January, 2015). Furthermore related to work related stress Daisy said, “That’s when you go home and you think about him, and you’re sleeping about them, and then you wake up in the morning. That’s really my primary stressor when it comes to this type of population” (Interview #5, January, 2015).

Daisy describes one of the transcendent growth experiences as being able to provide resources to families. When referring to a parent’s experience, “All I needed to do was get reinforced that this is what my kid is going through. Here’s some resources I can access. My kid needs monitoring, and I need to check in with them more about their feelings…” (Interview #5, January, 2015). Educating parents is also important: “Well, the greatest opportunity is just feeling like—just the ability to educate parents around what’s really happening with their kiddos, educating them around things that are very normalized for adolescents…” (Interview #5, January, 2015). Daisy believes
empowering parents is a transcendent aspect of this work. “I love them leaving here feeling empowered versus talked down to about their own kid because they’re the experts on their kids, and reminding them of that. Those are really positive experiences…” (Interview #5, January, 2015). Daisy enjoys connecting to her colleagues: “Positive experiences here at the agency has been really just identifying other like-minded therapists through doing the suicide assessments, so it really helps hone in your peer group…” (Interview #5, January, 2015).

In conclusion, as an experienced counseling professional and supervisor Daisy feels supported by colleagues, the organization, and describes her own self-care as processing with likeminded colleagues while struggling with providing herself routine self-care. Although Daisy does not receive routine supervision, Daisy is confident that she can reach out to the Director or an on-call supervisor. Daisy also enjoys connecting to her colleagues as a transcendent aspect of her work. Daisy views some of the high-risk ratings and parents as challenges and may experience a few work-related stress symptoms of VT in those circumstances. Daisy believes providing awareness of the struggling youth’s issues to the family or caregiver an important aspect of her work.

**Participant 6: Dora**

“Some of the kids come in here with some pretty brutal stories. I’m learning to keep some distance for your sake and for theirs.” -Dora

Dora is an Advanced (A/l) low counselor who has been conducting SA’s for youth for over five years when she began with Vistas. Dora began SA’s when her supervisor suggested she become familiar with assessing for suicide. Dora utilizes a combination of Cognitive Behavioral therapy (CBT) and client-centered therapy
depending on the situation and/or client. Dora is a Licensed Mental Health Counselor (LMHC) and attends agency trainings.

Dora is supported by colleagues, family, and the organization and participates in her own personal self-care. Dora stated, “Usually someone’s always around to pick their brain or just say, ‘Hey, I need to talk.’ That’s just the setup here. There’s always someone available most of the time. That’s nice” (Interview #6, January, 2015).

Furthermore, Dora refers to her routine self-care: “I go hiking quite a bit, go out with some friends and socialize, exercise is a huge thing. I’ve noticed that if I don’t fall into my routine I can feel myself just hitting limits” (Interview #6, January, 2015).

When discussing immediate supervision Dora said, “Is this really a high (SA) or should it be more a medium (SA rating) and why? Am I missing something? Why are you going medium (SA rating) instead of low (SA rating)? Just sort of bouncing those ideas off of each other and having that support…” (Interview #6, January, 2015). When referring to her routine supervision Dora states, “We have a great relationship. If there’s ever a time where I just need to talk about something she’s a phone call away usually (Interview, January, 2015).

Dora believes some of her challenges are listening to difficult stories, addressing family members who may have contributed to the situation and when parents do not take the recommendations seriously. Dora refers to her challenges and said, “If you get too emotional or you feel like you can’t listen or whatever, then it sends a message to the kids, so having that bit of detachment is important and sometimes a challenge” (Interview, January, 2015). Dora describes the challenges:
Sometimes dealing with the frustrations of the family members that have put the kids in these situations or have done the damage, so to speak, that’s challenging to sit across from someone and deal with the frustrations of whatever the situation is (Interview, January, 2015).

In addition, Dora views high-risk SA’s as a challenge:

I guess sometimes there’ve been a handful of situations where either they declined our recommendations, especially the more severe ones where we feel like it’s very important that they go to the hospital or get further assessed or what have you, and the family or the parents don’t take it seriously. There have been a few times where I leave the office and just think about it over and over and over again (Interview, January, 2015).

Dora has experienced some symptoms of VT related to this work such as burnout, compassion fatigue, and PTSD/work related stress:

I think a few years ago, maybe four years ago, I felt burnt out where it was just difficult to deal with people. It was like my capacity had hit its limit. I couldn’t hear any more stories. I couldn’t deal with any more problems. (Interview, January, 2015).

In relationship to reflecting on SA’s Dora said, “Other examples of stress or PTSD, mostly just that inner process of if that, then this. Could I have done this? Would this have helped? I wish that—just sort of that mulling it over after hours. I think that’s it” (Interview, January, 2015). Finally, Dora is not triggered by past trauma and believes her past trauma cannot be compared to that of her clients and the families she serves.
Dora describes her transcendent growth experiences: “The greatest opportunities are when you really connect with a kid or a family and you just feel like everything fell into place. You really get to be a part of something that’s pretty good stuff” (Interview, January, 2015).

As an experienced counseling professional Dora feels supported by colleagues, the organization as a whole, and engages in her own personal self-care. Dora participates in immediate and routine supervision and believes it is important to process SA’s to ensure accurate assessments/ratings. Dora mentioned parents and high risk assessments as a challenge when parents have declined the recommendations and associated with work-related stress. Dora reported some symptoms VT such as burnout, compassion fatigue, and PTSD/work related stress and had enough self-awareness and the ability to take time off during that period. Dora believes participating in a client’s life is a transcendent aspect of this work.

**Participant 7: Carmen**

“I mean, I really do—as weird as it sounds to say, I do really enjoy doing SA’s. Just seeing the big picture of it.” – Carmen

Carmen is a new (N) counselor that began SA’s as part of her internship with Vistas and has recently become a Licensed Mental Health Counselor (LMHC). Carmen identifies with a Humanistic client-centered theoretical orientation and attends agency trainings.

Carmen feels supported by colleagues, the organization as a whole and practices her own personal self-care. For example, “I would say that the organization, as a whole—I mean, there is support everywhere throughout the organization, so I would say that that
has been helpful in alleviating stress” (Interview, January, 2015). In regards to self-care Carmen states, “Self-care is so important. Currently, I’m working on—I do need to find an exercise routine or go do yoga or something. I haven’t quite done that yet, but that’s in the working for self-care, because I know that always helps me” (#7, Interview, January, 2015).

Carmen believes supervision has assisted her in her learning for instance, “…the supervision here is just a great opportunity as well. We get different supervisors, and hearing just different angles of things and how everybody has their different approaches. I’ve just found, oh, I’ve been able to grow a lot in that” (#7, Interview, January, 2015).

In regards to immediate suicide risk assessment supervision Carmen said,  

Definitely it’s been—I would say suicide risk assessment supervision, that immediate supervision that we get, has been a huge role in processing my reactions and feelings. Just going through whatever I went through with the supervisor, summarizing everything up, is just a great way. I think that if I didn’t have that, I would be leaving feeling super-anxious or super-stressed out about it. ‘Because just having that backup, someone else as a sounding board and being, “Oh, yeah, they said this” and just process—going through that with another person, another supervisor, it’s just been so helpful (#7, Interview, January, 2015).

Carmen regards one of her biggest challenges as finding a personal balance in this work:

Just making sure that I am taking care of myself, really, and processing things and not taking in too much of the client’s stuff that they have to bring into session. At
the same time, having the balance with really being present and in the moment with them (#7, Interview, January, 2015).

Furthermore, Carmen feels parents and families can be challenging:

I know that there—it’s different stories to everyone’s—what anyone’s going through, but, yeah, just being really careful about what I’m picking up on as being truthful. Or what could maybe be maximized—some families minimize things. Where the child’s, “No, this is really what’s going on.” Then I have the parent saying, “Oh, it’s not that big of a deal.” They’re just totally minimizing. Maybe not really validating what the child has to say, which validates why the child is feeling suicidal at the time, or depressed or whatever they’re going through (#7, Interview, January, 2015).

In relationship to symptoms of VT Carmen mentions that her anxiety is decreased when the assessment is complete. Carmen has experienced some compassion fatigue. For example, “I think that there’s definitely—I can identify with having some symptoms of compassion fatigue. I’ll find that I’ll go home and the last thing I want to do is listen to someone” (#7, Interview, January, 2015). Carmen also points to one assessment that triggered past trauma and depressive symptoms of VT and stated,

There was this particular assessment that I remember. The girl was extremely depressed. I remember leaving that assessment feeling really low and down. Not that everyone has been that way, but that was one that I just—I don’t know. I just remember feeling after the assessment just really—almost depressive-type symptoms (#7, Interview, January, 2015).
However, depressive symptoms of VT do not seem to be the norm for Carmen and she demonstrates a high level of insight in identifying her feelings as a result of SA’s.

In regards to transcendent growth experiences Carmen has a greater awareness about individuals struggling with coping with anxiety and depression and feels good about providing families with resources. Carmen stated,

Knowing that these—there are so many kiddoes that are struggling, and so many families that are struggling. Knowing that they’re leaving with resources and with things to—those extra supports to help them get through (#7, Interview, January, 2015).

Carmen added the built in structure assisted her in assessing for suicide:

In particular with the risk assessments, I would say just having such a structured format to go through with them through the assessment. Then the fact that they—they’re leaving, but they’re leaving the office with all these resources to, hopefully, follow through with (#7, Interview, January, 2015).

As a relatively new counseling professional Carmen feels supported by colleagues and the organization. Although Carmen does not always engage in personal self-care, she is aware it alleviates stress. Carmen believes weighing in on the many diverse views during immediate supervision is essential in processing her thoughts, feelings and reactions. Carmen views maintaining her own personal balance a challenge at times. Carmen has experienced some symptoms of VT including compassion fatigue and depression triggered by past experiences yet, was able to work through and recognize those feelings. Carmen believes providing resources is a fundamental aspect of this work.
Participant 8: Linda

I think it (supervision) plays a big role, especially when I am in one (SA) where I just feel like the parents are not listening. It gives me a chance to just gripe to someone; that’s just relief to just have someone be like, “It is frustrating.”–Linda

Linda is an intern who became interested in SA’s because she feels it is important to give a voice to youth. Linda has a curiosity for learning while keeping a varied routine. Linda is pursuing a Master’s in counseling while completing her internship. Linda works from a behavioral affective perspective incorporating a lot of play and art therapy. Linda is interested in research related to the development of youth.

Linda feels supported by her colleagues, the organization, her family, and participates in self-care activities. In relationship to collegial support Linda describes the working environment at Vistas:

I think I like—we have the staff room where everyone sits in there, especially if they’re just eating food or just working on something, and we can all—especially since we’re all therapists, we can all gripe about a difficult day or how hard something was. Then they’ll be like, “Oh, yeah, I’ve done an assessment like that. It’s really tough (Interview #8, January 2015).

Linda participates in her own self-care and described her outlets:

After a really difficult assessment—that’s my regular care type of stuff—after a really difficult assessment, I usually go out dancing with my (partner). It’s really physical, and it’s just nice to have a date with (partner) for one, and connect with my partner, but also it’s so physical it burns off a lot of the anxiety energy (Interview #8, January 2015).
Linda believes immediate supervision has been extremely useful in processing difficult assessments:

I’ve had a couple where I've had to call Child Protective Services, for example, and having that person there (supervisor) to really discuss it with me, and then seeing them again after where they again reassure that we’ve done the right thing, I think that solidifies it for me and reduces the anxiety (Interview #8, January 2015).

Linda has also participated in routine supervision and group supervision with other interns. Linda explained hearing about other intern’s experiences:

That was interesting, just one, you got to hear how other people go home and shed that stress right after a tough one. Also just being reminded, that especially for interns that there’s other people who are brand new at this and feel like that have no idea what’s—what they’re doing and they’re having the same kind of stress. That in itself is comforting, I guess (Interview #8, January 2015).

Linda describes herself as a generally anxious person and is learning to balance her work. “I pace a lot when I’m anxious. I won’t think very straight. I’ll be home. “Got to do the dishes. Got to do the laundry. Work on homework. Oh, I never finished the dishes” (Interview #8, January 2015). In relationship to anxiety Linda mentioned a specific troubling assessment:

You could see he had cut so deep, like you could see bone, and so we definitely sent him to the hospital to get those stitched up. That image lingered with me. It took me a few weeks to shake that off” (Interview #8, January 2015).
In terms of compassion fatigue Linda states, “Within a specific session, I will hit a point of compassion fatigue with a specific client, and especially if I feel like they’re not participating, they’re not connecting, or even trying to” (Interview #8, January 2015). In terms of work related stress Linda described, “I don’t like when I feel like I’ve gone against my instincts and it turns out my instincts were right. That usually will haunt me until I can fix it. It’s really difficult for me to shake that off” (Interview #8, January 2015). Linda grew up in an area where she felt youth were not validated. In regards to past trauma Linda said,

I have seen kids head-to-toe black and blue tell a police officer, tell a teacher, tell a counselor, tell a dozen different people in that area that they were being abused and just have them, but he used the word “dramatic.” I don't know how many times I heard someone tell a kid like that, “They’re dramatic.” (Interview #8, January 2015).

Alternatively, when describing a parent balancing two special needs children Linda also has learned “I think my perceptions have changed to give a little more leniency for parents. A lot of the time, parents don’t really hear themselves or what they’re saying” (Interview #8, January 2015). Linda appeared to be enthusiastic about her work and may experience symptoms of VT as temporary while learning to balance her new profession. Linda mentions because of her role within the agency she is able to see clients after assessments and that has been an encouraging experience:

It’s really rewarding when you see a client who’s just really low, really depressed, high risk in assessment and a few months later you’re seeing them at (program) and they’re just in a completely different place; maybe they’re in therapy or
whatever and they’re just doing way better because of the recommendations you made. I think that’s usually a big high point, to be able to see that (Interview #8, January 2015).

Linda also enjoys the ability to provide resources:

We have a list of things they can do or try, and things they may not have realized they had access to, especially if they don’t have health insurance or something like that. I had an assessment the other day who has no access to her parents and she’s considered homeless (Interview #8, January 2015).

Working as an intern Linda feels supported by her colleagues, family and the organization. Linda believes the informal working environment is conducive to receiving feedback from her colleagues. Linda engages in self-care to balance high-risk assessments. Linda participates in immediate SA and routine supervision and finds immediate supervision helpful for difficult assessments and routine group supervision for validating her experience. Linda describes herself as generally anxious and has experienced symptoms of VT such as anxiety, compassion fatigue, and can be triggered by her past experiences particularly when she believes youth have not been understood by their parents. Linda has also learned parents are balancing many demands and she subsequently became more empathetic to parents as a result. In addition, the ability to provide resources Linda describes as an encouraging aspect of her work. By witnessing client change/growth when a client continues counseling following an SA recommendation is rewarding to Linda.
Participant 9: Rosa

“I’m not feeling any burnout or anything. It does definitely get overwhelming when you do three or four back-to-back in one day.” -Rosa

Rosa is an intern pursuing a Master’s in counseling while completing her internship. Rosa has conducted a relatively high number of SA’s in her role as intern. Rosa does not identify with any particular theoretical orientation. Rosa is learning about the problem of suicide through her Master’s program.

Rosa feels supported by her colleagues and the organization. Rosa views spending time with family as self-care. “A lot of the social workers as well as counselors are helping interns, so—and they tell you, “This is what I did, and I got burnt out, so try not to do it.” They tell us from their mistakes on…” (Interview #9, January 2015). Spending time with family has been essential to Rosa, “Really spending time with family has been my self-care” (Interview #9, January 2015).

In regards to immediate SA supervision, “I like working with the different supervisors. Each one gives you something else to bring to the assessment. They give you good feedback whether you did it right or not” (Interview #9, January 2015). In regards to routine supervision Rosa states,

I have weekly supervision. As far as stress goes, no, it hasn’t helped me. I guess I haven’t been in the spot where I have gotten stressed because the supervisor constantly tells me, “Make sure you take some time out for yourself so you don’t get overwhelmed. Don’t get burnt out.” I haven’t hit any stress yet (Interview #9, January 2015).
Although Rosa is reminded not to internalize what she encounters during SA’s, she experiences difficult feelings. “With some, you definitely feel down and depressed because you can tell that the individual’s really hurting, but we’re taught that you can’t take it to heart. You just have to move on and get them help that they need” (Interview #9, January, 2015). Rosa has experienced past trauma through self-harm committed by a close family member “It didn’t necessarily trigger me, but it helped me to understand where she (client) was coming from. I got to give her (client) what I felt was better guidance on what she can do to deal with the death of her dad” (Interview #9, January, 2015).

Rosa believes, “Greatest opportunities for me—it’s working with a variety of people, different ages, different male/female, different everything. It gives me experience around a lot of stuff” (Interview #9, January 2015). Providing safety to her clients is empowering to Rosa: “Positive experiences—I love to see when you actually help a family out or a kiddo out, and you know that they’re safe, and you know that they are just looking for help, and you’re the person who helped them” (Interview #9, January 2015).

Rosa feels supported by her colleagues, the organization, her family and views self-care as spending time with family. Rosa believes the organization supports her self-care and regularly spends time with her family to balance SA’s. Rosa participates in immediate and routine supervision and maintains the constant reminder from her colleagues to take care of herself which alleviates most of her symptoms of VT from conducting SA’s. Although Rosa acknowledges hearing difficult stories can be depressing she does not report any VT. Rosa describes experiencing a close family member engage in self-harm and believes it gives her better insight into her clients
struggles versus triggering her while conducting SA’s. Rosa enjoys working with a
diverse group of counseling professionals and providing safety for youth.

Participant 10: Kendra

“I always want to bring light to the situation while still matching the seriousness of the situation.” -Kendra

Kendra has been conducting SA’s for youth for a few years and has recently
begun supervision as a Mid-level (M/a) advanced counseling professional for Vistas.
Kendra considers herself a solution focused marriage and family systems counselor.
Kendra is a Marriage and Family Therapist (MFT) also pursuing a doctorate. Kendra
began SA’s based on a personal interest and continued undertaking them to supplement
her regular client load. Kendra enjoys attending conferences and staying up to date with
current research.

Kendra feels supported by her colleagues, family and values self-care. In regards
to familial support Kendra said,

I think there are several ways that you can get support as a therapist, and though
we’re bound by confidentiality that we can’t tell exact stories and state specific
people, but we still can tell them the overall situation that’s going on (Interview
#10, February, 2015).

Furthermore, Kendra describes what self-care means to her in doing this work:

It’s like when I talk to people about their marriage and they got rid of all the stuff
they loved just because they got married to this individual. I’m like, “No, you
need to keep that stuff. You need to still continue to do the things you enjoy on
your own or together because you’re going to lose yourself,” so I don’t ever agree
with just totally losing yourself in your work. (Interview #10, February, 2015).

Kendra believes her emphasis on self-care and her experience has buffered her from
challenges and accompanying VT from conducting SA’s:

I mean, cause I can’t really say I have any huge challenges in working with it, but
I think cause I’ve been working with people who have struggled for a long time
cause my internship was at the mental health hospital and then I worked with rape
survivors for a while, so I can’t really say it’s anything that would prevent me
from continuing doing it or makes me wake up at night in a cold sweat or
something (Interview #10, February, 2015).

In respect to immediate supervision Kendra stated, “There’ve been clients I’ve
seen whether in suicide assessments or regular practice that I’m like, “Oh, my goodness. I
need to call (therapist), or I need to call this person to tell them what happened.” Then
I’m good” (Interview #10, February, 2015). Kendra does receive routine supervision and
finds it helpful. Kendra said, “…I think just processing cases with anybody as far as if
it’s other therapists or a supervisor just helps because you just get everything out on the
table before you go home” (Interview #10, February, 2015).

Although Kendra does not mention any specific symptoms of VT from
conducting SA’s she described past trauma that she believed aided her in this work.

Kendra stated,

For me, I can’t say that really triggered anything, but I will say it allows me to
have more compassion for the parents and the individuals going through this
struggle cause I can’t say there was—I mean, it was heart-wrenching because
that’s my (family member) and I love her to death, but I can’t say I have any negative results from it (Interview #10, February, 2015).

In regards to transcendent growth experiences with SA’s in comparison to being a client’s regular therapist Kendra stated, “I can be a lot more direct with people I think in suicide assessments” (Interview #10, February, 2015). Last, I think in doing this work, “I feel like I’m always encouraged by someone that I’m working with even the families because this is a difficult situation for most families” (Interview #10, February, 2015).

As a relatively new supervisor Kendra feels supported by colleagues, family and values routine self-care. Kendra participates in immediate SA and routine supervision. Kendra believes supervision is an important aspect of processing her feelings as well as leaving work at work. Due to Kendra’s extensive experience she does not report challenges or VT. However, Kendra does report self-harm by a close family member and believes it enables her to have more empathy towards families. Kendra enjoys witnessing clients persevere in light of challenging circumstances.

**Participant 11: Anita**

I would like to think that it could be very empowering to the client when they have somebody that can fully listen to them and not judge them and not tell them that they should be feeling something different than what they’re feeling. –Anita

After being involved in crisis work for many years Anita has been conducting SA’s for youth for a few years and has recently begun supervision as a Mid-level (M/a) advanced practitioner for Vistas. Anita practices from a family systems post-modern feminist counseling paradigm. Anita is a Marriage and Family Therapist (MFT). Anita has always been involved in crisis work and considered SA’s a natural fit to her practice.
Due to experiencing suicide firsthand by a partner she considers this work a personal calling.

Anita feels supported by her colleagues, and family and understands the importance of carving out time for self-care. “I think being able to talk to other colleagues is a big one” (Interview #11, February, 2015). In regards to self-care Anita said, “Even if I’m doing—I have paperwork or whatever, once the kids go to sleep I always try to make sure that I at least get 30 minutes of—I’m doing nothing. Whether it’s reading a book for pleasure or whatever it is. I just need to just be with myself” (Interview #11, February, 2015).

Anita participated in routine supervision yet, at times found this experience unhelpful. In regards to immediate supervision Anita explained,

I think that it really depends on the supervisor. I think that when it was supervisors that I felt like I had a good rapport with, it could be really enlightening and really beneficial and really growing as a therapist. Then there’s supervisors that you don’t connect well with or they don’t like you or whatever the case is (Interview #11, February, 2015).

Anita has had difficulty maintaining regular supervision and found it more helpful when she first started. “I think there’s a definite drop in people’s radar of me needing that once I became independently licensed, though I do seek it out because I like supervision. I love supervision” (Interview #11, February, 2015).

Anita does not believe she experienced many VT symptoms of VT from doing this work except becoming more vigilant with her own children, “Just—with my (children), just making sure that none of that’s going on, I would say, is one of the things
that’s probably affected me from doing some of these suicide assessments” (Interview #11, February, 2015). Although Anita does not feel triggered by past trauma Anita believes her personal experiences may affect her outlook when conducting SA’s:

I feel like doing these assessments and seeing them—that triggered and then that moment where something needs to change, just reiterates my thoughts and feelings of how much trauma that there is in this state… (Interview #11, February, 2015).

In relationship to transcendent growth experiences Anita describes being there for an individual as an important role. “I think that’s a benefit of doing this type of work is being able to be that type of person for them” (Interview #11, February, 2015).

Anita feels supported by her colleagues, family, and views self-care as personal time. Anita participates in immediate supervision depending on the supervisor available. Despite the lack of having a supportive supervisor in some instances, Anita values supervision. Anita has also had difficulty participating in routine supervision since she became independently licensed. Anita maintains that parents can be challenging. Due to Anita’s extensive experience working in crisis settings she reports being more vigilant with her own children and no pervasive symptoms of VT. Growing up in a state where Anita has witnessed a lot of family trauma has reinforced her perception of the problems families experience.

**Participant 12: Clint**

“I have not ever experienced any past trauma that would even probably remotely come close to what these kids are experiencing.” -Clint.
Clint is a new (N) counselor who began SA’s as part of his internship with Vistas. He recently became a Licensed Social Worker (LMSW) and a full time counseling professional with Vistas. Clint identifies with a family systems social work paradigm and attends agency trainings.

Clint feels supported by colleagues and participates in his own personal self-care. Clint describes the informal atmosphere as supporting his work:

Or you're just walking around the agency and there's a supervisor in the agency just dropping off paperwork or whatever, but they're completely willing to stop and talk to you. Talk to you about what's going on specifically and how they would approach it. Just this kind of, I don’t know, it's very informal but remains professional, so you feel like you're always supported no matter where you're at and you'll always have people to reach out to (Interview #12, February, 2015).

Clint mentions getting together with colleagues from his master’s program and dialoguing with them about what is going on as well as maintaining his own personal self-care. “Outdoor activities, biking, tennis, anything that I can really get my hands on to keep me in a positive frame of mind” (Interview #12, February, 2015).

When describing immediate supervision Clint said, “Because when you're in that crisis mode, you may skip over things that you don't necessarily feel are important, but going into supervision and reflect back on it, it is actually integral to the outcome that you want” (Interview #12, February, 2015). Clint also found it helpful to receive the many perspectives offered by his supervisors: “Every time I go in for supervision, I'm always asked to look at it from a fresh lens” (Interview #12, February, 2015). In regards to regular supervision Clint said,
It makes you feel like you're being heard, like what you're doing is worthwhile. What you're doing is going to benefit someone in some way, which is the ultimate goal, I think, of a lot of these professions. I think that it does allow me to breathe a little bit easier after I go to my sessions with my supervisor (Interview #12, February, 2015).

One of the challenges Clint described are the parents:

That they're not taking the time to really spend with their children to understand everything that's going on in their lives, because life is stressful and they're absorbed in their own world, in their own patterns of behavior and thinking and all of those things (Interview #12, February, 2015).

The short-time frame needed to make an assessment, addressing systemic issues and ensuring clients have been given everything they need to follow through has been a challenge for Clint. Clint stated,

I guess that really just understanding that I need to be more focused on getting these families taken care of at the very basic level, at the foundation to make sure that their basic needs are getting met in the near future or as soon as possible so that they can focus on the emotional piece. (Interview #12, February, 2015).

Clint added when describing parent/caregivers as a challenge:

Usually they're maybe resistant to feedback that's offered or maybe they just don't have the ability to empathize with someone so young. I feel like there's a disconnection between the two groups, the client and the guardian, often with very different perspectives and expectations for life in general. (Interview #12, February, 2015).
Clint believes connecting to his clients has prevented many symptoms of VT resulting from this work:

Just allowing them to understand that there are caring people in the world that do want to help them, I think has been extremely beneficial to me, which I think has prevented a lot of that burnout type feeling with the adults that we work with (Interview #12, February, 2015).

Clint adds connecting to his peer group has prevented compassion fatigue. Clint said,

A really supportive professional environment that's understanding of some of the things that you'll probably be facing by doing these assessments all the time, and looking back into that burnout and that compassion piece and loss of compassion if you're not careful (Interview #12, February, 2015).

Clint does not believe any past trauma that he has experienced has come close to the trauma of his clients.

Clint views his greatest opportunities similarly to the greatest challenges. “I think that's an awesome opportunity to get the parent re-involved, specifically with a client in mind and everything that's impacting the client from all sides” (Interview #12, February, 2015). Also Clint said, “Having a child, I mean anywhere from 5 to 18 feel like someone's hearing them, really hearing them for one of the first times, and is there just to help them and seeing their perception change because of the interaction” (Interview #12, February, 2015).

Clint feels supported by colleagues and participates in his own personal self-care by taking time out to meet regularly with his peer group. Clint values and participates in immediate and routine supervision and appreciates differing perspectives. Clint does not
believe he experiences symptoms of VT related to SA’s and asserts his past trauma can in no way compare to that of his clients. Despite Clint describing parents/caregivers as a challenge he also views SA’s as a transcendent growth experience to reconnect clients to parents/caregivers.

**Participant 13: Jane**

“We don’t get to just chat with our friends and family with any detail at all about what we do. The opportunity to do that with someone who’s in the same line of work and has more experience than you is very much a stress reliever.” –Jane

Jane is a mid-level (M/b) beginner counseling professional that had been engaged in crisis work for a few years and entered SA’s through her internship. Jane became a contracted counselor through Vistas and has been practicing for a few years. Jane identifies with Humanistic client-centered counseling orientation and utilizes Cognitive Behavioral Therapy at times. Jane is licensed as a Mental Health Counselor (LMHC). Since Jane completed her internship through Vistas she has chosen to minimally participate in conducting SA’s while carrying a part-time client load. Jane values feedback from her routine supervisor and keeps up to date by reviewing evidence-based practices in counseling journals. Jane feels supported by the organization as a whole, colleagues, continuing education, family, friends and routinely engages in personal self-care. Jane said,

“I’ve even, when I felt the need for extra support, called one of the owners and met with them on a client just to get some more ideas about how to help a particular client. It was—their doors are open. They’re accessible, the owners. In addition to
my immediate supervisor, the organization as a whole provides me a feeling of support that is also very stress-alleviating (Interview #13, February, 2015).


In regards to the immediate supervision Jane receives, “You’re collaborating with another person who has more experience than you. It feels like a safety net. A comfort and a support. Very important” (Interview #13, February, 2015). Jane receives routine supervision. “I get to share the kinds of things you would share with your supervisor doing this kind of work, given the confidentiality that we have to uphold in this line of work” (Interview #13, February, 2015).

Jane reflected about symptoms of VT related to this work in terms of when she began SA’s:

My sleeping a little bit disturbed thinking about—worrying about someone that I’ve seen that day. Occasionally even carrying it past several days or weeks. Just the sense of worry that someone is—was in a—needed more help than maybe they got that day. Or is in a really bad situation and I couldn’t do more for them. Feeling helpless because I couldn’t do more for them. As time has gone on, I’ve gotten better at compartmentalizing my work. Having a self-protective attitude about the work that has just come along with experience and maturity (Interview #13, February, 2015).
Jane believes another challenge is processing a lot of information in a short time “Making sure that if, for instance, someone’s minimizing something that I don’t allow that to go unnoticed” (Interview #13, February, 2015).

When describing transcendent growth experiences Jane states, “The opportunity to inspire them to continue in counseling in an ongoing basis. That would—might eventually be helpful for the child and possibly the whole family eventually is a great opportunity” (Interview #13, February, 2015).

Jane trusts she can check-in with the Director if needed and that creates an environment of feeling supported by the organization. Jane routinely participates in personal care routines. Although Jane is not currently participating in SA’s, Jane values immediate supervision and participates in routine supervision. Routine supervision gives Jane an outlet to process her thoughts, feelings and reactions that are guarded by confidentiality and difficult to share with others outside of the profession. Jane appreciates being able to inspire her clients.

**Participant 14: Nora**

“We get to see a full range of people and people struggling to make life work whether they are making a lot of money or whether they’re just living in a very chaotic household without a lot of support.” -Nora

Contracted through Vistas, Nora is an advanced (A/h) high counseling professional who also conducts supervision. Nora has been engaged in crisis work for many years conducting SA’s as one of the original counseling professionals with Vistas. Nora identifies with a Humanistic client-centered counseling orientation and is Licensed as a Professional Clinical Counselor (LPCC). Nora has participated in extensive training
related to trauma work with youth within Vistas, and regularly participates in her own continuing education.

Nora feels supported by the organization, colleagues, friends, and engages in personal self-care. Nora describes the working climate at Vistas “I know that we (Vistas) have really given a lot of thought to what we’re doing (SA’s) and that it’s not just me coming up with some idea. It’s really based in experience and other people’s input” (Interview #14, February, 2015). Self-care is important to Nora and she points out “I have my own therapist that I’ve seen on and off over the past few years. I think that’s been a really important part of this process for me” (Interview #14, February, 2015).

Nora does not attend regular supervision, however, believes she can call upon her colleagues to assist her with processing and confirms that she is on track with recommendations. “It’s actually more informal in talking to other supervisors or sometimes even talking to other therapists getting some insight. Being at the office allows some of that, but it’s not like it’s a scheduled supervision” (Interview #14, February, 2015). Nora adds she hopes supervision will expand to supervisors receiving routine supervision: “Although that is the direction that we are going is that we would have—even supervisors would have monthly supervision” (Interview #14, February, 2015).

Nora views parents as one of the challenges she faces. Nora describes some of the parents she encounters:

Then there are some parents who are almost cut off from it. I don’t know if they don’t understand the severity of what’s happening or if they just don’t believe that their child would ever do that, so they’re just going through the motions of what the school recommended them to do (Interview #14, February, 2015).
Nora also views one of the challenges as meeting the diverse needs of the clients. “I think everybody is—there is no particular income level that is spared from having kids who report suicidal thoughts or who actually follow through with it.” (Interview #14, February, 2015).

Nora has experienced some symptoms of VT including anxiety, work related stress and compassion fatigue as a result of this work. Nora said,

Well again, I think it’s that sense of when an assessment is borderline and the individual is—it’s just not really clear in that I continue to feel I’d say maybe haunted, or pressured, or stressed because I want to make sure I had appropriately assessed and provided guidance for people. I don’t know that I’ve had any post-traumatic stress, but certainly anxiety and a few sleepless nights because of doing this work (Interview #14, February, 2015).

In regards to past trauma being triggered Nora mentioned the loss of a family member. The trauma really was more about just not being able to hold all of the loss, the pain for myself as well as for family members and friends. As far as suicide assessment, again, a lot of kids come in because they’ve had somebody who they’ve lost, a parent or guardian, a grandparent. I think there are some of those where I feel really impacted by those and find myself going back to those other personal experiences where I felt overwhelmed and unable to maybe even grieve in a way that I would have liked to have been able to do (Interview #14, February, 2015).

Nora illustrates being able to help interns grow in this process is a transcendent growth experience in addition to also being able to help parents. Nora stated,
Some of the things that I have valued and have told new interns is that there’s something—even with kids who are low risk, the majority of those kids come in because there are family stressors going on, even if it’s just a little bit (Interview #14, February, 2015).

Alternatively, when describing parents positively Nora said, “For the most part parents are really appreciative just knowing where to turn because so often they don’t even know where to start. I think that’s some of the greatest opportunities” (Interview #14, February, 2015).

Nora has participated in the development of the organization and views the supportive environment Vistas has created as the result of a group effort. Nora balances personal self-care and attends her own therapy. Although Nora does not attend regular supervision, Nora feels comfortable calling upon her colleagues to review difficult SA’s. Nora has experienced some symptoms of VT encompassing anxiety such as not knowing whether her recommendations were comprehensive. Nora eludes to some symptoms of VT including compassion fatigue when hearing about pain and loss. On the other hand, Nora also describes the parent’s gratitude as an opportunity.

**Participant 15: Kerry**

“They rely on you to be sort of their sense of calm and logic and rationale.” –Kerry

Kerry is a mid-level (M/a) advanced counseling professional who had been engaged in crisis work for a few years and has recently begun supervision for SA’s. Kerry identifies with a Humanistic client-centered counseling orientation and enjoys working with children and engaging in play therapy. Kerry is licensed as a Mental
Health Counselor (LMHC). Kerry values feedback from her supervisor and attends agency trainings.

Kerry is supported by colleagues, the organization and participates in her own personal self-care. “Just getting other ideas from other people and hearing some of the other therapists talk about what they’re doing in session. Different interventions or different books that they’re reading” (Interview #15, February, 2015). Kerry balances difficult sessions with self-care. When describing high risk assessments Kerry said, “That was the last person I saw. I think it does stay with you for a little bit, but I utilize—I try to utilize self-care to help with that” (Interview #15, February, 2015).

In relationship to immediate supervision following a suicide risk assessment Kerry said,

I think getting those two different views and perceptions then…just provides a greater well-rounded—I don’t know—view of what’s going on and what the family is needing. Then also assessing the level of risk, too. Because sometimes the therapist and the supervisor disagree with the risk rating, so then it really—it encourages you and the supervisor to really take your time and figure out what’s going on with that kid. Even going back in to the session and getting more information if they just can’t settle on a rating (Interview #15, February, 2015).

Kerry receives routine supervision and values the supervision relationship. Kerry is also concerned that since she has become independently licensed she receives less supervision. Kerry stated,

They (supervision) are mini-therapy sessions. I think that’s really helpful. I think I’d be a lot more stressed and affected a lot more by my—by what’s happening at
work if it wasn’t for supervision. I’ve actually noticed since I have my independent license I get less supervision. I feel that, definitely. I think it’s still important, even if you’re independently licensed, to have somebody to staff things with and bounce your ideas off of and process things (Interview #15, February, 2015).

Kerry describes some of her challenges as maintaining a balance and the parents not taking the recommendations seriously. “Probably just hearing the stories and the sadness that the kids are going through. Having to stay detached from that” (Interview #15, February, 2015). Kerry added,

Sometimes the families, the parents, can be really challenging if they don’t take your recommendation seriously or if you feel like they’re high risk and it’s very important that they go to the hospital and the parents don’t follow through with that. That’s a client challenge, too (Interview #15, February, 2015).

Kerry experienced some symptoms of VT comprising of anxiety when she first started SA’s and utilized self-care. “I think in the beginning, obviously just starting out and doing them for the first few times on your own, I think that just brings anxiety in itself” (Interview #15, February, 2015). Kerry experiences work related stress related to high risk assessments:

I think it stays with you for a little while, especially if they’re is ones (SA’s) that are very high risk and your recommendation is to send them to the hospital and maybe the parents don’t follow through with that or say, “No, we’re not going to do that.” Naturally, you worry about them, because they’re not getting the help that you feel like they need (Interview #15, February, 2015).
Most of Kerry’s symptoms of VT have diminished. Kerry does not report any
compassion fatigue or burnout. Kerry said, “Burnout, I don’t think I’ve experienced that
yet, either. I don’t think I do enough to feel burnt out” (Interview #15, February, 2015).
Kerry has experienced past trauma, however she does not believe it affects her client
work. When referring to a past trauma Kerry said, “I don’t feel triggered by it.”
(Interview #15, February, 2015).

Kerry believes having a lot of experience has helped her to grow as a counseling
professional. “Just gaining experience, I guess, in working with high risk. I think the
more experience you have in working with this, the calmer you can stay” (Interview #15,
February, 2015). Kerry views her opportunities as providing resources. “I guess just
learning about their story and their struggles. Trying to provide for them what you can.
Hope that they get what they’re needing with what we recommend” (Interview #15,
February, 2015). Although Kerry mentioned some parents not following through with
recommendations as a stressor Kerry also said, “I think for some parents, they’re really
strong and they have a great sense of strength” (Interview #15, February, 2015).

In summary, Kerry feels generally supported by her colleagues, the organization
and balances difficult SA’s with self-care. Kerry attends both immediate and routine
supervision. Kerry values the supervision relationship and the element of healing
supervision contains. Kerry experienced some symptoms of VT including anxiety early
on when assessing SA’s; however, currently does not experience symptoms of VT.
Kerry had described significant past trauma yet, does not feel it interferes with her work.
Kerry views the experience itself of SA work as important, providing resources to
families, and parents sharing their struggles as a constructive aspect of this work.
**Interview Themes**

Five (5) themes emerged from the individual interviews: Care, Supervisory Relationship, Challenges, Symptoms of Vicarious Trauma and Transcendent Growth Experiences. Table 3 represents the emerging textural descriptions from the individual interviews.

Table 3. Individual Interviews: Textural- Description

<table>
<thead>
<tr>
<th>Participant</th>
<th>Emergent theme</th>
<th>Illustrative Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>#9 Rosa</td>
<td>Care</td>
<td>“A lot of the social workers as well as counselors are helping interns, so—and they tell you, “This is what I did, and I got burnt out, so try not to do it” (Interview #9, January 2015).</td>
</tr>
<tr>
<td>#5 Daisy</td>
<td>Supervisory Relationship</td>
<td>“Having that other person involved in the decision or just reinforcing your decision or questioning your decision, which gives you the opportunity to go back to that family and say, ‘After talking to one of my colleagues, maybe we should be looking in this area’” (Interview #5, January, 2015).</td>
</tr>
<tr>
<td>#2 Maria</td>
<td>Challenges</td>
<td>“That’s been a challenge just trying to have the faith that the parents will take it seriously and do their part once the client leaves here” (Interview #2, January, 2015).</td>
</tr>
<tr>
<td>#12 Clint</td>
<td>Symptoms of VT</td>
<td>“I have not ever experienced any past trauma that would even probably remotely come close to what these kids are experiencing” (Interview #12, February, 2015).</td>
</tr>
<tr>
<td>#10 Kendra</td>
<td>Transcendent Growth Experiences</td>
<td>“I always want to bring light to the situation while still matching the seriousness of the situation” (Interview #10, February, 2015).</td>
</tr>
</tbody>
</table>
Focus Group

A Focus group was conducted with seven (7) of the original fifteen (15) interview participants. The Focus group lasted approximately ninety (90) minutes in length and all the participants were actively engaged. The emerging themes were presented in the following order: Challenges, Symptoms of Vicarious Trauma, Transcendent Growth Experiences, Supervisory Relationship, and Care. Most of the participants agreed with the emerging themes and added further elaboration. In addition to the interview themes discussed during the Focus group, psychological numbing and empathy were presented. These two constructs were revealed in the literature review, however; not incorporated into the individual interview questions.

Psychological numbing was supplementary to the development of the Symptoms of VT theme. Dunkley and Whelan (2006) asserted vicarious trauma and related symptomology can lead to psychological numbing, denial and distancing for counseling professionals working with trauma clients. In terms of psychological numbing a few participants discussed his/her shopping addictions and watching multiple episodes of television. Lisa describes psychological numbing in relationship to shopping and watching multiple episodes of television programs. Lisa said,

There’s no attunement with I’ve been sitting on the couch for five hours on Saturday. I know I need to get up, but I don’t. I think that that part goes with the psychological numbing of I’m not in tune with myself (Focus group #1, April, 2015).

Empathy was presented in terms of a facet of stress reduction when working with clients and auxiliary to the emergent theme of Transcendent Growth Experiences. Hunter
(2012) who conducted a qualitative study with eight therapists described the therapeutic bond as crucial to effective therapy yet, few studies examine this bond. The therapeutic bond could be both enriching and challenging (Hunter, 2012). Related to empathy and the counseling relationship Lisa elaborated:

Our session is not tense because I’m telling you things, and I’m not understanding where you’re coming from. I’m trying really hard to understand where you’re coming from. As a result, we’re collaborating rather than me dictating what I think you should do (Focus group #1, April, 2015).

Table 4 represents the emerging themes and textural descriptions from the Focus group interview.
Table 4. Focus Group: Textural- Description

<table>
<thead>
<tr>
<th>Participant</th>
<th>Emergent theme</th>
<th>Illustrative Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>#3 Glenda</td>
<td>Care</td>
<td>“It doesn’t work for me to think about getting rid of stuff. What works more for me is the idea of just be willing to be with something” (Focus group #3, April, 2015).</td>
</tr>
<tr>
<td>#14 Nora</td>
<td>Supervisory Relationship</td>
<td>“Even as a supervisor, knowing I have access to supervision, it makes a huge difference for me, too” (Focus group #14, April, 2015).</td>
</tr>
<tr>
<td>#7 Carmen</td>
<td>Challenges</td>
<td>“Well, I’m working so hard for my child. What do they have to complain about?” That’s the attitude I’m getting. How to balance that out and showing that you understand the parent, but also advocating for the child, and showing the severity of what it is they’re going through” (Focus group #7, April, 2015).</td>
</tr>
<tr>
<td>#8 Linda</td>
<td>Symptoms of VT</td>
<td>“I think I’ve seen every (television) episode 1,000 times. I just watch all the way through the seasons over and over again. That’s me not participating” (Focus group #8, April, 2015).</td>
</tr>
<tr>
<td>#1 Lisa</td>
<td>Transcendent Growth Experiences</td>
<td>“Our session is not tense because I’m telling you things, and I’m not understanding where you’re coming from. I’m trying really hard to understand where you’re coming from” (Focus group #1, April, 2015).</td>
</tr>
</tbody>
</table>
Core Themes

A composite representing the group was developed to describe the essence of the experiences (Moustakas, 1994). Table 5 represents a list of meaning units contributing to the core themes and forming the structural definitions. As a result of the individual interviews and the Focus group twenty (20) meaning units emerged contributing to the core themes: Care, Supervisory Relationship, Challenges, Symptoms of Vicarious Trauma, and Transcendent Growth Experiences. The core themes are described in the sections to follow.
## Table 5. Core Themes and Structural Definitions

<table>
<thead>
<tr>
<th>Core Themes</th>
<th>Meaning Units</th>
<th>Structural Definitions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Care</td>
<td>Colleagues</td>
<td>Collegial support contributes to self-care and a balanced work environment.</td>
</tr>
<tr>
<td></td>
<td>Organizational</td>
<td>Organizational culture alleviated VT.</td>
</tr>
<tr>
<td></td>
<td>Self-Care</td>
<td>Self-care rituals and routines alleviated VT.</td>
</tr>
<tr>
<td></td>
<td>Family, friends</td>
<td>Interacting with family, friends mitigated VT.</td>
</tr>
<tr>
<td>Supervisory</td>
<td>Immediate SA Supervision</td>
<td>Collaboration and a second opinion are important and assist in stress reduction or the</td>
</tr>
<tr>
<td>Relationship</td>
<td>Helpful</td>
<td>feeling of not being alone in the assessment/decision. The availability of diverse</td>
</tr>
<tr>
<td></td>
<td>Routine</td>
<td>Supervisors with differing theoretical orientations was valued.</td>
</tr>
<tr>
<td></td>
<td>Absent/Unhelpful</td>
<td>Routine supervision was absent for a few independently licensed supervisors; most felt</td>
</tr>
<tr>
<td></td>
<td></td>
<td>it was important or utilized collegial and organizational support. In a few instances</td>
</tr>
<tr>
<td></td>
<td></td>
<td>immediate supervision was unhelpful.</td>
</tr>
<tr>
<td>Challenges</td>
<td>Parents/caregivers</td>
<td>Parents/ caregivers caused VT specifically, when not following through with</td>
</tr>
<tr>
<td></td>
<td>Suicide/High-Risk</td>
<td>recommendations.</td>
</tr>
<tr>
<td></td>
<td>Balance</td>
<td>Connecting to clients while being engaged posed some challenges.</td>
</tr>
<tr>
<td>Symptoms of</td>
<td>Anxiety</td>
<td>Usually temporary and associated with high-risk assessments. Also, with being new to</td>
</tr>
<tr>
<td>Vicarious Trauma</td>
<td></td>
<td>SA’s.</td>
</tr>
<tr>
<td></td>
<td>Compassion Fatigue/Burnout</td>
<td>Difficulty listening to problems of friends or family. Awareness was high and</td>
</tr>
<tr>
<td></td>
<td>Work-Related Stress/PTSD</td>
<td>counseling professionals usually took time-out.</td>
</tr>
<tr>
<td></td>
<td>Past Trauma</td>
<td>If mentioned counseling professionals could not compare to client trauma. Most believed</td>
</tr>
<tr>
<td></td>
<td>No Symptoms of VT</td>
<td>it assisted in the process of assessing SA’s.</td>
</tr>
<tr>
<td>Transcendent</td>
<td>Awareness</td>
<td>Awareness of suicide, problems facing families. Ability to assess better was related</td>
</tr>
<tr>
<td>Growth Experiences</td>
<td></td>
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Theme 1: The Care and support counselors receive

All of the counseling professionals interviewed reported that collegial support was an important aspect of alleviating stress due to assessing for suicidality. Cohens and Collens, (2013) report from a metasynthesis on vicarious trauma and posttraumatic growth (PTG) that the impact of trauma work can be mitigated through personal and organizational coping strategies. Collegial support was related to the organizational structure and an open dialogue between counseling professionals. “Again, just having lots of supervisors around, that’s pretty helpful in case yours is busy, or occupied, or just the friendly nature of this place” (Interview # 6). Most participants believed that they could discuss cases with their colleagues and dialogue formally and informally outside of supervision:

I think I like—we have the staff room where everyone sits in there, especially if they’re just eating food or just working on something, and we can all—especially since we’re all therapists, we can all gripe about a difficult day or how hard something was (Interview #8).

Particularly, learning from other counseling professionals was helpful. “Each one of these (counseling professionals), because we're all from different professions I think, again, we all have that different lens of looking at things, and so we can always—it can always be recommended that we talk to somebody new” (Interview # 12). Collegial support was a theme that revealed itself throughout all of the interviews.

Overall (14, 93%) of the counseling professionals mentioned how the organizational culture contributed to alleviating stress associated with SA’s. Particularly
how accessible the supervisors and oftentimes, the Directors were available to staff high-risk assessments.

    I feel very supported by the organization as a whole. They’re just colleagues and other supervisors who I have regular access to just in the course of my work here. They’re all very supportive and open to helping, whether you’re their supervisee or not (Interview #13, February, 2015).

Most of the counseling professionals (14, 93%) mentioned practicing routine self-care. “No, I have really good boundaries and I have excellent self-care. I don’t—I mean, I think there’s always a client that comes home with you here and there, but, for me, that happens once or twice a year” (Interview, #11). Many of the counseling professionals were aware that setting appropriate boundaries and taking care of themselves was essential. If self-care was not routine in the case of one participant who struggled with maintaining personal self-care; the awareness of its importance for alleviating stress was emphasized: “I think self-care for me really is just being very, very aware of when something starts to feel off or overwhelming or too much and immediately doing something about it” (Interview # 5). Self-care practices varied from physical activities, rituals/ routines, and engaging in her/ his own therapy. “I also make sure I get outside and do things like walk my dog as much as possible. A daily basis. Being outside. Being with my animals” (Interview #13). Many counseling professionals (13, 86%) remarked on the importance of connecting with their family members, partners and/or friends to alleviate stress. “I connect with them (children) and there's nothing heavy or serious about playing with them, it's just laughing and playful and light, moving around” (Interview #4). The role of the family as a support was also discussed during the Focus
group and lightened up the discussion. “Speaking of spousal support, somebody was saying that we should have a support group for people who work at Vistas, their spouses” (Focus group, #1). A few of counseling professionals mentioned seeking out her/ his own therapy “I see my counselor off and on when I feel like life’s getting way too stressful” (Interview #1). In sum, collegial support organizational culture, individual self-care, and having supportive families, partners and friends played a vital role for alleviating stress and feeling supported in her/ his own work.

Theme 2: The role of the Supervisory Relationship

A majority of counseling professionals (14, 93%) felt that the supervisory relationship was an important aspect of alleviating stress:

I feel like being able to confide in somebody in a professional setting who's been around all these things for many years and can give you some, like impart wisdom does relieve a lot of stress. It makes you feel like you're being heard, like what you're doing is worthwhile (Interview # 12).

The majority of the participants described the importance of immediate supervision following a suicide risk assessment and being able to process with another person. Specifically, confirming the risk rating a client would receive and not being alone in her/his decision. “Especially to be able to talk to someone about, “Did we do the right thing?” (Interview #1). Also, getting diverse opinions was important to the counseling professionals. “I like working with the different supervisors. Each one gives you something else to bring to the assessment” (Interview # 9). All of the counseling professionals from intern to advanced level of practice had access to immediate supervision during a suicide risk assessment. Furthermore, the supervisor’s emphasis on
self-care was an important aspect of the supervisory relationship. Lisa described a situation whereby a newly hired counseling professional was contacted by her supervisor while she was on vacation:

She (counseling professional) had talked about how surprised she was because usually organizations want you to be productive and want you to do stuff and want you to keep going and going—and how her supervisor—the supervisor here—was very much, “Take care of yourself,” and, “I’m sorry I had to call you on your break,” and, “Enjoy your time” (Interview #9).

Interns (I), new (N) and mid-level (M/b) beginner utilized immediate supervision more frequently than (M/a) advanced and Advanced (A) low/ high counseling professionals. An intern stated,

I would say for supervision, that has been one of the things that I really appreciate having here at this agency because ever since my internship, and now that I’m outside of my internship, that really does give me confidence to—because when you first come in, it is really scary doing the assessments. It’s very intimidating. The moment I found, okay, well, I have these supervisors that are here. They really do have my back (Focus group, #8).

The advanced (M/a, or A) counseling professionals may have only had access to an on-call supervisor in many circumstances. Many advanced counseling professionals (M/a, or A) believed they could access a supervisor or the Director particularly, in difficult cases. There were a few (2, 13%) counseling professionals’ disconfirming cases where counselors reported immediate supervisory relationship was unhelpful. “That was my one bad experience with supervision in this agency. You can see it still stings” (Focus group,
In both these cases they were described as rare incidences due to individual personality conflicts although, impactful.

Routine supervision and their experiences varied by level of practice and licensure. Approximately (11, 73%) of counseling professionals engaged in routine supervision at no cost provided by the agency varying from weekly, bi-weekly, and monthly supervision in most cases. All interns (I), new (N), and mid-level (M/b) beginner counseling professionals engaged in routine supervision and found it helpful in processing their thoughts, reactions, and feelings:

I definitely receive it every week, and it has been very, very crucial in alleviating stress, and just support, mainly. I’m very lucky to have my supervisors extremely supportive. This definitely helps with burnout, stress, everything related to different clients, and expertise. I think that’s very important. I’m very appreciative of that (Interview #12).

One out of three advanced mid-level (M/a) advanced and none of the Advanced (A) low/ high counseling professionals engaged in routine supervision. Some mid-level (M/a) advanced counselors reported a noticeable drop in routine supervision since they had become independently licensed:

I don’t receive as routine supervision as I used to since I’m independently licensed. The nature of the agency being that people are always around and there’s always a supervisor—I feel like I can talk to someone if I need to” (Interview #1).
This may have been due in part to the fact that independently licensed counseling professionals are not required to attend routine supervision. Another possibility exists that due to agency constraints routine supervision is unavailable. A supervisor said,

It’s actually more informal in talking to other supervisors or sometimes even talking to other therapists getting some insight. Being at the office allows some of that, but it’s not like it’s a scheduled supervision. Although that is the direction that we are going is that we would have—even supervisors would have monthly supervision (Interview #14).

Even if counseling professionals did not engage in routine supervision the majority of the counseling professionals valued the importance of routine supervision for all levels of practice.

In sum, the supervisory relationship played a role in stress reduction, providing a conducive learning environment with diverse opinions, and not feeling alone in a SA decision. Immediate supervision played a role in processing thoughts, feelings and reactions to SA’s. Particularly, for counseling professionals not feeling isolated in ultimately making an important decision. Routine supervision was valued yet, not practiced regularly by all participants. Although not all the advanced (M/a, A) counselors participated in routine supervision, most had access to a supervisor particularly with high-risk assessments.

**Theme 3: Challenges counselors encounter conducting SA’s**

A majority of counseling professionals (11, 73%) described their challenges related to parents and high-risk assessments. Specifically, a parent’s lack of immediate
concern for her/his child receiving a suicide risk assessment produced stress for the counseling professionals:

I would say the biggest challenge is the parents. I think it’s a lot of times, the kids are just reaching out and they’re—don’t know how to say how bad this sucks than saying, “I wanna die” or “I wanna kill myself.” Then parents not being able to step up and do what need to—do what they should be doing so their child no longer feels this way (Interview #11).

Furthermore, not knowing whether the recommendations were followed after the SA was conducted was a significant stressor for counseling professionals. Coupled with high-risk assessments and hearing difficult stories were associated with work related stress:

After I’d sent them on—and I don’t even remember what the rating was—but through the night I just found myself tossing and turning and feeling like I hadn’t covered everything, that there were some other questions that I didn’t ask that I think I needed to ask, and then called them the next day” (Interview #14).

A few of the counseling professionals (4, 26%) mentioned maintaining a balance between personal engagement with clients during a SA and maintaining appropriate boundaries as problematic:

Greatest challenges are, I think sometimes staying in my role as a professional and not coming out of that boundary for any reason. Still trying to connect with the client, yet gather the information that is really important to assessing the depth of their situation—their family life, their school life, all of that (Interview #4).

A couple of counseling professionals reported having to address many issues in a short-timeframe as complicating matters:
Really just focusing on all of the systemic issues, having to do it in such a short amount of time, focusing on all the systemic issues that are facing these families and how a lot of these basic system issues are impacting these relationships so negatively (Interview #12).

Last, several counselors mentioned coordinating with other entities such as hospitals, child protective services (CPS), school counselors and teachers posing additional frustration and challenges. “Well, for me, one of the big challenges is when we do have a high-risk kid, and we know they need to be hospitalized, and there’s no bed” (Focus group #14). A few counselors mentioned having a translator for Spanish speaking, “Another challenge is a language barrier with Spanish-speaking people. It’s hard to sit in with a translator and know if they’re actually translating what you’re saying, so those are some challenges” (Interview #9).

The Focus group added an additional consideration for parents initially presenting as a challenge to the counseling professionals. Specifically, that it may not be that parents are disengaged rather, parents may have additional barriers that inhibit them from fully expressing their concerns:

Some of these parents may not be—that they don’t care, maybe this is just the way they deal with high levels of stress is by disengaging cause they don’t know how to cope with it in a healthy manner (Focus group, #11).

Miscommunication or cultural anomalies may also factor into to the participant misinterpretation of parental disengagement and warrants further investigation. In sum, many counseling professionals mentioned parents in relationship to high-risk SA’s and uncertainty that the parents would follow-through with the SA recommendations as a
stressor. Maintaining a balance and appropriate boundaries was discussed by a few counseling professionals. Coordinating care posed additional challenges.

**Theme 4: Symptoms of Vicarious Trauma counseling professionals report conducting SA’s**

Many of the counseling professionals described symptoms of VT related to this work, however, these symptoms of VT when reported were termed as transient and mitigated by collegial support, the organization as whole, the supervisory relationship, transcendent growth experiences and self-care. Trauma work may result in changes in schemas however, distress does not preclude growth (Cohen & Collens, 2013). The counseling professionals interviewed had a relatively high awareness of what was needed to alleviate their symptoms of VT and addressed them accordingly. The symptoms of VT were coded by category: anxiety (8, 53%), work-related stress including: secondary stress, PTSD, and depression (5, 33%), compassion fatigue (6, 40%), past trauma; described as low in comparison to client trauma in all cases (8, 53%), being triggered by past experiences (3, 20%), the experience of no symptoms of VT (3, 20%) in a few cases, and burnout in only one case. When no symptoms of VT were reported also, experiencing suicidal ideation or the personal tragedy of the suicide of a family member or friend was reported in three out of four cases. It is interesting to note, the unexpected experience of no symptoms of VT in association experiencing a personal tragedy of suicide/ or a suicidal ideation in one case. Only one participant mentioned burnout. Finally, psychological numbing was added during the Focus group discussion.

When counseling professionals mentioned symptoms of VT they were usually associated with high-risk SA’s and not the norm:
I think it’s only happened maybe four times out of the—I don't know if I’ve done probably about 100 assessments. It’s very notable when that does happen, where it’s just like almost secondary. It’s like it’s rubbed off (Focus group, #7).

Even though difficult high risk assessments associated with symptoms of VT was irregular; these experiences were impactful for the counseling professionals. Most participants were aware of the occurrence of symptoms of VT and mitigated them with support and personal self-care:

No, I have really good boundaries and I have excellent self-care. I don’t—I mean, I think there’s always a client that comes home with you here and there, but, for me, that happens once or twice a year. It’s very rare (Interview #11).

Anxiety was described in combination with high risk assessments, being unaware of what would follow during a SA and not knowing whether recommendations were followed. “There’s some that they don’t even hit the level of what is coming in. You just don’t know what’s coming in the door. That’s anxiety-provoking. I think I’ve had restless nights.” (Interview #1). Also, anxiety was discussed in terms of occurring more in the beginning of a counseling professional’s career or specifically as an intern. “I think the more experience you have in working with this (SA), the calmer you can stay” (Interview #15).

Work related stress was described as having sleepless nights particularly following a high-risk assessment. “I don’t know that I’ve had any post-traumatic stress, but certainly anxiety and a few sleepless nights because of doing this work” (Interview #14).

Compassion fatigue was discussed in relationship to emotional exhaustion or not being able to fully listen to friends and family member’s issues. During the Focus group for instance, the discussion centered on compassion fatigue:
I’ve never felt like that physical sensation of my head is full. With my husband talking to me or whatever I have to say, I have to say, “I’m really sorry. I hear what you’re saying, but nothing’s going in” (Focus group, #1).

If past trauma was mentioned by participants it was described as low in comparison to her/ his clients in almost all cases. “Have I experienced trauma? Not in any sort of a way that relates to these kiddos” (Interview #5). The majority of participants believed that they were not triggered by their past experiences. However, a few stated being raised in challenging family settings and in some instances were triggered by witnessing dysfunctional patterns during a SA. “I grew up in a culture that really doesn’t listen to kids at all, and so that was a hits-home thing for me” (Interview #8).

If triggered most believed it enabled counseling professionals to understand the client’s needs more accurately:

I would say any assessment that has that kind of component to it really speaks to my heart and makes me feel even more like I wish I could do more in like—I don’t know. I think that that’s probably—any suicide or at-risk—but also any client in general that has that situation triggers me. It’s hard because I can fully understand where they’re at (Interview #1).

A few participants mentioned no symptoms of VT, however, later described having experienced a suicide from a partner, or family member when discussing personal triggers. Most counseling professionals believed experiencing suicide firsthand, aided them in assessing SA’s or described SA’s as a personal calling to this work:

The only thing I’d want to add is that I think one of the reasons that I enjoy this work so much is because I did have a (partner) that committed suicide. We
weren’t together when he committed suicide, but I think that’s—that was a large part of me being able to feel a calling to it, if that makes sense (Interview #11).

In the few instances when past trauma was shared counseling professionals believed it helped them to provide empathy for clients:

I’m thankful that I had, because now I understand what it’s like to be depressed and have anxiety and stuff like that, and I can really, truly empathize with someone on that and truly understand what they’re going through is so hard (Interview # 7). Some participants mentioned the absence of symptoms of VT and particularly burnout due to the fact that as private contractors they have more control over their schedule. “I think it’s easier to keep that compassion, because you’re not seeing them weekly” (Interview # 15).

I don’t know if I’ve experienced that with doing suicide assessments. In the isolated case when burnout was revealed the counseling professional had taken time off and later returned to work.

Psychological numbing was added to the Focus group discussion. Participants mentioned shopping and watching multiple television episodes. “It’s not—I mean I’m not regulated. I find myself—afterwards, I’m like oh, man, why’d I buy that? I didn’t even need it, but I’m not in tune with my body at all the entire time (Focus group #1). Participants found the topic interesting as a new iteration in the literature.

In conclusion, counseling professionals discussed anxiety and compassion fatigue at greater length and a few instances work related stress was mentioned in conjunction with high-risk assessments. Past trauma and triggers were usually diminished when compared to client trauma and triggers were not viewed as a detriment to this work.
Theme 5: Transcendent Growth Experiences

All of the counselors interviewed reported transcendent growth experiences as a result of doing this work. Brockhouse et al. (2011) describe that exposure to vicarious trauma and the utilization of empathy may precede post traumatic growth (PTG) rather than preclude PTG. Furthermore, as a relatively new construct in the literature PTG warrants further exploration (Brockhouse et al. (2011). Most (12, 80%) counseling professionals reported a greater awareness of the problem of suicide and an increased competence related to effectively assessing clients for suicidality. Providing empathy was included as a transcendent growth experience (9, 60%) and significant for counseling professionals in terms of: providing hope, connecting to clients, providing resources, empowerment, non-judgmental listening, and witnessing client growth. Many (8, 53%) counseling professionals also believed that by providing tangible resources they felt a meaningful contribution to this work. Despite parents being presented as a challenge many (9, 60%) counseling professionals remarked that witnessing parental growth as the result of a SA was alternatively also a transcendent growth experience. To a lesser extent however, important to mention, counseling professionals discussed being able to connect to like-minded colleagues, witnessing counselor growth, working with diversity, the ability to be more direct with clients, and the structured format of the SA as an important aspect of this work.

The understanding and awareness of the problem of suicide was viewed as an asset to many counseling professionals. “Just gaining experience, I guess, in working with high risk. I think the more experience you have in working with this, the calmer you can stay” (Interview #15). The many encounters with suicidality lead to increased
competence in many of the counseling professional’s abilities. Further, the awareness extended to a deeper understanding and appreciation of client strengths:

I’ve really been learning how children, that have things they’re interested in, things they enjoy doing, how much more resilient these kids seem than the ones who just really don’t have much going on (Interview #3).

The utilization of empathy was mentioned as a transcendent growth experience during the individual interviews and discussed more at length during the Focus group.

The utilization of empathy created meaning for the counseling professionals:

I think, also, just the ability to reach out to somebody who's feeling more than likely that they're not being heard. I feel like it's an excellent opportunity to catch something that would obviously escalate to something much more grievous. To really create a very short term but strong attachment or therapeutic relationship that allows them to express things that they might not necessarily express otherwise (Interview #12).

Empathy led to transformative experiences for the counseling professionals:

Our session is not tense because I’m telling you things, and I’m not understanding where you’re coming from. I’m trying really hard to understand where you’re coming from. As a result, we’re collaborating rather than me dictating what I think you should do (Focus group #1).

Providing parents and caregivers with a specific plan of action or more succinctly, resources was viewed as an important outcome of this work. “The kid makes a statement like that and what I think is really one of the things I really value about the opportunities I can link families up with services…” (Interview #14). Specifically, the SA format allowed
counseling professionals to link clients with services. “Then, just our recommendation sheet gives a lot of extra resources and support” (Focus group # 1). The SA enabled counseling professionals to increase awareness for parents and caregivers while delivering specific recommendations and resources. “One of my goals in addition to assessing risk, personal goals, is to make sure I’ve given them at least one useful tool they can take with them when they walk out the door that day (Interview #13).

Although parents’ perceived lack of involvement in the SA process initially presented as a challenge for counseling professionals alternatively, parental growth was also a transformative growth experience for the counseling professionals. “For the most part parents are really appreciative just knowing where to turn because so often they don’t even know where to start. I think that’s some of the greatest opportunities” (Interview #14). At times counseling professionals mentioned parents as a challenge and later stated that parents could be equally inspiring. “Some of the parents are really wonderful and actually are quite attuned to their kids” (Interview #3). The Focus group added additional considerations for understanding the parent perspective:

Some of these parents may not be—that they don’t care, maybe this is just the way they deal with high levels of stress is by disengaging cause they don’t know how to cope with it in a healthy manner (Focus group #11).

Further, cultural considerations were revealed:

“Like you’re saying (Focus group #11), they really do care about their kids, but they’re just…why are you doing this?” You have the home (Focus group #7).

The experience in itself was rewarding to counseling professionals:
As we talked, and then brought the parents in, I asked her, “Can we let her know?” The amount of care on the part of those parents. They just both wrapped their arms around her. The mom was right—and just said, “Listen, yes, things happen, but we’re a family. Families are here to listen to each other and be there for each other.” It was just so moving for me to be a part of that (Focus group #14).

In summary, all of the counseling professionals were able to discuss transcendent growth experiences when conducting SA’s. A greater awareness of suicidality was related to competence in providing SA’s to clients. Providing empathy and resources was highly regarded. Parents initially viewed as negatively effecting the counseling professionals work was equally reported as an affirmative experience. The idea that VT may preclude PTG warrants further exploration (Brockhouse et al., 2011).

Conclusions

This chapter outlined the themes that emerged from the individual interviews with the fifteen (15) counseling professionals and the (7) seven returning participants for the Focus group. The data analysis produced the following themes: Care, Supervisory Relationship, Challenges, Symptoms of Vicarious Trauma and Transcendent Growth Experiences. Each counseling professional added her/ his unique experience of conducting SA’s that contributed to the development of these themes individually and as a group during the Focus group meeting.

The following chapter summarized the findings and discussed future considerations for research. The chapter outlines how the analysis and literature review contributed to the emerging themes. The final chapter concluded with clinical and
training implications. Limitations of the study and ideas for future research are presented.
Chapter Five 5: Discussion

Overview of the Study

The purpose of this phenomenological study was to distinguish how counseling professionals experience the unique phenomenon of conducting suicide risk assessments (SA) for youth. Several themes developed throughout this study. The descriptions of each theme to follow elaborated on the multiple meanings or tensions found within the thematic data analysis (Hays & Singh, 2012). As a result of the individual interviews and the Focus group five (5) themes emerged. These were Care, Supervisory Relationship, Challenges, Symptoms of Vicarious Trauma and Transcendent Growth Experiences. Each theme is discussed and related back to the literature. Limitations of the study, clinical and training implications are presented. The chapter ends with conclusions and reflections.

Discussion of Themes

Theme 1: The Care and support counselors receive

The Care theme included mitigating factors of support. These were collegial, organizational, having supportive family, partners and friends. In addition, the counseling professionals' use of self-care was an aspect of the Care theme. Collegial support was a dominant theme throughout all of the individual interviews and mentioned during the Focus group as well. Organizational support was described in terms of the overall culture of Vistas whereby counseling professionals could access support as needed. Ling, Hunter, and Maple (2014) assert having access to appropriate support structures and incorporating variability and diversity in the work lead to sustained engagement. Having supportive family members, partners and friends was valued by
many counseling professionals. The utilization of self-care strategies was an important aspect of this work. Although several studies look at the support counseling professionals receive working with diverse client issues in a variety of settings the current literature neglects counseling professionals conducting SA’s for youth.

Cohen (2013) reported the impact of trauma work can be lessened by personal and organizational coping strategies. Particularly, the ability for counseling professionals to process difficult SA’s with colleagues who were readily accessible to them was crucial. Hunter (2012) maintained family therapy agencies should provide counseling professionals both informal and formal debriefing with trusted colleagues. Counseling professionals often described the informal supports present within Vistas. Kendra said,

I feel like a lot of people who work here are very open, very friendly, you can just chill after your clients and process whatever happened with that client so by the time you get home you’re over it, especially if it’s a stressful event (Interview #10, February, 2015).

Collegial and organizational support have been recognized in the literature for alleviating stress among counseling professionals working in crisis settings (Maier, 2011; Brockhouse et al. 2011). Collegial support was described with more regularity than organizational support. Brockhouse et al. (2011) found organizational support only predicted moderate posttraumatic growth. Nevertheless, it is important to recognize that Vistas supported debriefing with colleagues. At times, collegial support and organizational support were difficult to differentiate. For instance, the ability of the counseling professionals to take on as many SA’s as needed without pressure from their supervisors may have contributed to the collegial atmosphere. Rotter’s (1966) theory of
internal versus external locus of control may partially explain why the counseling professionals in this study felt supported in her/ his work. For instance, counseling professionals could control the number of SA’s they would perform. The organizational culture and a sense of interconnectedness found within Vistas appeared to contribute to the alleviation of stress reported by the counseling professionals and/ or symptoms of VT. Rourke (2007) stated encouraging conversations on the impact of work was a strategy for lessening the impact of VT.

Clint stated,

> A really supportive professional environment that's understanding of some of the things that you'll probably be facing by doing these assessments all the time, and looking back into that burnout and that compassion piece and loss of compassion if you're not careful. I think just having all these avenues—or having the avenues of support that you can seek out or check in with, I think, has probably been extremely helpful (Interview #12, February, 2015).

The literature rarely referenced the role of family, partners and friends in alleviating stress and few studies if any describe how the role of family sustains care for counseling professionals. The role of supportive family members, partners and/or friends was interwoven throughout the interviews and Focus group discussion. Bober and Regehr (2005) explained personal strategies for balancing work and private life could lessen VT. Carmen said, “He (husband) gives me my space and understands I might not be totally available mentally to hear him out on his day. Then, afterwards, I’m more available” (Focus group #7, April, 2015). The presence of supportive family, partners and/or friends was important to the counseling professionals in this study. Many
counseling professionals practiced a family systemic counseling orientation in addition to the mission of Vistas recognizing the role of family that may have contributed to this finding.

It has long been recognized in the counseling profession self-care may assist counselors when encountering traumatic material (Bober et al., 2006). Many of the counseling professionals in the current study emphasized the importance of self-care to alleviate the stress associated with SA’s. Venart, Vassos, and Pitcher-Heft (2007) maintained that in order to avoid sending a message to clients that one’s well-being is unimportant one must make an honest appraisal of her/his health, balance, and self-care throughout their careers. Halloran and Linton (2000) explained counseling professionals are oftentimes more adept at providing for client care than for themselves. Bober et al. (2006) developed the Coping Strategies Inventory (CSI) to measure self-care in counseling professionals who work with clients who have experienced trauma. However, ways to describe self-care routines and practice remain insufficient (Venart, Vassos, & Pitcher-Heft, 2007). A majority of the counseling professionals did not hesitate to mention their regular practices of self-care incorporated into their daily routines to alleviate the work-related stress associated with conducting SA’s. The counseling professionals in the present study were skilled at realizing the need for self-care to alleviate stress. In only one instance when routine self-care was missing from the counseling professional’s regular practice the professional added that the awareness of experiencing stress resulting from this work was a form of relief. Daisy said, “For me, its awareness. I’m just that person. As soon as I realize, oh damn, that’s that, even that’s a pressure release in some ways. I go I need to do something here for that (stress)”
In sum, self-care was vitally sustaining to most of the counseling professionals in this study.

Studies pertaining to counseling professionals working with sexual, domestic violence and natural disasters represented useful coping mechanisms when encountering crisis and trauma yet, studies pertaining specifically to SA’s, and youth were insufficient. For instance, in a qualitative study examining nurses who assist victims of sexual assault coping strategies included talking or reaching out to family members or colleagues, and discovering relaxing activities (Maier, 2011). Studies examining counseling professionals encountering crisis, trauma and specifically, pertaining to counseling professionals conducting SA’s for youth were insufficient. This research adds to the developing literature regarding the support counseling professionals receive to sustain themselves while experiencing crisis and trauma and more succinctly conducting SA’s for youth.

**Theme 2: The role of the Supervisory Relationship**

Supervision in the form of immediate SA meetings with a supervisor following an SA was indispensible to the counseling professionals in this study. The presence of diverse supervisors with differing professional backgrounds was beneficial to many of the counseling professionals. When routine supervision was absent it was nevertheless, valued and oftentimes accessible informally, through organizational and collegial support. Furthermore, the emphasis on self-care within the supervisory relationship was helpful to the counseling professionals. This research emphasized that supervision for novice, mid, or expert level counseling professionals conducting SA’s was fundamental.
Furthermore, this research augmented existing literature and the importance of the supervisory relationship while conducting SA’s in the absence of suicide.

It was imperative for the counseling professionals to receive immediate supervision following an SA. Particularly, given the demands of high-risk assessments supervision was critical. Tracey et al., (1989) explained whether novice or expert supervision for suicide risk assessment was fundamental. Counseling professionals in this study found that the supervisory relationship played a pivotal role in processing their thoughts, feelings and reactions when conducting SA’s. Immediate supervision appeared to be a strength of the agency for processing difficult or high-risk SA’s.

Maria stated, “Having supervision immediately after has really helped me to see maybe something in a different light, and even incidents where I wasn’t sure about whether to send (client) to the hospital or not” (Interview #2, January, 2015). McAdams and Foster, (2002) confirmed pre-crisis education would be important particularly to novice professionals.

Glenda an intern said,

I found supervision for suicide assessments to be just really phenomenal here. I’ve worked with you—all of, once. I’ve worked with (supervisor) tons and tons of times. I think supervision in general is one of the strengths of this agency, just across the board, but within the suicide assessments, it’s always a training experience (Focus Group #3, April, 2015).

Having diverse supervisors following an SA coupled with the supervisor’s emphasis on self-care was constructive to the counseling professionals in this study.

Clint elaborated,
I feel like the supervision piece is actually probably one of my most favorite pieces of the suicide risk assessments. I think especially in the setting of Vistas there's very different perspectives from the supervisor, so LMFTs, LPCCs, MST supervisors. Really just the way that they look at a family and a client in their just the setting in general, I think it's really fascinating the way that they view it differently from the next supervisor over another (Interview #12, February, 2015).

All of the interns, newly hired, and most of the mid-level counseling professionals received routine supervision. In the cases when advanced practitioners did not receive routine supervision many believed they could access the expertise of their colleagues. Nora said, “Again, just knowing that I can pick up the phone and call if I need some kind of guidance, that is huge, especially with some that are really so borderline” (Interview #14, February, 2015). Wachter et al. (2008) recommended when supervision was unavailable specifically in a school setting, the ability to process with colleagues was recommended. When supervision was unavailable being able to access colleagues and supervisors was imperative to the counseling professionals. In disconfirming cases where supervision was absent or even unhelpful, the counseling professional maintained that supervision remained an important facet of their practice

The ability to process SA’s and alleviate stress with their supervisors was mentioned by counseling professionals when describing supervision. Lisa said, “I felt like that—her talking to me and being in tune with me alleviated stress” (Interview #1, January, 2015). Abassary and Goodrich (2014) emphasize in their development of the CARE model for supervision that including an aspect of self-care dialogue in the supervisory relationship is also an important aspect of providing quality client care. Two
disconfirming cases where supervision was absent or unhelpful pertained to the immediate SA’s and not the routine supervisor. In sum, within the supervisory relationship an emphasis on self-care sustained the counseling professionals.

Supervision may be essential for sustaining the well-being of counseling professionals when conducting suicide risk (McGlothlin et al., 2005). McAdams and Foster (2002) assert the role of the supervisor was paramount to post-crisis recovery when counseling professionals experience the tragedy of client suicide. Although it is imperative to study the impact of client suicide on counseling professionals, studies continue to ignore the impact of SA’s in the absence of suicide. The literature emphasized that differing supervision approaches must be used given low, medium, or high client suicidality for counseling professionals. Extant literature emphasized supervision differences between novice, mid-level and expert practitioners (McAdams & Foster, 2000; Bernard 1979; McGlothlin et al., 2005). However, the literature did not include what features of supervision were important to counseling professionals from a qualitative perspective. Rather, prior research prescribed techniques utilized to conduct supervision at the differing levels of risk and experience. For instance, Roberts and Yeager (2005) recommended applying a decision tree leading to a determination to rate a client as: a.) Imminent risk b.) Moderate risk and c.) Low risk for suicide. McGlothlin et al., (2005) illustrated through the Cube Model that depending on a counseling professional’s level of practice differing roles prescribed by Bernard, (1979) such as teacher, counselor, and consultant would be retained. All of the counseling professionals including interns, new, mid-level and advanced practitioners valued routine supervision although, routine supervision may not have been as readily accessible to the advanced
practitioners. In conclusion, this research augments the current literature focusing qualitatively on experiences versus solely on methodology in the absence of client suicide.

Theme 3: Challenges counselors encounter conducting SA’s

Granello (2010) affirmed that assessing SA may be one of the most challenging roles for counseling professionals. In the present study, counseling professionals faced a number of challenges when conducting SA’s. Challenges to counseling professionals in this work included parents, high-risk suicide SA’s, maintaining a sense of balance and appropriate boundaries with clients, and coordinating services with other entities. Cultural anomalies may have played a role in challenges to counseling professionals. High-risk assessments coupled with parent’s seemingly indifferent attitudes posed challenges to counseling professionals. Maintaining personal boundaries while eliciting empathy and support for clients was difficult for some counseling professionals. Analogous to the research, counseling professionals reported challenges when assessing personal boundaries and eliciting the empathic engagement necessary to provide effective care during SA’s (Pearlman & Saakvitine, 1995). Providing services within a short time-frame and at the same time coordinating with other agencies was problematic for a few counseling professionals. The effects of cultural influences and beliefs was mentioned during the Focus group as a potential consideration for challenging aspects of conducting SA’s.

Initially, parents/ caregivers were associated with difficult aspects of SA’s. McCann and Pearlman, (1990) assert that schemas can be challenged when new information cannot be easily assimilated into existing schemas. When parents were given
a high-risk rating to send their child to the hospital counseling professionals were
challenged by parents seemingly apathetic responses. Nora stated,

Sometimes the families, the parents, can be really challenging if they don’t take
your recommendation seriously or if you feel like they’re high risk and it’s very
important that they go to the hospital and the parents don’t follow through with
that. That’s a client challenge, too (Interview #14, February, 2015).

At times lingering feelings of anxiety for counseling professionals accompanied whether
or not a parent/caregiver would take her/his child to the hospital. Also, if the counseling
professional believed the parent to be indifferent during an SA or noncompliant when
given the recommendation to take her/his child for follow-up was inconceivable to many
counseling professionals. Lisa said, “You’re wondering why the parents don’t care that
their kids—they’re obviously here for a reason. Then it makes sense why they’re here
because nobody cares” (Interview #1, January, 2015). In regards to not taking the SA
recommendations seriously Clint said, “I guess as far as that goes, it would just be that I
do sometimes feel like I lose some compassion for the adults in the relationship within
the therapeutic setting for that reason (Interview #12, February, 2015). Particularly,
when coupled with high-risk assessments, counseling professionals typically perceived
parents lack of caring as a disturbing aspect of SA’s. The Focus group added more
considerations concerning parents. Anita reflected,

Maybe as I was providing these services to people, maybe I could’ve been more
supportive of the parent, instead of the focus always being on the child. How to
ease this for the parent and to support the parent in this information that I’m sure
is very difficult to hear (Focus group #11, April, 2015).
Although parents continually surfaced as a challenge for counseling professionals alternatively, parents are also presented in Transcendent Growth Experiences.

Schauben and Frazier (1995) reported counseling professionals having difficulty maintaining boundaries while establishing trust is potentially challenging. Sexton (1999) contends the empathic involvement necessary to effectively address client concerns can resemble a double-edged sword. A counseling professional can be impacted adversely experiencing symptoms of VT and/or compassion fatigue. Maintaining personal boundaries while still being present for clients and families posed some challenges to counseling professionals. Dora said, “Some of them (challenges) are just managing the heartbreak that comes along with the stories” (Interview, January, 2015). Also, trying to meet so many needs within a short time was difficult. Jane stated,

Feeling like I have given something useful during the course of an assessment to either the child who’s being assessed or the family members who’ve brought them in. Hopefully both, but since I only have them an hour and a half I typically do not ever see them again (Interview #13, February, 2015).

Westefeld et al. (2000) conclude SA’s incorporation of biological, psychological, and environmental factors can be complex. Meeting the multiple needs of youth within the short-time frame was reiterated by the counseling professionals in this study. Also, Barrio (2007) conveyed SA’s can be more complex when considering younger children since typically SA’s are designed for adolescents. Addressing multiple needs and services within a short-time frame was presented as a challenge to the counseling professionals. Clint stated, “Another greatest challenge, I would say being able to probably assist the client at the age level that they’re at within the short amount of time
that you have” (Interview #12, February, 2015). The challenge of coordinating services was not extant in the literature. The coordination of services is an additional challenge for counseling professionals in the present study. Lisa said, “The other thing that I’ve encountered, and it’s with just one hospital in particular, the intake lady is so rude.” (Focus Group #11, April, 2015). Coordinating with other entities caused some distress for counseling professionals. Nora stated, “Well, for me, one of the big challenges is when we do have a high-risk kid, and we know they need to be hospitalized, and there’s no bed.” (Focus Group #14, April, 2015).

Last, although not the focus of the present study, it is equally important to mention that cultural differences may have impacted the perceptions of the counseling professionals in this study. For example, high-context cultures value silence and may make use of implicit messages (Lustig & Koester, 1999). In the short-time frame of a SA, verbal and explicit dialogue may be warranted to communicate distress. A parent’s lack of adequate communication may lead counseling professionals to assume parents/caregivers are not participating. Cultural implications caused some challenges to counseling professionals. Cultural implications may have ultimately influenced how the counseling professionals viewed families and youth. Rosa added, “Another challenge is a language barrier with Spanish-speaking people. It’s hard to sit in with a translator and know if they’re actually translating what you’re saying, so those are some challenges” (Interview #9, January 2015). Maital (2000) explains reciprocal distancing can occur when clients are not understood leading to avoidance, withdrawal and hopelessness. Splevins, Cohen, Joseph, Murray, and Bowley (2010) add feelings of guilt may ensue due to the provider’s perceived privileged majority status. For instance, counseling
professionals continually stated their personal trauma could not be compared with that of their client’s trauma. The majority of counseling professionals also are privileged educationally when compared to their clients. In sum, one could infer cultural misunderstandings by the counseling professionals may have existed rather than the perceived apathy by the parents/caregivers. In conclusion, this research contributes to the literature concerning the complexities and challenges for conducting SA’s in youth.

**Theme 4: Symptoms of Vicarious Trauma counseling professionals report conducting SA’s**

Most of the counseling professionals were comfortable speaking about the work–related stress associated with SA’s. Some symptoms of VT were mentioned by the counseling professionals when conducting SA’s; however, the symptoms of VT appeared to be transient. The symptoms of VT included anxiety, compassion fatigue, work related stress/secondary stress and/or PTSD like and psychological numbing. To a lesser extent were burnout, past trauma and/or accompanying triggers with SA’s and in a few instances the presence of no symptoms of VT. Some counseling professionals mentioned more anxiety at the beginning of their work with SA’s. Compassion fatigue was identified by less than half of the counseling professionals. Counseling professionals also consistently stated their trauma could not be compared to that of their client’s trauma. A few counseling professionals who experienced past trauma also believed their experience may have enhanced their ability to conduct SA’s more effectively. Burnout was only mentioned in one instance and in only a few cases were counseling professionals triggered by past experiences when conducting SA’s. Given the preponderance of literature concerning symptoms of VT such as anxiety, compassion fatigue, PTSD/work
related or secondary stress, burnout and countertransference, it was unanticipated that symptoms of VT in this study appeared to be transient.

In the present study, about half of the counseling professionals reported anxiety associated with high-risk ratings and perceptions about parents not taking the recommendations seriously. Culver et al. (2011) confirmed anxiety was a common symptom among counseling professionals. Particularly, symptoms of VT such as anxiety were associated with high-risk assessments and parents/caregivers not taking the SA recommendations to heart. Most counseling professionals also reported it was not the norm for them to experience anxiety associated with an SA’s unless paired with high-risk assessments and parent’s ambivalent attitudes. Daisy stated, “Maybe mom took him to the hospital, or maybe she blew us off, or maybe kiddo got to the hospital and said, “You know what, I’m fine. Everything’s fine.” The hospital can’t do anything so they send him home” (Interview #5, January, 2015). Some counseling professionals mentioned if they had a higher number of SA’s and severe trauma in one day it could be associated with anxiety. Carlos added,

Oh, and there was incest, too. Really? It’s like that emotional roller coaster to sit through and hear these jarring things for me that yeah, for a second, it’s hard to even believe it. I know it happened. I believe them (Focus group #4, April, 2015).

Compassion fatigue, work related stress/ secondary stress/ PTSD and/or depression was mentioned with less frequency. Figley (2002) termed the very act of being compassionate engendered risks for counseling professionals. Compassion fatigue comprised some symptoms of VT for counseling professionals. Lisa stated, “I feel bad when I’m so depleted for my family and I can’t be the one to make him (husband) dinner
or something like that” (Focus group #1, April, 2015). Splevins, et al. (2010) reported in a phenomenological study among interpreters for asylum seekers and refugees some interpreters had difficulty “switching off” after sessions. Symptoms of VT may have been more present when counseling professionals began as an intern or new counseling professional. Jane said,

Early on, in my tenure here and at Vistas in performing these risk assessments, this was more of an issue. I remember back in the first year I was performing them that there were times when it was quite stressful. I experienced symptoms of VT such as empathy to the point of carrying it with me when I left work (Interview #13, February, 2015).

The counseling professionals gave the impression of having awareness of when compassion fatigue manifested itself and how to address symptoms of VT. Linda said,

Yes, on my longest days since being here, I know I’ve been like—I know I’ve told friends, I’m like, “No, I’m sorry. I’ve used all of my compassion today. I’m all out. If you want to complain to someone, I’ll talk to you tomorrow because I have spent it all today. I’m out (Focus group #8, April, 2015).

Work-related stress, secondary stress, PTSD like symptoms of VT including depression were reported by roughly a third of counseling professionals. Work-related stress including secondary stress, PTSD, and depression were revealed particularly when counseling professionals believed recommendations were not followed. Kerry said, “I don’t like when I feel like I’ve gone against my instincts and it turns out my instincts were right. That usually will haunt me until I can fix it. It’s really difficult for me to shake that off” (Interview #15, February, 2015). The discussion during the Focus group
included psychological numbing. Counseling professionals discussed activities such as shopping and watching multiple episodes of television programs in order to psychologically distance themselves from SA’s. Linda said, “I think I’ve seen every episode 1,000 times. I just watch all the way through the seasons over and over again. That’s me not participating” (Focus group #8, April, 2015). In the present study symptoms VT such as PTSD such as sleepless nights and depression appeared to be a rarity and associated with high-risk ratings.

Past trauma when mentioned was usually accompanied by the statement that a counseling professional’s trauma could not be equated to that of client trauma. When counseling professionals mentioned being triggered by past experiences during SA’s many also believed their experiences contributed to more insight on behalf of the client. The ability to raise awareness of how the youth were suffering when conducting SA’s with their families was important. Rosa described how past trauma affects her work: “It didn’t necessarily trigger me, but it helped me to understand where she was coming from. I got to give her what I felt was better guidance on what she can do to deal with the death of her dad” (Interview #9, January 2015). The role of past trauma in counselor effectiveness studies has been inconsistent. Approximately, half the participants reported past trauma although, when discussing past trauma in all cases they emphasized that their experience of trauma could not compare to that of their clients trauma. When describing past trauma counseling professionals also explained they were not triggered by past trauma when working with clients. Glenda said, “I’ve had quite a bit of past trauma, but I have to say that I haven’t had a suicide assessment that has triggered any of that for me. Yeah. Most of my trauma was many years ago, many years of therapy later now, and
nothing that really came close” (Interview #3, January, 2015). Very few counseling professionals were triggered by past trauma and accessed support as needed. For example, Linda experienced past trauma of observing youth that were disregarded when they were clearly experiencing abuse. Linda expressed,

If I see a parent just saying, “Well, they’re just trying to get attention,” and just not listening, especially if they have all the qualifiers and that’s what the parent’s response is, that’s usually a big button-pusher for me. I’ll start leaving the room a lot to go talk to the supervisor, but it’s really just to take some air for a second. (Interview #8, January 2015).

In a few cases no symptoms of VT were reported as a result of this work. It was interesting to note, in three out of four cases the counseling professional with no reported symptoms of VT also had experienced a suicide and/or suicidal ideation either by a partner or close family member. Dunkley & Whelan, (2006b) asserted counseling professionals with higher trauma histories are positively correlated with symptoms of VT including PTSD. Alternatively, in the present study in a few instances the presence of no symptoms of VT was indicated. It was dually noted that those counseling professionals had also experienced a suicide and/or suicidal ideation by a close family member, partner or friend. Anita who had experienced the suicide of a partner stated,

No, I have really good boundaries and I have excellent self-care. I don’t—I mean, I think there’s always a client that comes home with you here and there, but, for me, that happens once or twice a year. It’s very rare (Interview #11, February, 2015).
Burnout was rarely mentioned. Many counseling professionals demonstrated when symptoms of VT manifested they were aware and knew how to access self-care to mitigate these symptoms of VT. Dora stated when referring to burnout, “I couldn’t deal with any more problems. Just taking some time off and doing some self-care, things that I enjoyed, processing a lot of what I was going through definitely helped” (Interview, January, 2015).

Neuman and Gamble (1995) affirm disruptions to a sense of safety, trust, esteem, and control can lead to VT. Bloom (2003) describes VT as an emotional contagion encompassing symptoms of VT that resemble PTSD. Even more disturbing, changes in worldview including identity, sense of safety, trust, self-esteem, intimacy and sense of control consist of the more potentially toxic aspects of VT. Alternatively, Hayes (2004) suggested counseling professional’s ability to have self-insight, self-integration, conceptual ability, empathy and manage anxiety facilitate the management of compassion fatigue. This research seeks to illuminate that some symptoms of VT were mentioned by the counseling professionals when conducting SA’s; however, the symptoms of VT appeared to be transient. Also, the counseling professionals in this study demonstrated tremendous insight recognizing VT and addressing any symptoms of VT. Awareness of when to access support when needed by the counseling professionals was also captured in this study. In sum, symptoms of VT were mentioned with less frequency than expected given the abundance of literature on VT associated with crisis counseling.

**Theme 5: Transcendent Growth Experiences**

For the purpose of this study Transcendent Growth Experiences for counseling professionals included increased awareness of the problems families and suicidal youth
encounter, the increased competence gained from conducting SA’s, parental growth, eliciting empathy and providing families and youth tangible resources. During the initial individual interviews parents were viewed primarily as contentious by the counseling professionals. However, equally important was to acknowledge how professionals reflected on being able to appreciate parents/ caregivers strengths. Herman (1998) maintained the experience of trauma could be disempowering and based on a disconnection from others. Thus, restoring the feeling of empowerment is associated with connection to others.

When describing transcendent growth experiences counseling professionals exhibited a greater awareness of the problems families encounter when confronting suicidal youth. In a naturalistic study conducted by Arnold et al. (2005) a participant stated, “I’m just more tolerant …I feel my tolerance for human frailty has increased…I just think my compassion has grown a lot from doing this work (p. 250).” Counseling professionals described being aware of the problems families face as an important aspect of this work. Jane stated,

I see more—people who have experienced more and deeper trauma than I would just…on a normal basis with the kind of clients that I treat. Just more severe, more—younger people experiencing things like sexual abuse and incest. Physical abuse and mental illness in the family. Domestic violence. Those kinds of things are more prevalent in the suicide risk assessment families I see versus the non-assessment work I do. That just broadens my perceptions about the kinds of suffering, the kinds of traumas that lots of young people are going through (Interview #13, February, 2015).
Also, the ability to assess suicide risk effectively increased the competence level for counseling professionals in this study. Greason and Cashwell (2009) affirm mastery experiences lead to counselor self-efficacy. By assessing so many youth and families SA was viewed as increasing counseling professional’s competency. Lisa said, “It’s (suicide) always alarming, but I feel like because I’ve done it for so long, I’m more equipped to deal with it and know what to say or how to assess for it” (Interview #1, January, 2015). Lazarus (1985) describes challenges versus perceived threats when one believes they have a sense of control reiterated through Rotter’s (1966) emphasis on internal locus versus external locus of control. Counseling professionals in the present study felt competent about conducting SA’s given their experiences and perceived support.

Despite parents initially presenting as a problem, some counseling professionals also enjoyed the capacity to observe parental growth. Steed and Downing (1998) acknowledged recognition of the enduring human spirit when counteracting tragedy contributed to posttraumatic growth. During the individual interviews parents/caregivers lack of involvement during the high-risk SA’s was viewed primarily as a challenge to counseling professionals. Subsequently, parental strength emerged as a developing theme during the focus group when parents also demonstrated caring and compassionate attitudes towards their youth. Providing tangible resources to youth and their families in a short-timeframe was vital. Empathy as a transcendent growth aspect of SA’s was added to the Focus group discussion. Hunter (2012) stated the therapeutic bond between counseling professionals and clients can be equally challenging and satisfying leading to ‘vicarious resilience’ to counterbalance hearing traumatic material. In the present study
the ability to provide empathy to clients was viewed as a transcendent aspect of this work.

Calhoun and Tedeschi, (1999) explained an important aspect of acquiring posttraumatic growth is eliciting increased levels of compassion and empathy. Glenda stated,

Yet, at the same time, I’ve been so impressed by many, many parents. Some of the parents are really wonderful and actually are quite attuned to their kids. I think that maybe it’s been a little surprising at how well some kids keep things hidden from their parents, although I probably shouldn’t be surprised because I was [laughter] a pro at that when I was young (Interview #3, January, 2015).

Arnold et al., (2005) found that by witnessing client growth counseling professionals could also experience posttraumatic growth. Regardless of parents/ caregivers being associated with challenges for counseling professionals, alternatively, parents could be described as resilient when encountering SA’s.

Jordan (2001) contends traditional theories are associated with clients gaining independence and moving towards autonomy. On the other hand, a relational cultural model emphasis on growth relates to providing empathic support at the root of the healing connection (Jordan, 2001). Providing empathy can also be viewed as a strength for counseling professionals. In terms of working with clients and the incorporation of empathy Glenda stated,

Well, I think it does alleviate stress in that if I’m doing an assessment with a family, and I can really connect with them, connect with the parent, connect with the child, I feel like they are really present to what’s going on, and my empathy is helping facilitate a change for them; there’s a certain amount of reward in that. A certain
amount of satisfaction. I think in that way it does reduce stress (Focus group #3, April, 2015).

Furthermore, empathy and altruistic inclinations may be intimately tied to posttraumatic experiences (Cohen, 2009). The utilization of empathy could cause challenges for counseling professionals when considering boundary violations yet, empathy may have also had a moderating effect of sustaining counseling professionals (Brockhouse et al., 2011; Linley, et al., 2003; Tedeschi & Calhoun, 2004). Hunter (2012) recognized counseling professionals viewed empathy as a basic component in the therapeutic bond. Linda said, “I think there’s more confidence in what you’re doing when you’re really successful at being empathetic with the client. I think you can really tell that you’re connecting with them. You have a little bit more confidence in the recommendations and the ratings you’re making” (Focus group #8, April, 2015). In sum, counseling professionals described the use of empathy as a transcendent growth experience.

Bell (2003) emphasized that maintaining the role of “helper” led to lower levels of stress among counseling professionals. Lisa asserted, “It’s exciting to see people that are struggling that didn’t have resources get to have those resources” (Interview #1, January, 2015). Providing accessible resources to youth and their families was positively affirmed by many of the counseling professionals in this study. Daisy said, “It’s really worth it to have the family come in because the parents really learn something about their kiddo, and they really want to do something about it” (Interview #5, January, 2015). Counseling professionals viewed the ability to provide resources to youth and families as a transcendent aspect of this work.
Cohen (2009) described counseling professionals experiencing vicarious trauma as alternatively, a precarious growth opportunity underlying a traumatic experience. Joseph and Linley (2008) asserted that positive accommodation of client trauma can be equated with growth whereas, negative accommodation with psychological distress. In conclusion, this study seeks to augment the growing area of research concerning posttraumatic growth experiences while working with traumatic material.

**Limitations**

This research provided a glimpse into the lives of counseling professionals conducting suicide risk assessments for youth within a particular time, setting, and place providing a unique service for youth and their families. The study was voluntary and the counseling professionals that chose to partake may not have been representative of the counseling professionals conducting SA’s. For example, the counseling professionals who ultimately participated in this study may have differed from those that chose not to participate. Through purposive sampling and by choosing a relatively balanced group of counseling professionals at the intern, new, mid, and advanced level of their counseling practice in addition to having differing theoretical and educational backgrounds the researcher sought to eliminate this bias. Due to the highly sensitive nature of this topic, counseling professionals may have chosen not to reveal certain aspects of their experiences including vicarious trauma and challenges in their work with SA’s. The study presented innate challenges for initially framing the research due to the complexities associated with suicide. The lack of significant research pertaining specifically to counseling professionals who conduct SA’s for youth and related VT and posttraumatic growth experience was initially challenging. Qualitative research seeks to
understand phenomena (Creswell, 2013) and does not always neatly lend itself to the traditional process of research because the data is integrative and emergent versus prescribed and methodical. For example, suspending all judgement is difficult when conducting a literature review. Also, being an emergent researcher poses some challenges utilizing a research protocol to outline the initial research questions. On the other hand, it is the researcher’s expectation that by choosing phenomenology and developing the subsequent themes, the study could lend itself to conceptualizing future research for counseling professionals conducting SA’s.

**Suggestions for Future Research**

A strength of phenomenology is the exploratory nature that captures many aspects of the participant’s experience. Thus, each theme presented in the study warrants further investigation. Utilizing grounded theory (Strauss & Corbin, 1997) there are several facets of this study I would choose to advance. For instance, I would examine the role of collegial support and the supervisory relationship both informally and formally in conducting SA’s to develop an effective supervision model. In addition, I would investigate how counseling professional’s worldview is modified towards parents contributing to VT or alternatively, posttraumatic growth. Surveying how worldview is influenced when conducting SA’s in a variety of settings could be important for discovering how to address and prevent VT among counseling professionals conducting SA’s. Arnold et al. (2005) emphasized that prior research has focused more on the negative sequelae versus the positive aspects of counseling professionals encountering trauma in their clients. Investigating how counseling professionals experience posttraumatic growth when confronted with SA’s warrants further consideration.
Particularly interesting was the presence of no symptoms of VT and the corresponding reports of experiencing a suicide or suicidal ideation with a close partner, family member or friend in three out of four cases. A study examining counseling professionals who have experienced suicide and how they may have developed subsequent coping strategies may reveal more in-depth findings. Furthermore, using a quantitative approach to measure transient symptoms of VT when conducting SA’s versus emphasizing enduring symptoms of VT could prove to add to current symptomology inventories. Expanding upon the role of empathy within the construct of posttraumatic growth and alternatively, including psychological numbing within the construct of VT would broaden the inquiry. Using a critical lens to examine how cultural factors contribute to counseling professionals perceptions when conducting SA’s merits further inquiry.

**Clinical Implications**

When accessing imminent harm for a client it is imperative to include debriefing, supervision and furthering educational opportunities (Kinzel & Nanson, 2000). When suicide risk assessments are major part of the counseling professionals work immediate supervision is essential. Therapeutic work environments can also foster a collegial atmosphere that supports counseling professionals given the oftentimes challenging work of conducting SA’s (Neumann and Gamble, 1995). When formal supervision opportunities are not available informal and peer-to peer meetings can be established to sustain counseling professionals (Wachter et al., 2008). Whether informally or formally counseling professionals need time to debrief given complex assessments and specifically, high-risk assessments. Clinical settings can also recognize that symptoms of VT albeit transient may interfere with a counseling professional’s ability to provide
quality care. Providing an organizational structure that allows counseling professionals to take on fewer caseloads and/or high-risk assessments as needed is an important consideration for designing programs. Rourke (2007) examining palliative care among pediatric care providers acknowledged that a respectful work culture could potentially contribute to managing VT. Particularly, for interns and new counseling professionals mentor relationships can be developed. According to Wachter et al. (2008) the identification of mistakes can result in teachable moments. A non-judgmental work culture that encourages the open dialogue amongst counseling professionals and supports self-care will not only individually sustain counseling professionals it also has the potential for improving the care clients receive. It is important to emphasize to counseling professionals that personal growth although, painful at times can lead to more meaning in their work. Last, eliciting feedback among counseling professionals in clinical settings, while continually, evaluating the challenges that they encounter can potentially lead to improved services.

Training Implications

The American Counseling Association (ACA, 2014) and associated bodies can continue to build support for collegial collaboration through conferences, training opportunities, and sub-committees that specifically address crisis care. Although at times described as “soft skills” in the counseling profession self-care vitally impacts the counseling professional’s ability to maintain composure faced with SA’s in youth. Self-care can be easily incorporated into the curriculum. Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) can consider augmenting existing training and supervision standards to include self-care and collegial
collaboration as a part of everyday practice. Faculty can communicate that collegial support and self-care is a necessity for sustainability in the field. Providing quality supervision experiences through training and internship experiences can enhance early successful experiences and provide a framework for counseling professionals to seek out these experiences in their future workplaces. The awareness that in order to do this work effectively while providing adequate empathy symptoms of VT such as, anxiety or compassion fatigue may surface. Pearlman and Saakvitne (1995) explain that although VT can include a host of symptoms of VT, alterations in worldview is one of the most disturbing aspects of VT. It is correspondingly important to recognize how these symptoms of VT can be mitigated and dealt with before they lead to permanent changes in worldview (McCann & Pearlman, 1990). Educational environments can foster open dialogues between counseling professionals for enhancing self-awareness. Recognizing the common challenges when working with suicidality in youth can lead to the alleviation of stress by revealing common patterns for early detection of VT. There is a growing body of research within the movement of Positive Psychology (Linley & Joseph, 2004; Seligman & Csikszentmihalyi, 2000; Snyder & Lopez, 2002) recognizing the positive psychological perspectives of posttraumatic stress leading to posttraumatic growth. Research addressing how posttraumatic growth experiences evolve in trauma work among counseling professionals can be included in future research.

Conclusions and Reflections

Coupled with the complex problem of suicide, evaluating familial dynamics and identifying subsequent resources counseling professionals may only have a brief opportunity to regain hope for the youth and the families they serve. Mitigating factors
of support including collegial, organizational, having supportive family, partners and friends in addition to the counseling professionals’ use of self-care was important to the counseling professionals in the present study. The supervisory relationship plays a vital role in addressing the immediate needs of the client and particularly important to high-risk assessments. Having diverse supervisors who provide a component of self-care to address the needs of the counselor is important. Symptoms of VT for counseling professionals may have been transient and counseling professionals acknowledged their trauma history could not compare to that of their clients. Although this work may include inherent inescapable challenges it is equally important to recognize the transcendent growth aspects of this work. The researcher anticipates that this study may contribute to a.) the importance of collegial and personal supports, b.) the necessity for self-care when conducting SA’s, c.) the essential role of the supervisory relationship in SA’s, d.) some of the inherent challenges and/or transient symptoms of VT one may experience, and e.) the transcendent growth aspects of this work. Future research can continue to explore the themes that emerged in this inquiry. Clinical and training implications can be addressed by the counseling profession to enhance counseling professionals’ ability to conduct SA’s for youth.

Ultimately, the researcher remains indebted to the counseling professionals who participated in this study providing their unique contributions to describe at times, a very challenging, and the equally rewarding experience of conducting SA’s for youth. It is the researcher’s sincere hope that by providing these experiences of counseling professionals conducting SA’s the counseling profession may continue to improve its practices to
prevent suicide in youth while at the same time providing compassionate care and renewed hope.
References


Blumenthal, S. J., & Kupfer, D. J. (1990). *Suicide over the life cycle: Risk factors,*


understanding the psychological effects of working with victims. *Journal of Traumatic Stress, 3*(1), 131-149.


Appendix A

Interview Questions

1.) What led you to your current role of conducting suicide risk assessments for youth?

2.) How have you informed or motivated your practice (education, training, experience)?

3.) Do you identify yourself with a particular theoretical orientation?

4.) What are your a.) greatest challenges in doing this work b.) greatest opportunities?

5.) Describe any symptoms of stress (anxiety, post-traumatic stress disorder/or work related/secondary stress) that you may have experienced as a result of conducting suicide risk assessments?

6.) Describe any symptoms of compassion fatigue and/or burnout resulting from this work if applicable?

7.) Have you experienced past trauma? If so please provide me with an example of when a suicide risk assessment may have triggered past traumas?

8.) How have your perceptions about children/families, and therapy changed after doing this work if they have changed?

9.) Describe any positive experiences you may have had resulting from this work?

10.) How has suicide risk assessment supervision (immediate/follow-up) played a role in processing your reactions and feelings when conducting suicide risk assessments if any?
11.) Do you receive routine supervision? Describe how supervision has or has not contributed to alleviating stress?

12.) Describe how organizational support has or has not contributed to alleviating stress?

14.) Describe some examples of self-care you have utilized to address your health and well-being?

15.) Describe any additional factors of support that you have utilized to assist yourself through the process.
Appendix B

Demographic Questionnaire:

1.) Age

2.) Gender (circle one)
   Male/Female/Transgender/Intersex

3.) Ethnicity (circle one)
   African American/Black Asian American Caucasian/White,
   Hispanic/Latina/Latino Native American Other: _______________________

4.) What is your educational background (highest degree attained)?
   Baccalaureate Degree
   Masters in Counseling
   Masters in Social Work
   Masters in Psychology
   Doctorate in Counseling
   Doctorate in Social Work
   Doctorate in Psychology
   Other
   Currently attaining degree:

5.) What is your current licensure/certification?
   LMHC
   LPCC
   LSW
   LAMFT
6.) How long have you been engaged in crisis work?

7.) How long have you been conducting suicide risk assessments for children?

8.) Approximately how many suicide risk assessments for children have you completed in the last year?
DATE: December 18, 2014
REFERENCE #: 22214
PROJECT TITLE: [685059-1] Counseling professionals conducting suicide risk assessments for youth
PI OF RECORD: Deborah Rifenbary, Ph.D.
SUBMISSION TYPE: New Project

BOARD DECISION: APPROVED
EFFECTIVE DATE: December 17, 2014
EXPIRATION DATE: December 16, 2015
REVIEW TYPE: Expedited Review
REVIEW CATEGORY: Expedited review category 6, 7
SUBPART DECISION: Not Applicable
PROJECT STATUS: Active - Open to Enrollment

DOCUMENTS: • Advertisement - Study announcement flyer/ email (UPDATED: 11/15/2014)
• Application Form - Project Information (UPDATED: 11/26/2014)
• Confidentiality/Non-Disclosure - Transcription (UPDATED: 11/15/2014)
• Consent Form - Consent (UPDATED: 11/15/2014)
• Letter - Agency Support (UPDATED: 11/15/2014)
• Other - Departmental Review Form (UPDATED: 11/20/2014)
• Protocol - Protocol (UPDATED: 11/20/2014)
• Questionnaire/Survey - Demographics questionnaire (UPDATED: 11/15/2014)
• Questionnaire/Survey - Interview questions (UPDATED: 11/15/2014)
• Training/Certification - Project Team (UPDATED: 11/15/2014)

Thank you for your submission of New Project materials for this project. The University of New Mexico (UNM) IRB Main Campus has APPROVED your submission. This approval is based on an appropriate risk/benefit ratio and a project design wherein the risks have been minimized. This determination applies only to the activities described in the submission and does not apply should any changes be made to these documents. If changes are being considered, it is the responsibility of the Principal Investigator to submit an amendment to this project for IRB review and receive IRB approval prior to implementing the changes. A change in the research may disqualify this research from the current review category.
The University of New Mexico (UNM) IRB Main Campus has determined the following:

Informed consent must be obtained and documentation of informed consent is required for this project. To obtain and document consent, use only approved and stamped consent document(s).

All reportable events must be promptly reported to the UNM IRB, including: UNANTICIPATED PROBLEMS involving risks to participants or others, SERIOUS adverse events, UNEXPECTED adverse events, NON-COMPLIANCE issues, and COMPLAINTS. All FDA and sponsor reporting requirements should also be followed.

The UNM IRB approved the project using Expedited procedures from December 17, 2014 to December 16, 2015 inclusive. A continuing review or closure submission is due no later than November 16, 2015.

It is the responsibility of the Principal Investigator to apply for continuing review and receive continuing approval for the duration of this project. If this project lapses past the expiration date, all research related activities must stop and further action may be required by the IRB.

Please use the appropriate reporting forms and procedures to request amendments, continuing review, closure, and reporting of events for this project.

Please note that all IRB records must be retained for a minimum of three years after the closure of this project.

The Office of the IRB can be contacted through: mail at MSC02 1665, 1 University of New Mexico, Albuquerque, NM 87131-0001; phone at 505.277.2644; email at irbmaincampus@unm.edu; or in-person at 1805 Sigma Chi Rd. NE, Albuquerque, NM 87106. You can also visit our website at irb.unm.edu.

Sincerely,
J. Scott Tonigan, PhD
IRB Chair
Appendix D

Email message

Greetings All,

Please find the following information and invitation to participate in the study I am conducting entitled, *Counseling professionals conducting suicide risk assessments for youth*. If you are a counseling professional including an intern who has completed 3 suicide risk assessments within the last year you are eligible to participate in this study.

Feel free to contact me if you are interested in participating in this study or if you have further questions. I can be reached by email or by phone. Thank you, -Christine

Email & Flyer

Introduction

The purpose of this study is to investigate counseling professionals experience of conducting suicide risk assessments for youth and what factors may support or impede them in their professional practice. Ultimately, by identifying themes that contribute to a counseling professionals background and experience in conducting suicide risk assessments for youth professional practices may be informed when providing this vital service.

What will happen if I decide to participate?

If you agree to participate, the following things will happen:

One in-depth, semi-structured interview will be the main source of data collection in this study which includes a follow-up focus group. The interview and focus group will last for up to one and a half hours maximum in duration. The interview and focus group will be audio recorded and transcribed by the co-investigator and/ or a professional transcription service.

For the present study two central questions are included:

1.) What are the lived experiences of counseling professionals conducting suicide risk assessments for youth?

2.) What are the circumstances in this counseling professional's life that have contributed to conducting suicide risk assessments?

Interview questions connecting to the two central questions will be included.
**How long will I be in this study?**

Participation in this study will take a maximum of 3 hours including interview and focus group participation.

**Eligibility:** Must have completed at least 3 suicide risk assessments within the last year.

**Confidentiality:** The agency receives a pseudonym for dissertation research and publication for scholarly purposes only. All participants will also receive a study id to protect participant confidentiality. Composite themes will be reported in a summary format for scholarly research and publication purposes only. If you wish to participate in IRB # (insert when applicable) in the research dissertation entitled, "Counseling professionals conducting suicide risk assessments for youth"

Please contact: The co-investigator, Christine Abassary, MA, MS, LMHC directly by phone: or email: for more information.
Appendix E

The University of New Mexico Consent to Participate in Research

October 22, 2014

Introduction

You are being asked to participate in a research study that is being done by Dr. Rifenbary, who is the Principal Investigator and Associate Dean of the College of Education and faculty from the Department of Counselor Education. This research is studying counseling professionals experience of conducting suicide risk assessments for youth including what factors may support or impede them in their professional practice.

You are being asked to participate in this study because you are a counseling professional who has conducted 3 suicide risk assessments for youth in the past year. Fifteen people will take part in this study located at (Vistas).

This form will explain the research study, and will also explain the possible risks as well as the possible benefits to you. We encourage you to talk with your family and friends before you decide to take part in this research study. If you have any questions, please ask one of the study investigators.

What will happen if I decide to participate?

If you agree to participate, the following things will happen:

One in-depth, semi-structured interview will be the main source of data collection in this study including a follow-up focus group with all participants. The interview and focus group will ask the same questions and will last for up to one and a half hours each in duration. The interview and focus group will be audio recorded and transcribed by the co-investigator and/ or a professional transcription service.

For the present study two central questions are included:

1.) What are the lived experiences of counseling professionals conducting suicide risk assessments for youth?

2.) What are the circumstances in this counseling professional’s life that have contributed to conducting suicide risk assessments?

Interview questions connecting to the two central questions will be included.

How long will I be in this study?

Participation in this study will take a total of 3 hours over a period of up to six months including two interviews (one individual interview and one follow-up focus group) for approximately up to one and a half hours each.
What are the risks or side effects of being in this study?

There are risks of stress, emotional distress, inconvenience and possible loss of privacy and confidentiality associated with participating in a research study.

For the Focus Group, there is a potential risk that information shared in the Focus Group might be disclosed by a member of that Focus Group to another audience. The possibility is out of the researcher’s control. However, participants will be encouraged to keep whatever is shared within the group stays within the group for purposes of the research study being conducted.

If any unintended psychological consequences should arise the contact information is provided to utilize at your discretion to obtain crisis or counseling referral information. Available 7 days a week 24 hours a day and website . You may also discuss any of your concerns with the study team members. For more information about risks and side effects, ask the investigator.

What are the benefits to being in this study?

There will be no benefit to you from participating in this study. However, it is hoped that information gained from this study will help inform counseling professional practices when providing suicide risk assessments for youth.

What other choices do I have if I do not want to be in this study?

You have the option not to take part in this study. There will be no penalties involved if you choose not to take part in this study.

How will my information be kept confidential?

We will take measures to protect the security of all your personal information, but we cannot guarantee confidentiality of all study data.

Information contained in your study records is used by study staff and, in some cases it will be shared with the sponsor of the study. The University of New Mexico Institutional Review Board (IRB) that oversees human subject research and/or other entities may be permitted to access your records. There may be times when we are required by law to share your information. Your name will not be used in any published reports about this study.

The agency will receive a pseudonym to protect confidentiality. The consent forms will be stored in a locked file cabinet only accessible by the co-investigator located at The University of New Mexico and destroyed 3 years following study closure. All electronic files will be stored and maintained by the co-investigator. The co-investigator will assign unique numerical study id’s to all participants at the beginning of the study. Study id’s will be stored on a separate electronic password-protected file and deleted at study
closure. Links to participants will be stored in a separate electronic password-protected file and deleted at the completion of the study. During transcription all identifiers will be removed by every possible effort by the co-investigator. Transcription will be stored in a separate electronic password-protected file only accessible by the co-investigator. The DE identified demographic questionnaire will be stored in a separate locked cabinet, only accessible by the co-investigator, and destroyed at the completion of the study. Recorders and USB’s will be stored in a separate locked cabinet only accessible by the co-investigator. Upon the closure of the study all recorded data will be permanently deleted. DE identified transcription will be destroyed after seven years following the completion of the study and stored on a separate password-protected file maintained by the co-investigator. Composite information will be shared with Vistas, and UNM faculty for dissertation and publication purposes only.

Finally, you should understand that the investigator is not prevented from taking steps, including reporting to authorities, to prevent serious harm of yourself or others.

*What are the costs of taking part in this study?*

**No Cost.**

*Will I be paid for taking part in this study?*

**No.**

*How will I know if you learn something new that may change my mind about participating?*

You will be informed of any significant new findings that become available during the course of the study, such as changes in the risks or benefits resulting from participating in the research or new alternatives to participation that might change your mind about participating.

*Can I stop being in the study once I begin?*

Your participation in this study is completely voluntary. You have the right to choose not to participate or to withdraw your participation at any point in this study without affecting your future health care or other services to which you are entitled.

*Whom can I call with questions or complaints about this study?*

If you have any questions, concerns or complaints at any time about the research study, contact the PI, Dr. Deborah Rifenbary at _ or the co-investigator Christine Abassary at _. 
If you need to contact someone after business hours or on weekends, please call and ask for Christine Abassary at _. If you would like to speak with someone other than the research team, you may call the UNM Office of the IRB at (505) 277-2644.

*Whom can I call with questions about my rights as a research participant?*

If you have questions regarding your rights as a research participant, you may call the UNM Office of the IRB (OIRB) at (505) 277-2644. The IRB is a group of people from UNM and the community who provide independent oversight of safety and ethical issues related to research involving human participants. For more information, you may also access the OIRB website at http://irb.unm.edu.
CONSENT AND AUTHORIZATION

You are making a decision whether to participate (or to have your child participate) in this study. Your signature below indicates that you/your child read the information provided (or the information was read to you/your child). By signing this consent form, you are not waiving any of your (your child's) legal rights as a research participant.

I have had an opportunity to ask questions and all questions have been answered to my satisfaction. By signing this consent form, I agree to participate (or let my child participate) in this study. A copy of this consent form will be provided to you.

________________________________________________________________________
Name of Adult Subject (print)

Signature of Adult Subject  Date

INVESTIGATOR SIGNATURE

I have explained the research to the participant and answered all of his/her questions. I believe that he/she understands the information described in this consent form and freely consents to participate.

________________________________________________________________________
Name of Investigator/ Study Team Member (print)

Signature of Investigator/ Study Team Member  Date