

A Crisis Responder's Experience with Youth Suicide:

A Self-Case Study Approach

by

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**Abstract**

The main goal of this research project was to explore the question “What is the crisis responder’s experience with youth suicide?” The primary researcher was a crisis responder who, over the course of seven years, worked in the field of crisis intervention and encountered situations involving youth suicidality. Research has shown that exposure to youth suicide can produce dramatic effects upon the perceptions and meaning of work for crisis responders. A self-case study approach based upon heuristic concepts and processes was utilized for the present study because a first-person account enabled the uncovering of phases of effects of exposure to suicidality, including immersion, incubation, and illumination. These phases were applied to clarify the nature of the lived experience of a crisis responder working in Manitoba, Canada on a mobile crisis team. Insight into the phenomenon was gained by synthesizing the personal experiences of being a crisis responder, and contextualizing it within the theoretical and empirical literature on exposure to suicidality. Based on current findings, directions for future research and implications for the professional development of crisis responder practitioners experiencing youth suicide were provided. The ramifications of long term service within this area were also explored.

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## Introduction

### *A Crisis Responder's Experience with Youth Suicide: A Self-Case Study Approach*

When a youth takes her or his own life, others are left with the memory of that young person's life and unfortunately her or his untimely death. Along with parents, other family members, and friends, there are also professional caregivers like crisis responders who are involved in the events surrounding the incident. A visit by the crisis response team is often precipitated by suicidal behaviours and this initiates each team member's own unique experience in knowing that youth. There is an abundance of research on the risk and protective factors precipitating youth suicide. This information is utilized by crisis responders when they assess the severity of risk of suicidality. Of main interest to the present study was the experience of the *crisis responder* with completed youth suicide.

While the literature on the risk and protective factors precipitating youth suicide attempts and completion is important, it is equally important to study the other side of the issue: we also need to study the consequences of continued exposure to life and death scenarios on those affected. Although research has addressed the impact of suicide upon family members, there is little information on the effects of exposure to suicide upon the front line responders involved (Isaak et al., 2009; Asarnow, Burke, & Baraff, 2009; Martin, Rotaries, & Pearce, 1995). The main goal of the present study was to address this gap in the research in order to better understand the experiences of crisis responders. This information may inform hiring, training, and retention of staff, as well as inform clinical practice through the promotion of healthy processing of these traumatic events.

In order to address this issue, relevant areas of the literature were reviewed, including: 1) the scope of the problem of youth suicide in Canada, 2) definitions of crisis responders, and their

role as it relates to youth suicide, 3) the extant literature pertaining to exposure to suicide in Canada and elsewhere, and 4) theoretical perspectives that provide a framework for understanding the experiences of crisis responders who are exposed to youth suicide. In sum, the current study addressed the central question of “What is the crisis responder’s experience with youth suicide?” The goal was to provide a rich, detailed and meaningful description of this experience, such that insights gained may be used to benefit crisis responders who are managing the effects of traumatic events in the workplace.

### **Review of the Literature**

#### **Prevalence of Youth Suicide**

Youth suicide is a serious problem in Canada; fully 24% of deaths among 15-24 years olds were attributed to suicide, making it the second leading cause of death for this age group (Health Canada, 2002). For adolescents, suicide is the second leading cause of death worldwide (World Health Organization, 2007). Global reports of the age distribution of suicide show a trend that completed suicides are happening at younger ages. Fifty years ago, those aged 5 to 44 accounted for 40 percent of completed suicides, but by the year 2000 this had increased to 55 percent (Canadian Mental Health Association, 2010).

This increase unfortunately does not depict the dramatic rise in adolescent suicide. Evidence from Canada confirms that the greatest increase in suicides occurred in the 15-to-19-year age group between 1960 and 1991, with a four-and-a-half-fold increase for males, and a three-fold increase for females (McNamee, McMaster, & Offord, 2010). Rates of suicide for the total population of young males and females in Canada are presented in Table 1 (see Appendix A1). Rates for Aboriginal males and females are included, and are strikingly higher than in the non-Aboriginal population.



As indicated by Langlois and Morrison (2002), males complete suicide at a rate four times higher than their female counterparts, as they often choose more lethal methods (Skinner & McFaull, 2012). Interestingly, females tend to attempt suicide at a rate of 1.5 times more often than males (Canadian Mental Health Association, 2010). Along with being male, being of Aboriginal descent is also a risk factor for youth suicide. According to MacNeil (2008); “Aboriginals in Canada have a suicide rate 3-4 times higher than non-Aboriginals” (p. 5). Each Aboriginal community has a different experience with the historical, cultural, sociological, and physical risk factors leading to variable suicide rates among communities. For example, in one Northwestern community of Ontario, the suicide rate of 470 deaths per 100,000 is one of the highest in the world (MacNeil, 2008). On the other hand, the suicide rate for the Inuit community of Davis Inlet Newfoundland is 178 per 100,000 (MacNeil, 2008). Some of these differences can be attributed to reporting differences and classification of the deaths.

Manitoba is one province that has startling cultural differences across youth suicide rates. Rather than being the second leading cause of mortality, suicide and self-injury is the leading cause of death for Aboriginal youth (Health Canada, First Nations Inuit Health Branch, 2003). Furthermore, compared to the general population, suicide for Aboriginal Peoples is three times higher than the remainder of the Canadian population (Royal Commission on Aboriginal Peoples, 1995). In a recent report on Aboriginal people living in Manitoba, one of the top three causes of death between 2000 and 2006 was suicide (Manitoba Aboriginal and Northern Affairs, 2012). Moreover, Aboriginal youth age 18 years and under accounted for more than half of the hospitalizations for attempted suicide for their age group between 1998 and 2008 (Manitoba Aboriginal and Northern Affairs, 2012). Similarly, between the years of 1997 and 2006, those age 10 years and up of Metis origin, completed suicide and attempted suicide at a higher rate

than other Manitobans (Manitoba Aboriginal and Northern Affairs, 2012). Table 2 shows the staggering evidence of disproportion in suicide rates between Aboriginal people and non-Aboriginal people in Manitoba (see Appendix A2). Furthermore, there is major disproportion in the Aboriginal community between those living on and off reserve. Unfortunately, data for more recent suicide trends is not available due to ownership and autonomy issues over health information for Aboriginal regions (Aboriginal Healing Foundation, 2007).

### **Youth Suicide Risk Factors**

While the main purpose of this study was to explore a crisis responder's experiences with youth suicide, a brief overview of the risk factors for youth suicide is relevant to understand both the scope of the problem and the breadth of assessment that is necessary for effective crisis response. Youth suicide is a complex issue; although there are standard assessments, people may not exhibit all signs and symptoms related to suicide. Furthermore, some people who commit suicide may not have been exposed to the common risks. The common precursors to suicide in youth are outlined below in order to provide background for the crisis responder's experience with youth suicide.

Ethno-cultural background is one major risk factor, especially in Manitoba. Mignone and O'Neil (2005) studied three First Nation communities in Manitoba and emphasized that adolescents and young adults were at particular risk of suicide due to their own uncertainty about their future. Similarly, whole communities were impacted by the loss of Aboriginal culture which has been passed on from generation to generation (Aboriginal Healing Foundation, 2004). The elders of Aboriginal communities strongly believe that this trauma has not been properly addressed and continues to plague their children (Mignone and O'Neil, 2005). Sadly, loss of culture and uncertainty about their future as an Aboriginal youth appear to be contributing

factors toward this cultural pre-disposition for suicide.

Likewise, family mental illness has long been recognized as a contributing risk factor to a suicide pattern in youth. Specifically, youth are at greater risk of suicide if one or more members of the family have a history of symptoms of depression, suicidal behaviors, or completed suicide (Blumenthal, 1990; Kostenuik & Ratnapalan, 2010). As Kuramoto, Brent, and Wilcox (2009) explained, a child's life is majorly disrupted, having profound negative developmental implications, when a parent commits suicide. Similar to other profound disturbances in the primary support group, like family violence, it is not difficult to see how grieving the loss of a significant family member can impact a child's development and outlook on life.

Other risk factors associated with youth suicide are mental illness and substance use. Tomlinson and colleagues (2004) purported that young people struggling with psychiatric symptoms are more vulnerable to using substances. This in turn affects their overall ability to cope with age-related stressors, which results in an increased risk for suicidal behaviors (Ramey et al., 2010). Mental illness and substance use are commonly co-occurring risk factors that adversely affect healthy participation in activities of daily living. Together, they serve to compound each other leading youth towards hopelessness and depression (Ramey et al., 2010).

Hawkins (2009) asserted that youth with co-occurring disorders are more difficult to be treated as they are at a higher risk for suicide and other difficulties, such as incarceration. In the past it has been common practice for youth-oriented treatment programs to treat mental illness alone without addressing substance use disorders (Cherry, 2008; Hawkins, 2009). Similarly, addiction services are inadequately prepared to address mental health problems due to the same clinical reasons, such as training of staff in one stream of treatment only, as well as barriers to funding and policy barriers (Cherry, 2008; Hawkins, 2009).

Personality disorders are another risk factor for youth suicide attempts and unintentional or determined suicides. Although personality disorders tend to develop during adolescence and are more widely diagnosed in early adulthood, the personality traits associated with borderline personality disorder-cluster b traits, alert clinicians to a suicide pattern with self-harm behaviours (Links, Gould, & Ratnayake, 2003). Indeed, family, school, peers, and other referral sources ask professional caregivers to intervene with individuals with such personality traits to prevent ongoing suicidal behaviour and promote healthier coping skills.

Other research has focused on gender and sexual orientation as risk factors that place LGBTQ\* (Lesbian, Gay, Bi-sexual, Transgender, & Queer) youth at greater risk for suicidal behaviours. Research indicates that it is more likely environmental factors such as stigma and discrimination that lead to low self-esteem and social isolation rather than “being homosexual” (Proctor & Groze, 1994). The risk of suicide is one among many concerns affecting the health of Canada's LGBTQ\* youth (Saewyc, Poon, Homma, & Skay, 2008).

In summary, the most considerable risk factors for youth suicide are mental illness and family history of suicide, substance use, male gender, sexual orientation, Aboriginal heritage and previous suicide attempts. Estimating the risk of suicide for individual youth involves a cautious evaluation of these risk factors, and as well as protective factors [spiritual beliefs, external resources] that correspond with an appropriate treatment plan (Canadian Mental Health Association, 2010). Undeniably, the clinician's job is a difficult one\ but it is often guided using a comprehensive assessment tool selected to meet the specific needs of the program for which she or he works. Despite these comprehensive assessment tools, the final outcome relies heavily on the crisis responder's judgment and experience.

### **The Role of Crisis Responders**

Crisis responders are part of an integrated team of professionals with various educational backgrounds who respond to youth and their families in the community experiencing immediate concerns related to mental health and addiction. Nelson, Johnson, and Bebbington (2009) defined crisis responders as those “dedicated to providing short term intensive home treatment for people presenting in acute psychiatric emergencies” (p. 541). Likewise, the majority of most mobile crisis teams in Canada support people in their community with a wide range of social and health crisis and emergency intervention services 24 hours a day (Manitoba Health, Regional Health Authorities, 2006; Canadian Association for Suicide Prevention, 2012).

While these definitions provide an overview of crisis response, it is important to note that the primary purpose of the crisis responder is assessment and development of an appropriate treatment plan that may include home treatment or necessitate removal from the home. That is, the crisis responder must quickly develop a suitable treatment plan in response to an emergency situation, based on her or his experience. The majority of referrals made to the crisis response team are known to have several substantial risk factors, so the context and presentation of the symptoms have more bearing on the treatment proposal than the presence of risk factors alone.

Typically, the bulk of training and practice for crisis responders focuses on youth suicide prevention. Crisis responders are trained to perform clinical assessments which include identifying any symptoms of mental illness as well as evidence of substance use, as these factors can increase the likelihood of suicidal behaviours (Manitoba Health and Addictions Policy, Program and Agency Relations Branch, 2005). In reality, many professionals are involved in the process of managing, educating, and treating youth that present with suicidal behaviours. The burden of assessing for these risk factors and implementing an achievable plan for reducing the

immediate risk of suicide often lies solely with the crisis response team. If a youth has completed suicide, the crisis response team can be utilized to support family or friends related to the victim. Thus the crisis response team is available for the prevention of youth suicide, which is often related to suicidal behaviours and attempts, as well post suicide events.

In 2006, a framework for suicide prevention was introduced in Manitoba which employed an inter-disciplinary or inter-jurisdictional approach to appreciating the crisis response team within a larger system (Manitoba Health, Regional Health Authorities, 2006). One goal of the program was to promote the idea that suicidal youth come into contact with professionals from a variety of different disciplines. The crisis responder often intervenes at a time when the stress is perceived to be high and the need for intervention immediate; she or he may feel that she or he represents all disciplines and jurisdictions that have been involved until the suicidality is perceived as acute.

Mobile crisis or urgent response teams are available across the provinces of Canada and provide support for mental health crisis intervention and follow-up (Macdonald Youth Services, 2010). These teams provide intervention and onsite therapeutic assessment for a variety of reasons, including suicide related services. In addition to helping bring crisis situations back to equilibrium, they determine if the situation is an immediate psychiatric emergency requiring emergency medical services, police, or hospital attention (Mental Health Mobile Crisis Team, 2010). They are often the first to arrive on scene and are responsible for decisions related to the coordination of care and the identification, and addressing, of unmet needs (Manitoba Health, Regional Health Authorities, 2006).

**Demands of the Role.** Because of the high demands placed on crisis response teams to resolve crises or psychiatric emergencies, there is a potential for feelings of low personal

accomplishment among the staff. In addition, staff may experience emotional exhaustion or feeling drained and used up (Maslach, 1982). Eventually, staff members begin to detach from others or take on an indifferent attitude. This is called *Depersonalization* or *Burnout* (Maslach, 1982). All of these symptoms may contribute to poor work performance, such as absenteeism, hostile and critical interactions with others, and “doing the bare minimum” (Maslach, 1982).

Most documentation from the crisis intervention perspective focuses on “the role” of the crisis intervener. That is, the available documentation describes techniques the clinician should follow, such as “active listening...asking open ended questions” (Roberts, 2000, p. 352). It is unclear what the clinician is actually feeling or how he or she is coping as the literature tends only to give a script on appropriate skills and interviewing techniques. It is difficult to use this documentation in ascertaining the actual feelings of the clinician based on communication techniques as they are devised to maintain objectivity. Client-focused therapies discourage clinicians from using any of their own personal reactions which may judge the client and interfere with the therapeutic process. While this is important for the crisis responder to address the crisis in the moment, it ignores the overall impact of the necessity to accept the complex emotions associated with suicide.

Is it the case, then, that an essentially healthy therapeutic process is akin to the crisis responder wearing a mask for concealing personal emotions and her or his own reactions? At what point and with whom does the crisis responder remove the mask? Due to patient confidentiality, often the closest support system surrounding the suicide consists of family members who are not appropriate resources for the responder for obvious reasons. The professional mask worn during the resolution of the crisis continues as colleagues speak with a professional voice to document the events. In a fast-paced setting where new crises arise at any

moment, where does the reaction get addressed, if at all? Even in an environment where they do let loose, co-workers may not be appropriately trained to respond or resolve stress reactions. Gallows humour, and the use of disrespectful language toward the clients they serve are regarded as inappropriate types of coping strategies (Maxwell, 2003).

Explorations into the role of management on the wellness of staff working in similar conditions of crisis response remain speculative. The inter-relatedness of general emotional wellness of workers and their perceptions of a supportive environment depends on many different elements in the workplace. Other considerations, such as job demands or resources, shape the atmosphere encountered by an employee each day. Moreover, this environment is largely co-created by all team members. It is unclear what the exact impact only management has on the personal experiences of workers (Laschinger & Finegan, 2005; Van Bogaert et al., 2009; Laschinger et al., 2001; Kramer & Schmalenberg, 2008).

### **Vicarious Trauma of Crisis Responders**

The symptoms described above resonate with a term known as vicarious trauma; experiences can be contagious whereby the client's traumatic experience is transmitted to the therapist (Pross & Schweitzer, 2010). In terms of the literature, vicarious trauma is often discussed in a disaster response setting and the reaction of humanitarian workers. Crisis responders can be seen as doing work similar to humanitarian workers, but in a local setting that is not characterized by war or natural disaster.

Consider the experiences of the Project Liberty Crisis Counselors in the Bronx connected with 9/11 recovery programs. Nine crisis counselors participated in focus group interviews resulting in five themes which represented their experiences on implementation of the recovery program (Moynihan, Levine, & Rodriguez, 2005). One respondent stated "I sort of sense that



even myself as a clinician working in social service agencies we were not allowed to respond when that tragic thing happened” (Moynihan et al., 2005, p. 669).

This qualitative study is a good example of the exploration of the view of the crisis counselors with regards to burdens of care. One theme was described as “9/11 as a socially acceptable way to express symptoms of psychological distress” (Moynihan et al., 2005, p. 670). While this related more to the counselor's view of clients using the service to address chronic emotional issues under the pretext of the 9/11 tragedy, it speaks to disaster response as a departure from the normal everyday, thus garnering awareness and public sympathy. Disaster response usually implies a group of vulnerable people in an exceptional circumstance. Crisis response workers continually witness other people's suffering and needs in marginalized populations that are often hidden from society's view and stigmatized.

Very little research to date has assessed the impacts of crisis response work on those who choose this profession. In contrast, there has been extensive research on the stresses of work in the nursing field and some on disaster relief workers. For example, Nelson and colleagues (2009) indicated that “there are no published data regarding the morale of staff working in [Crisis Response Teams]” (p. 542). They used questionnaires to explore reasons for burnout, satisfaction, and stress for crisis response teams, outreach, and community mental health staff. They found the crisis response team model to be “reasonably agreeable in terms of staff experiences” and showed moderate satisfaction without showing high burnout (Nelson et al., 2009, p. 548). This was based on scores on quantitative measures, such as the Maslach Burn-out Inventory along with the Minnesota Satisfaction Scale and two other job surveys (Nelson et al., 2009, p. 542-543).

While this research was pertinent and important, it was limited in that respondents were constricted to the choices on those particular questionnaires. Furthermore, it was unclear if there were statistically significant differences in the responses based on demographic factors. These limitations highlight the importance of using other methodologies, such as qualitative analysis, that would provide a more in-depth understanding of how to support safe work environments for crisis responders.

Trauma-related research has focused on “secondary traumatic stress” as an occupational hazard for the professional working within an emotionally demanding environment. The term “secondary traumatic stress” describes the likelihood that those working in a therapeutic role and exposing themselves to the trauma of others will experience a change in their own psychological functioning (Chrestman, 1995). Likewise, “Compassion Fatigue” is described as “a state of exhaustion and dysfunction-biologically, psychologically, and socially-a result of prolonged exposure to compassion stress” (Figley, 1995, p. 253).

One theme that is common throughout each of the above noted syndromes is that professionals who work closely with clients experiencing serious emotional suffering may, in turn, find themselves experiencing similar symptoms of negative emotional suffering (Figley, 1995, p. 253). These terms are used interchangeably to describe the experiences of counsellors, disaster relief workers, nurses and other health professionals. Unfortunately, it is currently not known how crisis responders deal with similarly traumatic situations such as youth suicide. The experiences of crisis responders are virtually over-looked in trauma-related research or traumatology (Nelson et al., 2009; Elwood, Mott, Lohr, & Galovski, 2010).

Related research on other helping professionals, such as nurses, can be useful in hypothesizing about possible effects of youth suicide work for crisis responders. Although most

nursing research indicates a high burnout rate and compassion fatigue, one example highlighted the positive outcomes of doing such work (Chris & Adbayo, 2010; Yoder, 2010). For example, Moustakas (1994) drew upon an example of grounded theory research which is “unraveling the elements of experience...to understand the nature and meaning of an experience for a particular group of people in a particular setting” (p. 4).

Montgomery (as cited in Moustakas, 1994) studied the care-giving relationship between nurses working as psychiatric/mental health consultants in hospital settings and their clients. In this study, 35 nurses were interviewed and asked about experiences that stood out for them. This sample was selected because they had a caring reputation for their clients. The results indicated the theme that caring was associated with “profound fulfillment and growth rather than burnout” (as cited in Moustakas, 1994, p. 7).

While this is a good beginning into exploring the nature of nurses' own reflective process instead of their attitudes toward their patients, it may prevent new insight toward improving actual clinical practice. In order to access more common feelings of nurses or other professional caregivers, a general sample of nurses may provide a better understanding of the intimate nature of their work, instead of being selected because they were considered particularly caring people. In particular, the complexity of nursing attitudes cannot be captured with predetermined expectations; they were given limited opportunity to envisage any ambivalence beyond either being profoundly fulfilled or burnt-out.

In an effort to explore ways to retain physicians, six family physicians were interviewed regarding their lived experience with patient death (Cave, Kuhl, Pearson, & Whitehead, 2011). The themes indicate how physicians cope with patients suffering and death. Specifically, “iatrogenic suffering” actions by health care professionals adversely affecting patients were

identified by both patients and physician and evidenced by the following quotes: One patient stated, "The way in which the doctor talked with me caused me more pain than from the disease itself" (Cave et al., 2011 p. 22). A doctor related, "The terror of how deeply responsible I felt to be competent in that moment...is so overwhelming that I wasn't sure if I could go on" (Cave et al., 2011, p. 28). The delicate balance for physicians to manage personal feelings and professional responsibilities may be analogous to the experiences of crisis responders in an emergency situation.

Research about nurses and other health professionals is more common than investigations related to crisis staff (McCaughey, Delligraine, McGhan, & Bruning, 2012). Additionally, nurses are historically and traditionally viewed as professional caregivers. As a result, there is a huge body of research about job satisfaction and burnout, while in other more recently identified professions such as crisis work, there has not been a similar initiative to understand what keeps people healthy and working.

In summary, this review showed that there is clear value in revealing the experiences of a variety of care giving professionals. In particular, there is a striking need to examine the experiences of crisis responders, separate from nursing and disaster response. In-depth insight into their experiences may help to produce useful solutions for crisis responders in the form of training, administration, and government policies that affect health and safety for this type of work. Drawing upon the literature describing similar experiences of nurses and disaster response workers may help to illuminate the lived experience of crisis responders exposed to youth suicide.

### **Theoretical Frameworks**

The experience of crisis responders is an emerging area of interest in the field of crisis intervention. Given the probable risk factors for crisis responders described above, the following theoretical frameworks have been selected within which to understand their perceptions of coping with youth suicide. These frameworks include; *Caregiver Strain*, *Demand-Control-Support Model*, *Job Strain Model*, and *Constructivist Self-Development Theory*. Each is discussed in detail below.

#### **Caregiver Strain**

Caregiver strain refers to the conflicted feelings which are experienced by those who take on the responsibility of the daily care of an ailing family member (Phillips, Gallagher, Hunt, Der, & Carroll, 2009). Symptoms like stress, exhaustion and feeling overwhelmed, as well as anxiety can emerge over time (Phillips et al., 2009). Certainly, taking care of a loved one can be stressful in emotional, physical, and financial ways for the family caregiver. Professional caregivers work in a trained capacity, and provide paid care for others without the added emotional burden of having an intimate relationship with their client. In contrast, family members may not be fully equipped to take on all that is involved with caring for their relative.

Most research to date focuses on the consequences of youth suicidality for their direct family caregivers, such as parents, rather than on youth crisis workers (Barksdale, Walrath, Compton, & Goldston, 2009). While this is an important contribution to the phenomenon of youth suicide, a complete picture requires an understanding of how crisis responders process and make meaning of their involvement. Direct family caregivers can resort to remembering positive memories that elicit caring and sadness as part of their grieving, whereas a crisis responder is limited by a shorter and more professional relationship. The very nature of this relationship may

prevent the crisis responder from accessing a healthy grief associated with care (Wagner, Aiken, Mullaley, & Tobin, 2000).

Although professional caregivers are guided by many program rules and limitations around the nature of services provided, the scope of practice for the crisis responder in the field must include flexibility with regard to effective physical and emotional interventions. As stated previously, most crisis teams are transdisciplinary and encourage workers to draw from a variety of resources among themselves to effectively resolve a crisis situation. However, the main focus of the team remains on how they must work together to mediate a process of relief for their client(s). Currently there is no opportunity for an exchange of mutual support or emotional care giving for each other during a youth suicide incident; perhaps more importantly, responders are not provided with resources to offset their own potential stress.

Caregiver strain may be difficult for those in the field to fully accept as a theoretical model applicable to research on crisis responder experiences. Crisis responders themselves may prefer to see themselves as providing care rather than being in need of it. A family member providing care for another family member may not have the same choice, and may therefore see their role differently. All of the strain symptoms and phenomena that apply to family caregivers may well also occur for crisis responders. However, the caregiver strain model alone is not an ideal fit to examine the crisis responder experience because of the imbalance of power inherent in the professional nature of the crisis responder and client relationship. While this theory is very relevant with regards to the symptoms of caregiver strain, other theoretical approaches are also needed to more accurately capture the crisis responder experience.

### **Demand-Control-Support Model**

The Demand-Control-Support model originated from the Job Strain Model, which is

related to human service work in general (Nelson et al., 2009). It describes “psychological strain in the work place” derived from patient-centered characteristics (such as suicidal or violent patients), job demands, and job control (Nelson et al., 2009, p. 542). Job control can be described as control over what tasks to complete first and how to go about completing those tasks (Tansey et al., 2004).

This model is pertinent to understanding the experiences of crisis responders in a situation of youth suicide because job demands are higher than normal, and control over events as they unfold may be limited or nonexistent. The job demands of the crisis responder are high because the well-being and life of a youth and their family is in their hands. The control is minimal because self-injurious acts may have already occurred and ultimately the crisis responder cannot act for that person despite their best efforts to intervene.

In addition to considering the demands of the job and a person's control in that job, the Demand-Control-Support Model also considers social support or levels of support within the team as an important factor of job strain (Karasek, 1979; Johnson & Hall, 1988). That is to say, in considering the experiences of a crisis responder in the context of youth suicide, this theoretical model emphasized that it may be very important to understand how social supports may mediate the effects of a high demands and low control situation such as youth suicide.

### **Constructivist Self-Development Theory**

Constructivist Self-Development Theory (CSDT) has been useful in the investigation of vicarious traumatization (Dunkley & Whelan, 2006; McCann & Pearlman, 1990). This approach “views the unique impact of trauma as arising from an interaction of aspects of the event that are psychologically meaningful to the individual with aspects of the individual, including his or her psychological resources, defenses, and needs” (McCann & Pearlman, 1990, p. 8). Subsequently,

the person's view of the world is altered with respect to their psychological needs concerning their safety, esteem, intimacy, trust and control. Survivors of traumatic events are often screened and may be treated for Posttraumatic Stress Disorder (PTSD). Symptoms include difficulties with concentrating and sleeping, withdrawing from normal daily activities, and becoming easily startled, among others (Elwood et al., 2011).

Crisis responders are frequently exposed to traumatic events and may be vulnerable to developing problems with their own security as their understanding of life is altered by witnessing the despair of others. The pressures of clinical work begin to construct a new reality for the crisis worker which can impact her or his life even away from the work environment. Their complex work role require that they be fully engaged, and able to quickly absorb detailed information on the presenting crisis, in order to better assist their client in coping through their ordeal. Like a "shell-shocked" war veteran suffering from PTSD, doing crisis work can result in similar harmful outcomes.

Constructivist Self-Development Theory (CSDT) is well-suited to understanding the experiences of crisis response workers in the context of youth suicide. It provides a framework in which to examine the specific ways in which these experiences have affected the psychosocial well-being and job-related performance of crisis responders. For example, CSDT may be most useful for understanding the possible cumulative negative effect of vicarious trauma on responder's views of safety, esteem, intimacy, trust, and control.

In summary, the innovative interdisciplinary combination of a caregiver strain approach, the demand-control-support model and CSDT may help to provide a better understanding of how potential burnout, emotional exhaustion, and disconnect from others in the form of decreased empathy toward clients stems from continued exposure to traumatic events (Elwood et al., 2011).



A combination of these theoretical frameworks will be used to explain and understand the experiences of youth suicide crisis workers in the present study.

### **The Present Study**

The main goal of the present study was to provide an in-depth, rich and meaningful description of the lived experience of crisis responder encounters with youth suicide. This is a first step towards bringing the subject to the forefront and filling the gap in current research that tends to focus more on the coping of the family caregiver experiencing youth suicide.

Unfortunately, current research on the experience of professionals exposed to traumatic events is mainly concerned with nurses or disaster response workers. By identifying how youth suicide influences crisis response work, it is hoped that the safety and well-being of both professionals and clients will ultimately be enhanced. Taking a heuristic approach challenges the researcher to investigate meaning in everyday life experiences while communicating their significance through the synthesis of themes. With extensive experiences as a crisis responder to youth suicide, a self-case study can produce valuable insights and may add depth to a more general understanding of the phenomenon (Stake, 1995).

As principal investigator of this project, I concentrated on one central question as my main research instrument: "What was my lived experience with youth suicide as a crisis responder?" Using self-inquiry, and considering myself as the case or the unit of analysis, I proceeded with an intrinsic case study approach into this phenomenon moving through a chain of experiences all related to that one central question (Stake, 1995). Reflecting on my own experiences, I endeavoured through a personal transformation in relation to the original question.

In doing so, I could not reduce the potential for the research to be regarded as an instrumental case study in addition to its unique intrinsic nature (Stake, 1995). The realm of

possibilities for this type of research grew to include ideas for improved practice and/or policy. Using myself as the case study, I was also able to illuminate the issue of crisis response and youth suicide, along with substantiating the reason I delved into the research to begin with.

I initiated a course toward exploring the nature of my experiences of youth suicide, looking at events which occurred even before my career in crisis response began. I committed to following the disciplined steps involved in heuristic inquiry such that I could attain a new awareness of the central issue. I gathered, organized and generated data using the research instruments of my personal journals, memories of youth suicide and other events, information obtained from the media, music, and observations of interactions with others to provide a composite, rich, detailed and meaningful description of the phenomenon.

Questions I asked myself while reviewing this material included, but were not limited to, "Were there similarities or differences in how I was feeling during different youth suicide events, and between my emotions and those of my co-workers? Were there similarities or differences in what I was thinking during different youth suicide events, and between my perspectives on these events and my co-workers' perspectives? Were there similarities or differences in what I did during these different suicide events, and between my behaviours and my co-workers' behaviours?" The contexts of work and family played an important role in these experiences, and descriptions of these people and events are included where appropriate.

The participant in a self-case study design is not anonymous; as the primary researcher, I agreed to waive my anonymity by undertaking this project and by signing the informed consent form. The fundamental nature of the heuristics approach is self-disclosure and transformation through the sharing of insight. To protect the confidentiality of the completed suicide cases that influenced this process, and to protect the confidentiality of co-workers who participated in these

cases with me, no private health information regarding any past or current patients who have completed suicide or their families were reported in the study. Additionally, no identifying information regarding any co-workers was included.

### **Methods and Procedures**

Moustakas (1990) maintains heuristics “is a way of scientific search through methods and processes aimed at discovery” (p.15). During my own journey to discover “what was my experience with youth suicide as a crisis responder”, I began to anticipate how I might carry out a heuristic research study for my graduate thesis question. Over a period of two years, I imagined using a sample of four crisis responders who had experienced youth suicide during their time working with a mobile crisis team in Canada. I considered conducting face to face interviews using a topical guide with specific questions (see Appendix B) and probing the participants further as needed during the interview. Insight into the research question would appear by synthesizing my very personal experience of being a crisis responder along with those of the participants or as the heuristic method describes them “co-researchers” (Moustakas, 1990, p. 34).

The main question aligned with heuristic concepts and processes was “As a crisis responder, what was your experience with youth suicide?” The study would have aimed to illuminate the ramifications of working long term within this service area. Instead, while I continued working in the field, learning more about suicide and the population I served, I began to reflect more on my own experiences realizing that I had more to share about this phenomenon as part of producing a thesis. The research idea became much more reflective, in that I felt that I had to first better understand myself before I could conduct truly meaningful interviews with others.

Through self-inquiry, and being open to full immersion into this question, I undertook an

analysis and synthesis of my own journals, information obtained from the media, memories of certain events, dreams, music, and observations of interactions with others to provide a composite rich, detailed and meaningful description of the phenomenon. The resulting themes reflected an expression of my own personal transformation and understanding of the original question and a direct result of the heuristic journey. As Douglass & Moustakas (1985) explained, "At the heart of heuristics lies an emphasis on disclosing the self as a way of facilitating disclosure from others-a response to the tacit dimension within oneself sparks a similar call from others (p.50). It is important to note that these personal experiences took place within a "bounded system" that included my coworkers and family environment. In order to better understand my journey, I have described these contexts where appropriate, and explained how and why they have shaped knowledge that was surfaced for me and where my journey led.

I followed the six phases of heuristic inquiry, which provided a comprehensive framework designed to capture the essence of a lived experience. In the *Initial Engagement* phase, the primary researcher has a profound personal pre-occupation with a particular subject matter having experienced it herself. This is followed by *Immersion* into the topic whereby the researcher is totally engaged in the phenomenon, actively searching for material wherever it arises via experiences in everyday life, the media, or art, for example. Throughout the first two phases, self-dialogue is essential to the heuristic inquiry. In Heuristics, self-dialogue is the beginning of generating data; an honest disclosure of one's own unique experience in order to begin exposing the phenomenon.

After allowing oneself to be immersed in the subject matter, the researcher experiences *Incubation*. Here, the researcher retreats from the material in an effort to expand her awareness of it; like lying down to sleep at night and suddenly recalling that detail that evaded you earlier in

the day. Next, the phase of *Illumination* allows for the incorporation of images and ideas to materialize insights regarding the resolution of the question. While *Illumination* allows for themes to begin developing, *Explication* involves a more detailed portrayal of the phenomenon so that, finally, a culmination of the research in a *Creative Synthesis* is possible (Moustakas, 1990, p. 27). While *Explication* is considered to be a phase, it is a point where the final themes are represented by the completion of the project. Likewise, the document as a whole represents the creative synthesis and the totality of the journey as expressed in written form.

In an effort to begin assembling all available material and experiences, the researcher draws on concepts and processes that inspire all heuristic research. Polany's (1983) term "tacit knowing" is a concept allowing the researcher to draw from a range of possibilities in carrying out the methodology (as cited in Moustakas, 1990, p. 20). Following the tacit dimension is the concept of intuition, necessary for uncovering the patterns that will eventually help in realizing the phenomenon. Moustakas (1990) clarifies "At every step along the way, the heuristic researcher exercises intuitive clues and make necessary shifts in method procedure, direction, and understanding which will add depth, substance, and essential meanings to the discovery process" (p. 23).

The researcher is also compelled to use a process of indwelling or inner reflection that leads to new meaning. Modification occurs to previous thoughts and patterns which are discarded, making room for new awareness into the phenomenon. This particular practice of turning inward is recommended during the illumination phase moving into explication of the core themes (Moustakas, 1990). However, it is also vital throughout all stages of the inquiry, especially in *Immersion*, for example, when journaling about the phenomenon. Douglass and Moustakas (1985) affirm, "In actually obtaining data, the tacit dimension is the forerunner of

inference and intuition, guiding the person to untapped aspects of awareness in nonlinear ways that elude analysis and explanation” (p. 49).

Following and using these concepts and processes of Heuristics, I developed an internal frame of reference to relate to others. Moreover, I then developed a creative synthesis, in which my journey from initial engagement to explication can be followed by another who has not yet experienced the phenomenon for her or himself.

### **Validation of Heuristic Research**

In heuristic research the validation of the results is not quantified or statistically measured. When co-researchers are involved, there is a process of validation through conversation and feedback regarding the conclusions and themes developed. In the present study I was the sole researcher, and thoroughly utilized the phases of heuristics to most accurately describe the experiences and phenomenon in question. Moustakas (1994) asserts, “However much we may want to know things with certainty and however much we may count on others’ experience to validate our own, in the end only self-evident knowledge enables us to communicate knowingly with each other” (p.58).

While forming the total creative synthesis to share results, it was necessary for me to maintain the openness and disclosure necessary for an accurate internal frame of reference. My processes of explication included anticipating questions from others reading my synthesis and taking into account other perspectives which entail a level of inter-subjectivity. Inter-subjectivity is defined as “In the back and forth of social interaction the challenge is to discover what is really true of the phenomena of interpersonal knowledge and experiences” (Moustakas, 1990, p. 57).

While there are reasonable limitations to any research design, the present research may understandably serve a more exploratory purpose rather than as an ultimate solution to a

problem. Stake (1995) affirms that, "In a qualitative case study, we seek greater understanding of  $\Theta$ , the case. We want to appreciate the uniqueness and complexity of  $\Theta$ , its embeddedness and interaction with its contexts" (p.16). The Illumination phase demanded a commitment to *reflection* and *patience* on the part of the researcher in revealing new knowledge; both are characteristics achieved by using the case study (Stake, 1995).

Since so little knowledge currently exists on the topic, the self-case study approach permitted an opportunity to lay a foundation for future research possibilities. Once the essence of the phenomenon is captured, it can potentially influence future work using larger sample sizes, and generate testable hypotheses normally assessed with more widely utilized quantitative methods.

At this early stage of developing and validating a reason to explore the phenomenon, a single case study was very appropriate to allow for rich, deep, detailed and meaningful description of this sensitive topic of inquiry based in the personal voice of one participant's extensive experience in clinical practice. Throughout this process I shared my own stories of events as I experienced them, and observations of others also involved in these events. I also included artistic material, in the form of a song I composed to explain through my own talents the discovery of what it means to know "youth suicide" (see Appendix C). Moustakas (1990) affirms, "Only the experiencing persons-by looking at their own experiences in perceptions, thoughts, feelings, and sense-can validly provide portrayals of the experience" (p. 26).

### **Heuristic Process & Findings**

I was on a crisis response team from 2004-2009. The particular program I worked for was the Youth Crisis Stabilization System (YCSS), which is part the non-profit organization of Macdonald Youth Services. The Mobile Crisis Team (MCT) which is the initial step in accessing

services with YCSS?, is a response team which offers services to children, adolescents, families and care-givers, as crisis services are needed. Mobile Crisis Teams aim to stabilize crises, provide on-site services, and establish treatment needs for intervention.

During this time, I dealt with approximately 20 completed suicides involving young people from 10 to 18 years of age, although suicidal behaviours and attempts were seen in children as young as 6 years of age. The team consisted of 20 people, including a supervisor, intake clinicians, community clinicians, and crisis workers. The mobile team is made up of one an intake clinician, a community clinician and one crisis worker. I served in several different capacities, including intake clinician and as a clinician providing community assessments.

### **Initial Engagement**

Thinking back to the first time I really contemplated the research question I had not yet started my career in youth crisis response. By stark contrast, I had just returned from Europe studying Greek antiquity on a surface survey project with the Classics department at the University of Manitoba. I was excited to begin my job working with young offenders as I was simultaneously taking courses in criminology. I was offered a job working on graffiti cover-up for mentoring young offenders needing to complete their court ordered community service hours. I had accumulated the most volunteer hours in the agency after a criminology field course and was ready to take on a paying position.

The coordinator of the program, who is to this day in my opinion one of the most skilled mentors I have had, took the staff out in the field of a park near our program office. Her leadership entailed patience and commitment. It was my first day back and she warned all of us that the news she was about to disclose would be upsetting. Furthermore, she explained that we had support from her and the agency as a whole and that the opportunity to debrief would



continue to be available to whoever needed it. She explained that there was no shame in having mixed emotions and we should be free to feel whatever came naturally to us.

A young person had died. It was sudden and “unexpected” as this youth had been involved in almost all programs available to troubled youth and families that our agency and child and family services had to offer. To disclose the mode and year of this particular young person's death would breach confidentiality. What is relevant was that this child had been a client of the crisis response team prior to his death on a number of occasions. More specifically, the crisis response team was accessed immediately preceding the suicide as well as post suicide events.

The child had a number of behavioural difficulties, namely Fetal Alcohol Spectrum disorder with symptoms like poor impulse control, difficulty learning from consequences, poor problem solving skills, and lack of control over emotions (Hosenbocus & Chahal, 2012). My coworkers were stunned that this child had died. I remember the emotional responses; “How could this child have slipped through the cracks? How did every professional caregiver miss this and especially the crisis responders? If they could not save this child who they assessed, then was there any hope in the first place?”

I had worked with the child in a treatment home as well as the community hour program. The staff from his treatment home lit a candle for the victim as it was believed that the candle would light the way for his path to finally rest. This was the spiritual ritual common to the region and this youth's Aboriginal culture. For a number of years people in the field continued to express disbelief that this particular death happened because the young person had so much support in social services.

Perhaps we were so shocked because we all personally felt that we did a good job

connecting with that youth and saw progress and positive outcomes despite that child's difficult history. I know I did. I felt this kid had hope, and I was left with very specific questions about why he ultimately chose to take his own life. It is one of those things in life that demands perfection or there will be consequences. You are nearly always left with very private, precise questions related to youth suicide that are so difficult to answer. No quantitative collection of data could truly describe a person's experience with youth suicide and the loss of a young, promising life. I was left with a heavy sense of emptiness and sadness—like I should have done something differently or better. This experience led me to search for answers through a career in crisis response.

### **Immersion**

Throughout my career, I reflected on each experience, and maintained my education to include best practices and to understand the varied techniques and philosophies of counselling. It was a natural transition for me to continue this researching as part of my graduate thesis. Initially, I began to more consciously immerse myself in the question while considering an interview process of others who work in youth crisis response- especially those who had personal work encounters with youth suicide. As I began to immerse myself more and more in the topic, I considered developing interview questions for others (see Appendix B). However, as I reflected on what I would like to learn from others, I discovered that this issue was still too tied to my personal experiences and perceptions. I considered that the most effective way to tackle the question would be a personal heuristic inquiry.

While focusing on the core of the study and reflecting on all other aspects observed throughout the process an unexpected shift occurred. To open up avenues to explore the essential experiences of others, it became apparent to me that I needed to better understand my own

experiences first. An essential part of the heuristic investigation is embracing those unrestricted changes (Moustakas, 1995). That unstructured shift really embodied the transition from seeking information from others to instead focus on and more fully understand my own experiences.

I was able to take on a one-year leave of absence from my job in youth crisis response. I continued working in a counseling capacity although during this time I began working with a high risk adult population with complex mental health diagnoses and concurrent complex addictions. This new job was also in a different city than my previous work role. After three months of working in this new role, my manager who had a youth program as part of her portfolio offered that I switch to the job of youth clinician. This was due to my extensive experience in working with youth. I declined this offer but shortly after she continued to encourage that I become the coordinator of the same program, which I also declined. I remember the emotions that were associated with my decision to reject those positions; I wanted a break from working with such a vulnerable population and having to make decisions that affected their lives.

More importantly, I felt strongly that in order to remain focused on my heuristic journey, I had to concentrate and reflect on previous experiences and clearly delineate those from any new work commitments. I immersed myself in the question of youth suicide and crisis response through reading books and news articles (see Appendix E), writing music and song lyrics (see Appendix C), journaling (see Appendix D), reflecting on memories, and conversing with others in the field about certain aspects of psychology that would occur to me as pertinent to my understanding of the question.

In the early stages of my career at a training workshop, I was given a manual that contained information that resonated with me. During the immersion phase I remembered this

content and used it to carry my investigation forward. In a handbook for suicide intervention, *Living Works*, it states that even with our best prevention efforts a significant number of people will be missed (Ramsay et al., 1999). This whole process for me has been a very personal journey that I believe can contribute to the ideal practice for suicide intervention techniques: by exploring my own thoughts there is potential for others to see value in transforming their own. The handbook most importantly offers true and false scenarios like the following:

I can learn almost all I need to know about suicide intervention from this handbook.

FALSE: You will discover yourself. You need at least two additional things this handbook cannot provide: 1) an open environment in which to fully explore your attitudes about suicide with other concerned people; and, 2) practice, and seeing other people practice, doing suicide interventions (Ramsay et al., 1999, p.17).

I remember contemplating during this period of immersion that the referral sources presenting their crisis to the crisis responder could be anyone: police, hospital, mom or dad (see journal entry "March '09", Appendix D). Child and family services would call and arbitrarily ask "Can someone who is Bipolar be a good mom?" This was in relation to a child in need of assessment because she had run away from their treatment home to be with her biological mother and was now suicidal as she refused to leave the mother's home. After repeatedly being called upon as the experts from such a variety of local systems (from family to other crisis response and social service programs), I soon came to feel strongly that our service (the crisis team) were the experts in the social service domain when it came to appropriate interventions and sound assessments in the community.

We would need to assess youth suicide for all sorts of reasons. Even calls that began as a child refusing to go to school or fighting with mom and dad over a love interest seemed to

escalate easily into a need for a suicide assessment. Even an apparently straightforward behavioural crisis that needed brief intervention and appropriate referral to family therapy required a suicide assessment. Suicidal intent may not be obvious to the naked eye upon attending to a crisis. Fortunately screening instruments such as the mental status exam and interview are effective tools used for thorough examination of the situation (Winnipeg Regional Health Authority (WRHA) Suicide Prevention Working Group, 2006). Above all, a crisis responder reviews information regarding personal/family history and experience with suicidal behaviours and the client's current state of mind and impulsivity with harming herself, himself or others.

In the beginning of my career as a crisis responder, I had some anxiety around closing files at the end of the day, which was protocol. We did not "create crisis situations". If we did not receive a call back from a referral source we did not follow up. If the child was under the influence of substances we could not provide an immediate assessment as they needed to be medically cleared first.

I had difficulty making sense of this rule at first. It is widely known among crisis responders that people are less inhibited when they are under the influence of substances and more likely to harm themselves (Goldstein & Levitt, 2006). With the risk being higher at these times, it was tricky for me to deny a crisis assessment; but instead connect the referral source with emergency service like ambulance or hospital. The crisis team could become involved once the client was medically cleared. For instance, a child ingesting a number of pills was an emergent matter that needed to be resolved by medical personnel before the crisis team could explore the urgent question of the youth trying to harm herself or himself,. For us, the question was not necessarily how many pills a youth has ingested, but the original intent for taking the

pills and the child's understanding of what they thought was going to happen as a result.

Subsequently, I have been sitting with this youth suicide question now for years and feel more vulnerable than ever. The complexity of my feelings toward the subject entails much more than the validity of assessment protocols. What would I do if my own son felt like dying? Would I be like those mothers beating their heads against the wall trying to get the right help for their child? I could see myself experiencing feelings of shame and confusion similar to those expressed by the mothers and fathers I have encountered when they ask themselves why this was happening to their family. While I have consoled families through their ordeal, I do not have any clear answers. Only that it just seemed to be one of those terrible things in life that happens.

### **Incubation**

I thought that perhaps I would be able to enter the phase of incubation earlier, while still working, because I had moved away from Winnipeg. However, I did not truly have an opportunity to remove myself and allow the "seed planted" to "undergo nourishment." The work environment, although dealing with adults and not specifically a crisis response position, required me to use the same set of skills and expertise that was essential during my time as a youth crisis response worker. There were also overlapping themes that kept me immersed in the question.

It was not until I went on maternity leave to have a baby for the first time that I was able to enter into the phase of incubation. Being a mother made me want to write instead about having a baby or becoming a mother. The topic of youth suicide seemed so depressing and I did not want to be thinking about those experiences or have any images related to that type of death. Breastfeeding, holding, and playing with my baby boy were so pleasant I wanted to give him my full attention. It seemed a good time as any to leave the research related to youth suicide aside

for a while.

I would put it out of my mind for about the first four months after his birth, cheating sometimes by having those same thoughts at night before bed. I tried to remember what I had ruminated on the night before that was so important so that I could write it down for this project. Nevertheless, I did forget by morning and so my retreat from the topic continued. People asked me how I liked being on maternity leave and if I wanted to go back to work. I responded that I loved being with my baby. That it felt normal and happy. I would go so far as to say I hated my job now. I did not want to deal with complex mental health, addiction issues, and especially suicide.

Was I done with all of that? I had been working in the field for 12 years and it had become so normal to talk about loss and symptoms of depression on a daily basis; but the price was that it exhausted me, making it difficult to talk to family and friends about what they were doing, or to do something good for myself. In the field we always talk about self-care. For me it was getting my hair and nails done, for others it was physical exercise. In fact, in one job interview they asked me what I do for "self-care". It seems obvious to people on the front lines that self-care has a huge impact on how you are managing probable stress with the job. When someone seemed irritable or withdrawn we would suggest they were burnt-out. Then the solution was always that they are not doing enough self-care. Even when they were with clients, it was evident that they did not want to be there or they were not as invested in really hearing things from the client's perspective. Instead they would rush to resolve the situation- often resulting in a complaint from a client who was not feeling heard.

Now I was away from it all, no longer listening to people regularly saying "depression's hitting hard" when you ask them how they are. I was not sure I wanted to go back there again. It

was hard to come to terms with the fact that maybe I had to let go of something I knew a lot about and with which I was extensively trained to deal. Maybe it was time to venture into something more uplifting, getting back to my natural bubblyness which had to be subdued over these years so that I could give these situations the seriousness and focus they deserved. On one crisis team I worked on, one co-worker received numerous complaints about his abrupt nature while dealing with those in crisis. He was infamous among program members and referral sources, such as child and family services workers and clients for being bossy and rude and not very helpful.

After being on the crisis team for a few weeks, my coordinator disclosed to me that he was hoping my bubblyness would rub off on this other worker, but also that his bossiness would rub off on me. His hope was that we would essentially balance each other out. I recalled that I would dread coming into work and seeing him, and every day I hoped he would call in sick. I thought "I never want to be like that person". Had I become him? Was it time to throw in the towel before I did the damage that he did? I still needed a job after my maternity leave. "He who fights with monsters should look to it that he himself does not become a monster. And when you gaze long into an abyss the abyss also gazes into you" (Nietzsche, 1990, p. 102).

### **Illumination**

During this phase, I had to be open to the natural progression of the original question. I was able to come back to it and suddenly see it differently--not wrapped up in all the emotion. As part of the process of indwelling in the phase of illumination, I had unwavering confidence in my choices to omit certain material while choosing to keep other material. I decided to reject certain pieces that at one point seemed related to the initial question, but no longer felt relevant to my personal experience as a crisis responder. For instance, I decided to remove a picture I had



taken of a yellow box supported by the province of B.C. on the Lions Gate Bridge that links people to crisis lines as a barrier to suicide. After asking others about their thoughts on the picture of the yellow box and noting their reactions, I determined there was no difference of opinion between theirs and my own. We all wondered about the effectiveness of this telephone box in preventing suicides. Therefore the general consensus was similar to my own response and not specific to what a crisis responder might say.

Moving along, I knew I had reached illumination as I could see clearly how to effectively locate myself as a crisis response worker, with the added layer of youth suicide. My memories, my experiences, and how I could report them were at last accessible. I could now be forthcoming about really describing myself and how I work. Given the intrinsic nature of the case study, I aimed to help others understand the possible relationship between the case and the experience.

When I first started in crisis response, I was one of the youngest clinicians on the team. I would sit in my intake chair for 10 hours straight taking no bathroom or lunch breaks just in case the telephone rang...I prayed the telephones would stop ringing. I dreaded the calls with heavy suicidal content. I was also too scared to be a clinician in the community. By sticking to mostly intake shifts, I became extensively experienced in the art of intake/triage. My fear of having to make the final decision out in community made me work extra hard at knowing all the intricacies of putting together the best intake assessment.

I envied the team members that would go out in the community; they were playful, confident, and easy going, and nothing seemed to faze them. This was not me, as in the beginning I was so nervous that I would say the wrong things or forget to say right things to clients and other staff. My anxiety caused me to speak too quickly which made it difficult for others to understand me. I was given feedback by my team mates that what I had to say was

important, and so I should speak slower so that people would hear me.

So I focused on where my fear forced me to work, on intake. I would watch other intake clinicians perform their assessments, listen carefully to their tone and pace when they spoke to clients, and how they introduced the presenting crisis to the team who would complete the assessment in the community. The only real training we received was a two day workshop on how to perform suicide risk estimation, as well as non-violent crisis intervention. I see now that more was definitely needed as it sort of felt like I was thrown to the wolves. Survival of the fittest also comes to mind as I remember experienced staff saying to me "we'll keep you" or "you'll stick around". Then they would refer to other newly hired staff proclaiming how they "won't make it" or "they're not suited for the job".

I tried hard to fit in. I was always concerned with knowing the most accurate up to date information on how many crisis beds we had or what teams would be available to address the next crisis. There was always one intake clinician on duty and in the evenings for 4 hours an extra person on intake to help with the volume of calls. Furthermore, there was one team only to address the crisis in the community as decided by intake. After 2 o'clock and up until 10 o'clock there was an extra mobile crisis team on duty to provide support for high volume call times.

The best case scenario was always to leave the child in her or his familiar environment with added support. These supports could be some respite services we would place in the home to help the caregiver to better cope, or make a referral to brief treatment therapists who worked upstairs from the mobile teams. We also had two six bed units, one for girls, and another for boys. Our female beds were always full, which led to a lot of controversial discussion around our own belief systems that girls seemed more vulnerable than boys. Most of us disagreed with this statement; yet, in practice, offering those girl beds were more precious than any other service we

provided.

I was slowly learning the nuances of the work requirements. I knew I had a handle on the ebb and flow of the job when my coordinator did not have to move me to another computer outside of the intake room to catch up on documentation of less serious matters. I recall him telling me he felt bad for my boyfriend who waited countless times because I was never out to accept my ride on time. Now, all these years later, I have been through so many circumstances where I have had to assert my boundaries at work that I am better able to be honest in my private life about my capabilities and what I need at home. Also, my family is my priority, my husband and my baby, and ultimately whatever I do is for their well-being as well as my own. My work comes second now. My husband knows when I am stressed about something at work because I have increased agitation around little things. He might tell me "you're not your bubbly self!"

It took about over a year, but finally I knew I had reached a comfortable point of self-confidence once I felt compelled to mentor newer staff. I could do this by highlighting the tricky little things no one really teaches you, like how to approach the teams, and what information they are looking for prior to engaging the client in community. Also I was ready to show how I could be just as good in completing a community assessment as I was on intake.

In the early days I would give referral sources what they asked for as much as I could, which was offering that a team would show up and help them face to face. This was unrealistic as there were just not enough mobile teams for that. Really, I would eventually disappoint the client as I could never meet her or his expectations. In addition, I was putting a lot of stress on the mobile teams as they had to resolve matters quickly to be available for the next thing I lined up for them. Most of those crisis calls could have been resolved over the telephone with intervention techniques which I did not possess at the time.

My reputation had gone from being too pleasant on intake and initiating too many unnecessary community visits, to an intake clinician that discriminated between the different risk levels and was able to resolve most crises over the telephone. The feedback from clients was mostly positive; I would always conclude the intake with asking if I had resolved the reason for them contacting us.

When I was still in a casual position, I would arrive to work and my team mates would provide feedback to me that they were glad I was working because I was not lazy and I was always positive. I understood what they meant because I was diligent from day one when I started in that role and careful to speak only when I was asked a question. Also, I tried to limit my information giving to others to only when it was absolutely relevant to the situation at hand. Perhaps there was a hint of burnout to those interactions on behalf of my more experienced co-workers because I remember firm boundaries around this rule. At the time I strongly believed it was the best way to address each other and each crisis situation along with maintaining confidentiality.

I still feel there was merit in not sharing too much information about the cases during any downtimes, just to help take the edge off the work we do. However, I did get the strong feeling that people reached a point where they were going through the motions and doing the bare minimum just to get through their shift. Somehow I avoided any conflict with my co-workers because I mostly adapted to the needs of the team, and tried to balance the requests of the clients with a tender style explaining the actual services we provided. I could always be counted on by others to put things in perspective and remind ourselves that crisis is self-defined, and correspondingly, to approach people in a fresh and respectful way.

I was beginning to see the themes develop that would eventually determine what it has

meant for me to be a crisis responder to youth suicide. Interestingly, at that time I met with a former colleague (a youth psychiatrist) over lunch. We discussed the future, precisely my return to work, and I was brought back to those images reflecting on crisis response, albeit hypothetically, with a job opportunity. I was offered to provide consultation on the development of a new youth crisis response system in Victoria, BC for outpatient services for youth at risk of suicide.

As I sat there, I had a surreal feeling. I remembered myself as an expert on the topic and from this place of separation I was able to see myself stepping back into that role. Looking back on that day, I can say that this was part of a catalyst that brought me to the phase of illumination. Again I had that “natural openness” to my question. I had had a breakthrough and could honestly assess the dimensions of the research problem and understand my own resolution to the question: “What is the crisis responder’s experience with youth suicide?”, although I began to feel the question had evolved into “What affect does youth suicide have on the youth crisis responder?”

Just prior to the meeting with the youth psychiatrist I had interviewed with the Vancouver Police Department (VPD) for a casual crisis intervention position with the Victim Services Unit. My qualifications exceeded the requirements but the evening hours and casual work would have suited my family lifestyle until I went back to working as a concurrent disorders clinician full-time when my son could be in daycare.

I received a rejection letter for this position with the VPD (see Appendix F) and experienced new emotions that were unfamiliar to me. Prior to removing myself from crisis response work, I was so sure of my skills. Once I saw this letter, although there could be a plenty of reasons I was not a candidate for the training, I went through a moment of doubt. Did the process of investigating the question somehow change my attitude or beliefs? Or was it my

presentation of myself during the interview? Or maybe I had a new outlook on this matter which now affected my current ability to commit to a position in crisis response.

These two things happened around the same time: getting rejected from a lower level opportunity, while being offered the fairly prestigious position creating a youth crisis response team in Victoria, BC. The same doubts that generated the question in the first place were growing. They were in such contrast from feeling proud as I believed I had gotten so far from being an able clinician not needing to question things.

This began my reflection about how that role affects the individuals that take it on. I came up with this question for a reason and now I had this reason to confront again. Now that I had illumination I was able to see what was behind creating that question. My illumination during this time reinforced the questions I had, and also raised others. The rejection from the one instance brought back questions that were latent. Having the questions resurged along with the conversation with the youth psychiatrist, I now had a clear view of the original query that was different and I was able to see themes emerge.

There was no longer any option to withhold information from myself or others, and finally, without doubt, tell the truth about this. I had always been the “nice one” on the team, the person to handle the difficult callers that so easily frustrated my team mates. I came to realize early on in my career that this was a role I played well; having a high tolerance for difficult situations/personalities was a gift and something that was considered an asset on a crisis response team. In choosing to do this work, I believe that most of us have to be open-minded and flexible in our approach to others, but, of course, we all have different communication styles.

I would describe most of my co-workers as having very firm boundaries with their manner of relating to others and translated our services in a matter of fact way. The really skilled

clinicians were gentle, yet firm, and empathized well with the clients. This gentle yet firm balance is what I strived for. Taking into account the phases of the heuristic process, specifically moving from illumination to explication, I was finally prepared to expose my feelings about the work with a confidence that I hoped could enlighten others as well as embrace the freedom that came with explaining the burden of my personal journey.

I came to appreciate that some people may talk about the difficult environment in which we work, but others may not feel comfortable doing so. We see so much trauma and despair among our clients, and so we tend to minimize what we see. We develop a thick skin to get through our day, which can lead to negative cumulative emotional and physical effects for us personally. Unfortunately, the policies in place do not fully translate into the kind of daily practice that supports empowering workers to address this vicarious traumatization.

Typical work policies do not include critical incident stress debriefing; however, we are encouraged to seek counselling through the employee and family assistance program if we need extra support at any time. I am unsure if supervisors are receptive to grief responses. I have never had an emotional response to a suicide where I approached my supervisor or been so visibly distraught that I required supervisor intervention. I suppose I followed in the footsteps of my colleagues, adapting to the way they conducted themselves around those events. I am hesitant to guess what my peers' experience has been going to supervisors around this subject, if they go to them at all. From what I could see, and it may be only on the surface, we all somehow "managed" or "controlled" any emotions that could "get in the way" of us doing our day to day job. This is one of the "unspoken" social norms preventing us from processing the incident or debriefing.

In the initial engagement phase, I struggled to find the right words for the question I

would eventually ask myself for this study and with placing them in the right order. Through immersion, I never knew how much information was too much and continued to gather anything and everything I could get my hands on that was related to youth suicide/crisis response. During incubation, the needfulness of my new motherhood brought me to a place of solitude and mostly a complete separation from my identity as a crisis responder. Without that intense involvement that I was so used to, it was only then was I able to emerge into the illumination phase with a new appreciation of my professional experience.

When I began volunteering with troubled youth, it was not long before I experienced penetrating feelings of accountability to do right by them. I remember telling my supervisor, "I was never involved in the criminal justice system nor did I grow up in the care of child and family services". I remember thinking; "What could I offer these kids and why should they even care what I have to say or teach them about life?" My supervisor stated that I could demonstrate positive alternatives. This made sense; I was inspired at that moment and developed a strong belief that there was hope for these troubled children and I could be involved with some progression of hope for their future.

I never had any passion for work with adults at that early point of exploring my career choices. I felt that as adults they could make their own choices and there was limited room to influence them any differently. Also, I was just a kid myself, starting to volunteer in the social services field at age 18, and felt it was inappropriate that I tell an adult how they should go about doing things.

Also adding to my motivation for doing this work, my family always provided me with love and support no matter what I wanted to do. Just last year, I considered becoming a chef...my father told me that I should try it out! Growing up in a loving environment where I



was accepted for who I was and the choices I wanted to explore motivated me to want to share this type of unconditional acceptance with others who were deprived of it. Between then and now, I feel I have blossomed into a person who cannot be accused of wearing rose coloured glasses anymore. I have a deeper understanding and a distinct view of crisis response to youth suicide as a result of my heuristic journey.

Also, my time away from work is spent with my baby boy and focused on my devoted marital relationship. Being with them on a day to day basis, I continue to gain a form of support that is specific to my own experience and a large part of my transformation into a more confident worker who can honestly look at my clinical abilities, areas needing improvement, and my vulnerabilities.

This expanded realization felt more sophisticated than my earlier ideas about crisis response and youth suicide. Previously, I believed I knew as much as anyone could know about this phenomenon. After accepting the challenge of this qualitative search to know even more, I unveiled aspects of my soul that I had learned so well to cover up or be too embarrassed to express for fear of judgement about my clinical competence. Consequently, this transformation of me is evident and described via themes with more detail below.

### **Explication/Themes & Essence of Experience**

As I moved through the designated phases of heuristic research, finally arriving at the point of explication, I was awakened to a renewed meaning of my lived experience as a crisis responder to youth suicide. The items in the appendix, including a personally composed song, are meant to compliment the themes described below. By a complete portrayal, or creative synthesis, I was now able to describe to others the essence of this phenomenon.

**Responsibility.** Every now and then I find myself trying to reconcile a discrepancy between my job expectations and knowing I cannot prevent the unpreventable. Even though I have done all I can, I second guess if I have done enough. My troubled conscience deep within struggles; I *assume an expert role* carrying out my day to day duties as a crisis responder. I *experience frustration as the expert* as I live with the painful reality and the inevitability that there will be another self-inflicted intentional death of a child.

**Assuming an expert role.** I am an Egoist, but not egotism in its purest form, because the work is for others. Rather, egotism is defined here in the sense of the workplace, my skills, my knowledge, and my motives for why I'm doing the work. I observe others as they observe me, and we each believe that our motives are more pure, genuine, and somehow more altruistic than the other's. I am contributing my thoughts and energy to understanding the lives of others while trying to add fulfillment and meaning to my life. This giving of myself is not entirely altruistic because I continue to be recognized as the expert from community members. As well, I get personal gratification that I am making some difference.

I am virtuous and can do no wrong because I am supposed to have answers to every question when there are no clear answers. This weighs heavily on my mind and, from what I can see, the minds of my team members, as well, because we have the responsibility of being the experts and foreseeing every possible situation. As noted in my diary "When team members are confronted with chaos it is our job to slow things down and relate to others in a calm manner..."

We are unlike nurses in the emergency room who have a duty to provide care for a specified period of time. For them, this duty begins and ends at the start and finish of their working day. We attend and resolve situations in the community where the safety issues that prompted our involvement can and do resurface at any time.

In assuming the expert role, I am pressured to use language and conduct myself in a manner that evokes certainty. I absorb the risks involved in the situation at hand. There is no option for me to refuse to provide service in the face of suicidality. This unreasonable burden is unique to my job whereas other professions have the option of refusing services due to of lack of resources or unreasonable expectations. I am a crisis responder; a professional, obligated and confined to relating in a very specific manner to the public. To express myself in any other way or to consider my own personal needs is not relevant.

It feels good that I can go to my managers with some questions about how to handle things. But I want them to see me as competent because that helps me believe in myself in those moments of doubt. It's just not possible to share the really deep fears about the work I'm doing (D. Tzotzolis, see journal entry "January '10", Appendix D).

**Frustration as the expert.** I am disappointed because things do not get better. With each suicide more questions emerge than answers. Learning from it and teasing out the positives is hardly possible. Essentially I have failed at my job requirement of youth suicide prevention. The next time a child is preparing to die, will we be able to stop them? There is nowhere to direct my questions and feelings associated with this failure. The issue of youth suicide impacts everyone directly or indirectly and so everyone is responsible and yet not responsible.

When that respectable psychiatrist told us there was nothing that could stop someone committed to the idea that suicide was their only option; in that small pocket of time she shared that particular information I felt relieved that if a client completed suicide it would not be my fault (D. Tzotzolis, see journal entry "May '11", Appendix D)

What good does it do to be part of this crisis response team and work so hard when the changes we see are so small? I feel tired. All can be reversed so quickly because of

uncontrollable events. I explore the wishes that our clients have to die as well as their wishes to live.

Draw closer, come

To really see me

A bright day

Appears

For me (Excerpt from song lyrics, written by D. Tzotzolis, see Appendix C).

I do my best to reveal the ambivalence they are feeling toward suicide as an option and not the only solution to their problem though this also contributes to my frustration. When a child tells you that they will stay safe and promises not to hurt themselves, it is such a relief, and I feel I have connected with them and bonded in a significant way. They are going to give themselves another day, *a bright day* with some hope to try and survive under the circumstances that made them suicidal in the first place. But once they have left this life there is no correcting it with a second chance. All efforts have been lost forever and I have failed.

I have an intense interest to know and help that child who is so determined to kill himself. He or she holds on so tightly to a personal secret moment that they will not share with me or expose until it is too late. What did I not do for them that I could have done? My sense of self and my world understanding is constantly violated. I call my identity as a crisis responder into question every single time a child kills herself or himself. My life's purpose is interrupted and I am challenged to restore meaning to my decision to work in crisis response. The song I wrote reflects these feelings of judgemental self-evaluation, inadequacy, and fear:

Now I am left

Unaided

And unmoving

And you are not here

To protect me

A bright day

Appears

For me (Excerpt from song lyrics, written by D. Tzotzolis, see Appendix C).

**Coping.** After addressing responsibility, and the loneliness and hopelessness that I came to realize is part of this job, I needed to confront another obstacle to really know how youth suicide has affected me as a crisis responder. I was challenged now to take a candid look at the system or the organization in which I worked and also gaze into my own style of coping with all of this.

I have always been like a sponge, soaking up information, learning from others, waiting, watching, and listening to know how I should behave. I never believed that coping effectively was a common sense thing, but something complex that would take practice. I did suppose, however, that I would learn to do this effectively and it would be something to add to my ever expanding skill set.

Even in the early stages of working with troubled youth, before my career as a crisis responder. I was encouraged to cope successfully. Co-workers and supervisors use their coping skills as a reflection of their abilities. By coping “effectively” I uphold the team’s professionalism and do more than I have strength to do. This is part of the reason we continue to

be viewed as the experts. "Effectively" meant that feelings of shock, grief, disappointment and guilt were not only not expressed, but also not acknowledged.

I am reminded regularly that there is an open door policy where I can ask my supervisor questions and request feedback. However, I have stood by and done nothing where a co-worker voices concern about their own sense of safety and the general culture in the office is that they should "suck it up" and remain congruent with the traditional medical model of providing care.

I got the sense early on as a young clinician that someone who talks about how she is impacted by the traumatic information we encounter, shares "too much", and her expressions of emotion comes off as an insecure approach to doing the work. Is it okay to be vulnerable sometimes? Or not? Even through the jokes, the silence, and distraction we all just want to be seen as effective crisis responders and to be effective means to remain objective.

When collaborating with coworkers, I tolerate the stress of a youth suicide and look for logic and meaning to help portray my professionalism. Hiding my questions and my frustration helps keep my "self" away from the horrible event, while painting the picture of the expert. Intimately, I cannot escape feelings of *hyper-vigilance* immediately after a youth completes suicide.

Some time passes, but eventually I will be able to avoid all the emotion that is normally associated with such a devastating event. Because of the high degree of responsibility to function at work, *depersonalization* occurs, and my private life suffers. I alienate my family members and progressively have less and less desire to relate to them. I notice a decrease in my motivation to connect with my family, because I do not share details about my day and have little interest in hearing how they are doing.

Observing my own responses makes me wonder: Should I expect a better level of *support*? Supervision makes an attempt to be present for those who need to debrief by offering impromptu conversations, and at general meetings discussing the facts of a particular suicide without emphasizing any emotional repercussions for us as crisis workers. Also, these attempts are offered in a context where few accept because “true experts don’t need help themselves”. It is difficult for me to admit to myself that I need help conquering the questions and sadness- I am one of the experts. I am good at what I do. Must I just accept that at this point there are no perfect answers to the problem of suicide, and no applicable support for the workers who address it?

**Hyper-vigilance.** Every day I make decisions that can significantly influence the life or death of a child. Most of the time I am centred, and I know without doubt that I have made the right decisions at work. I feel at peace. When a suicide happens, this balance is disrupted. Now my emotions are driving my actions. I feel tense around crisis situations involving suicide content. My emotions are telling me what to do and that familiar clarity that is so common place is replaced with bouts of insecurity.

For me, hypervigilance takes the form that something that may not have been considered a crisis before suddenly becomes important to address immediately. Each hint of despair in a child invokes a promise that “this time I will not let anything happen.” Yet, do we sometimes over reach because of fear? My senses are heightened as I attempt to detect any threat of suicidal behaviour.

We may attend a crisis call because mom was having difficulty trying to wake her kid and getting them to school and then after discussions realize the youth is depressed; sleeping too much, isolating, feeling low self-worth. All of a sudden the priority becomes

suicide prevention and not so much about failing grades (D. Tzotzolis, see journal entry "March '09", Appendix D).

With each incident of youth suicide I am changed, my soul is somehow altered because what I can tell you is that I know with certainty that I wish I did not know and never witnessed despair in this way.

My mother told me that *storge agape* was the kind of love you have for your child. "A protective love?" I asked. She said it was exactly that...at that moment I felt an intense connection to the word, and to my thoughts about the youth I have worked with (D. Tzotzolis, see journal entry "March '13", Appendix D).

I am unsure how I come to feel balanced again but I do. Somehow my confidence returns and my sense of security in my skills is strong again. Maybe it returns because of things my coworkers are saying or because I get distracted by the new situations that are demanding my attention. Somehow I adapt after the incident of a youth suicide.

To feel vulnerable in my skills and question my decisions is not seen as a healthy coping mechanism but a weakness, and I am lost in knowing where I can access help or if it is even okay to admit that I need to talk about how this has affected me. So I do not tell others what I am experiencing. I do not want my supervisors or my team mates to think that I am debilitated in any way or that my "professionalism" and ongoing ability to appropriately assess any crisis situation is compromised.

It feels good that I can go to my managers with some questions about how to handle things. But I want them to see me as competent because that helps me believe in myself in those moments of doubt. It's just not possible to share the really deep fears about the



work I'm doing (D. Tzotzolis, see journal entry "January '10", Appendix D).

Whatever stress response I had in my body and mind remains situational and will never be addressed in any pertinent way. It was a fleeting moment in time, a child lost her or his life and I will forget about it because of the ongoing emotionally demanding nature of helping other people, and because in crisis response, you come to know that "it's part of the job." So life goes on and I shut the door of that guarded place that holds that uncertainty until it will necessarily be opened again.

**Depersonalization.** I am physically and emotionally exhausted because of the demands of working intensively with others. When a suicide happens, I begin to work backwards beginning with asking myself why did this happen now? What were the series of events that led up to this child doing this horrible thing? I struggle to understand something that is so hard to relate to in everyday normal life. When the tragedy is in your city it is hard to understand why this is happening.

In contrast, I believe most people are responsive towards efforts to aid with humanitarian crises, and this support seems so natural to provide when some devastating event has occurred far away somewhere in the world. Crisis response and youth suicide is something that is not as widely known and the need it is not widely understood or accepted. Often families plead that we do not arrive at their homes with sirens or marked cars lest we inform the neighbourhood when something wrong is happening in their home.

As a crisis responder, I try to help those affected by mental illness that live in communities like the one I live in. I grew up in the West End of Winnipeg, a multicultural community. But my upbringing did not prepare me for how the real world can sometimes be relentless. I was raised to see the differences in others as a beautiful thing. Contending with

concepts such as stigma was a new beast I would come to accept as existing, and I strive to do my best to counter or prevent its powerful and negative impact on people and society.

Moreover, all those involved with youth suicidal behaviours battle with the stigma associated with it. If it is ten thousand miles away, as in the case of a natural disaster, thousands of people are going through the same problem. Being a part of something that is not well recognized I also feel like an outsider in normal situations where I used to belong, like family gatherings or laughing with friends over nothing. I am out of touch.

I have no energy left at the end of the day to give to family members or friends outside of the workplace. Relating to family members, or people that know me best, I feel that no one can understand me now; it is too much of an effort to explain. This contributes to feelings of isolation and loneliness, and sometimes hopelessness. Even though they may want to offer me support and comfort, it is too far outside of their experience to do so effectively. For someone who is unaware of crisis response and youth suicide, hearing about it doesn't sound as intense as someone who has lived through it. Also, in my own way, trying to protect my family from the heart-rending information of what I know and see. As written in a Vancouver Sun opinion article, "It's hard to know what to do in the face of suicide, especially when it's a young person. But a suicide pact? With 30 kids? What can you do about that?" (Thira & McCormick, 2012; See Appendix E). This article had meaning for me because it reminded me of a situation where one youth suicide incident escalated to a number of other suicide attempts and suicides for Aboriginal youth living in an isolated community.

When I am able to share some feelings associated with my experiences, it does not evoke the response for which I hoped. It is anti-climactic, and so I can only validate my experiences with co-workers inside or even outside of the work arena. Even when I do so, the work climate

culture discourages open vulnerability. Those who need to process their emotions and grief too often would be seen as unsuitable for the job, but the disadvantage of minimizing the processing may contribute to feelings of burn-out, or vicarious trauma. I am always looking for an external way to validate and understand what I am feeling from the work day with people who might accept my vulnerability and questioning. I acknowledge that all of this continues to be unresolved or unhealed and that eventually I may need to walk away from it all.

**Support.** We have all accepted that this is the work we are going to do. We believe that most days we are helping others, so that we can endure those days that we know our service did not make the difference we hoped for. We do support each other in some ways, by telling ourselves and others it was not our fault; it was a “perfect storm” and the suicide happened because everything was in place for it to happen. We talk about terms like “radical acceptance” to describe the terrible situation we do not want to accept; but we must admit that everything has a cause; the reality is as it should be. Looking at the all the aspects that led up to the incident make sense in hindsight.

We might give a brief awkward hug to another worker, or get one from our supervisor, because we are unsure if we should cry and show an overt claim of responsibility over the situation. I do not want any fingers pointed at me. I do not necessarily want to say too much about the incident and prefer that my supervisor handles the details. I do not want my supervisors or peers looking into my documentation and scrutinize my assessment in case I missed any details.

After experiencing youth suicides; both male and female, I can describe that these children mostly hang themselves, using their own clothing or bed linens. These children had multiple contacts with crisis response teams, and each year, there is definitely a spectrum of

apparent reasons why they do it: from experiencing an intolerable loss, a sibling, a parent, or a friend, to an impulse response of not getting something they asked for and in an act of retaliation towards someone they proceed with harming themselves. Most of the children are in the care of Child and Family Services, either living with foster families or in group care/treatment homes. They have also had experience with the youth correctional system, and stays in the Manitoba Youth Centre.

We are always encouraged by management to take a curious stance rather than a judgmental stance, especially when addressing our “frequent flyers” or those families who have contacted the crisis team several times. Also, management continues to remind team members that crisis is “self-defined” what may not seem to be that important to me personally, could be considered an “intolerable loss” to a client (see journal entry “Appendix D“, January ‘10).

The focus remains on the risk and protective factors for these children. My co-workers and I are ignored, because we must be solid as a rock and cannot concede to any personally difficult emotions when presented with suicidality. The situation and the expectations of co-workers demand that we act as professionals and that we do not show or concede vulnerability. My co-workers are also my best friends, the people that will come to my birthday party. The same people that will pick me up and drive me home at the end of the night. I will help them in any way that I can, as well.

My supervisors are also friendly, but I feel that they too have no one to understand their burden as leaders, just as we as crisis responders are required to provide the answers to the public we serve. I feel my supervisors don't do not have the magic tools or training yet, magic because so far the only tool offered is critical incident stress debriefing which alone cannot cure what feels like a lifetime of witnessed despair for me. I am not naïve to the process and so cannot feel

vulnerable. I do not hope for healing because I have provided critical incident stress debriefing for others, and it is very hard to put myself in that role of sufferer.

My family support system reassures me if anyone can handle the stresses of the job I can. Also on occasion, I have been told that I can change careers but I feel that is told to me out of their own frustration when they see me in a “weak” moment. I suppose in that moment they may feel helpless and are unsure how to help me, either. If my managers and coworkers are incapable of helping me cope, how can I expect my family members to comfort me? They do not know the despair that I see in children, the despair that is unleashed on others when they take their life. It is not a feeling that one can describe adequately, either. Since they cannot understand, I stop trying to explain it. I do not cry often, but this breaking down has increased since I feel I have paid my dues on the front lines and deserve to move on to something less hands on. In the beginning, I suppose I was in a period of shock and curiosity to know more about youth suicide, and now, I am transformed to a person who has had enough.

In summary, the themes outlined above were developed by a commitment to and thorough familiarity with the material assembled while embracing the original question. A comprehensive depiction of the core themes was described by way of a personal narrative account of the life experience of the primary researcher. These themes describe the essence of crisis response with youth suicide.

With responsibility, the crisis responder is accountable to promptly and calmly resolve urgent situations. Although, this is predominantly achieved despite an ongoing sense of failure because there is no certainty for bettering the cause with the prevention efforts employed. While coping with the situation, the crisis responder collects the pain as described by clients; however is unsure how to release the intensity of that information in a productive way. Support is the

process of recognizing the need for support in situations of youth suicide, as well as the culture of how support is perceived and offered within the crisis response unit. .

### **Discussion**

As Canada has shifted away from institutionalization of clients with complex mental health and addiction needs, a heavier reliance on community staff, including crisis response workers, has emerged. Suicidal youth are no longer taken to a hospital and locked up for months at a time. Staffing personnel are faced with addressing suicidal behaviours in the community or determining if hospital is needed, brief stabilization in a crisis unit, referral to another agency, or some other resolution to a psycho-social stressor, such as staying in an open door shelter.

Understanding the current state of crisis responders' experience in the field as it relates to known risks for burnout is important in sustaining this system. Although research with nurses has brought to light the issue of burnout, this work was conducted in a hospital rather than in a field or community setting. The experiences of crisis responders have been overlooked as they, too, perform therapeutic roles and address family crisis situations while in the community.

It is common practice for caregivers to prioritize the needs of the patient over their own. Although there are positive outcomes when helping those in need, there are also negative repercussions for the caregiver. It is necessary that their experiences of any harmful exposure be validated instead of overlooked as a result of focusing all energy helping the obviously debilitated person. The combination of the previously identified theoretical frameworks of caregiver strain, demand-control-support, and constructivist self-development theory serve to assist in framing the experiences of youth suicide crisis workers in the present study. Because these theories consider the unstable conditions that are characteristic of crisis situations they can, in turn, be associated with side effects such as burnout and vicarious trauma.

**Caregiver Strain.** The implication of the caregiver strain theoretical perspective for the care provider emphasized the urgency for extra supports to be given to those who take on a role of providing care- typically the family members (Phillips et al., 2009). Their involvement, while adding to the recovery, relapse, and other day to day treatment of an ailing family member, may be at the detriment of their own health. While contributing to the health care of their family member, financial and emotional stress must be confronted, thus leading to symptoms consistent with burnout. If they are able to adequately care for themselves, or are provided with support by others, they will be better equipped to manage the added burdens that accompany this arrangement. In applying this perspective to the findings of the present study, it is important to know that some family members may choose the role of caregiver and some may find it thrust upon them, but crisis responders are professional caregivers who are required to respond quickly to high stress situations.

When caring for others, crisis responders are required to make sound decisions while under a high level of stress, but to also maintain strong communication skills. Any factors that impair their personal functioning can impact how effectively they are providing services. Allowing more opportunity in the realm of self-care while on work time can create a culture that values the well-being of the worker, as traditionally workers are encouraged to seek self-care activities after work time (Yoder, 2010; Nwabuoku & Adebayo, 2010).

While family members can rely on past positive memories of their relationship with the suicidal youth to help process their grief and provide comfort, crisis responders cannot. Therefore, their context of grief is quite different from that of family members. In addition, because suicide is a preventable behaviour, both family members and crisis response workers must also shoulder feelings of self-doubt and guilt in addition to their grief. The theme of

*“frustration as the expert”* in the present study reflects these concerns within the context of the caregiver role, as well as the reluctance to show or acknowledge these feelings to co-workers or other professionals, despite the fact that they may be feeling exactly the same way. Findings of the present study show that the potential for support between crisis response workers has been under-explored, both in research and in practice. The relationship between stressors and support is further discussed below.

**Demand-Control Support.** This model highlights the mental and emotional demands pertaining to the professional crisis responder role of expert on youth suicide and the burden of anticipating all possible situations. The nature of crisis intervention is such that the crisis response team is entering a chaotic situation that requires restoration to equilibrium. Moreover, crisis response is a relatively new field in the realm of health care services, and an appreciation of the short and long-term consequences of this type of work on the crisis response professionals is not yet widely understood or accepted. Findings of the present study, including themes of *hypervigilance* and *depersonalization* show that signs of vulnerability and uncertainty are definitely present, but are not accepted as positive coping and processing of events for professionals. At the organization level, it is essential to acknowledge whether the culture of co-workers as well as supervisors allows crisis responders to ask for support, or have support recommended to them, when they are suffering. Perhaps this “down time” should be a requirement for crisis responders as well as for other first responders, such as police officers and firefighters.

The culture of support or lack thereof is such that the workers have not yet accepted that there is value in practicing trauma-informed principles on themselves. The very team providing trauma informed care for its clients still struggles with understanding how the clinical care it



provides affects its own sense of safety and security. It is important that all care providers, and especially supervisors, are informed of trauma reactions and understand that it is healthy for workers to ask for support if needed, and that supervisors routinely offer support

**Constructivist Self Development Theory.** This theory describes how, because of the need to profoundly and empathically engage with others, crisis responders are at risk of experiencing vicarious traumatization. They are constantly immersing themselves in the traumatic content involved with youth suicide, thus increasing their own vulnerability for negative emotional symptoms and decreased overall mental wellness. The themes concerning *Coping, Hypervigilance, and Depersonalization* speak directly to the effects of vicarious trauma for the crisis responder. These findings indicate that even a seasoned and well-trained crisis responder was transformed as a result of continued exposure to traumatic events and the experience of youth suicide. These findings are similar to those of other researchers who find that, due to conditions of work, some professionals begin to share some of the characteristics of those they serve (Elwood et al., 2010; McCann & Pearlman, 1990).

Crisis responders that work with trauma victims may experience negative effects that are similar to those of the victim. Crisis responders could be trained to understand how critical it is that they do not develop avoidance techniques for themselves or for their co-workers but rather address the trauma in a safe, designated environment that is specific to their experience. This, in turn, can help avoid potential emptiness in their own lives, which is a common outcome of vicarious trauma and instead restore meaning for them personally and their future in crisis response. Research with nurses confirms that education around awareness of vicarious trauma has been effective in preventing and reducing the related negative physical and emotional effects (Tabor, 2011).

The heuristic model of self-exploration along with the theoretical perspectives used to guide the research presents issues that are clinically relevant to those providing care in the community. Appropriate support for crisis responders who work mainly in community is missing and must be addressed as community care continues to grow. The tacit knowing I gained during the exploration of my experience with youth suicide has transformed me to look at things in a new way and question my own vulnerability. Prior to this heuristic journey, I had learned to maintain my professionalism at all costs. Through the discovery of new knowledge I believe I can be a better professional that understands and embraces the implicit side of doing this work and the self-acceptance that is reached toward becoming a more actualized person. I have adapted my definition of professionalism to include that it is okay to be vulnerable sometimes and the routine coping following suicide should take this into account.

#### **Limitations & Directions for Future Research**

In addressing the research problem, a heuristic design was selected to best describe the phenomenon. The results of the present study are therefore subjective, and should not be seen as a template of experience for all working in crisis response or related fields. Rather, by exposing the primary researcher's personal experience, it is hoped that others may consider the process of reflecting on their own experiences. The process of reflection and sharing insights may lead to dialogue in the profession about health provider knowledge and skills, including strengths and weaknesses as well; as areas for professional development.

Given the lack of research on this topic, there is an obvious need for multiple case studies to strengthen and generalize findings; as well as empirical work comparing crisis response workers to others who may share similar experiences, such as nurses and disaster response personnel. The present research was a first step towards considering how the difficult issue of

youth suicide impacts the professionals exposed to it. Historically this is a difficult area to delve into because of the sensitive nature of the topic. By focusing on the experiences of one individual crisis responder, generality of the findings to all crisis responders was not the aim of the research. The learning associated with one single experience can inform and help make sense of situations for others. As the account provided by the primary researcher is autobiographical in nature, the intention was for the outcomes of the present self-case study to provide a rich and congruous description of the phenomenon.

The present research was also intended to inspire others to generate appropriate hypotheses that are of value to future consideration into the phenomenon. Without a diverse sample, the differences in the range of responses are unknown. Ideally, looking into more than only one case study can identify practice issues for further consideration. Furthermore, the outcomes from the present study are proposed to grow a new perspective and construct meaning and awareness that guides actions in practice.

There are many variables that affect the best ways to facilitate crisis responders' coping with the known stressors of what constitutes a crisis. Due to the lack of existing research, more is needed on the specific experience of crisis responders working with youth. Determining how age differences and mixing seasoned workers with new workers affects team dynamics can inform hiring practices to maximize social support. The dynamics of gender diversity and ethnic diversity can also be an area of interest in terms of anticipating psychological strain.

Ongoing mindfulness of the potential negative characteristics of clinical human dynamics can advance client care. In the health care system, various services are available to address youth suicide and/or related needs of the community. These services range from nurses and doctors in the emergency department to clinical psychologists providing therapeutic interventions.

Professionals gaining exposure and insight into the different practices committed to the issue of youth suicide may improve personal capabilities. Beginning with the best interest of the clients in mind, a concept of interpersonal collaborative learning and practice may improve both quality of care as well as work experience for the different professionals involved.

Future research may consider how people of various educational backgrounds begin to feel fulfilled working within an inter-disciplinary environment. With a collaborative care approach, crisis responders with a diverse range of skills could also alleviate traumatic experiences for each other. This is especially important because the specific stressors of crisis response include completed youth suicide among a range of other emotionally difficult assignments.

Likewise, understanding people's experiences with different management styles is also relevant to the general function of employees and organizations. More research on crisis responders can urge managers to gain awareness of the adverse effects of repeated exposure to traumatic events for their workers. The potential harmful effects of working in crisis response can be mitigated by thoughtful managers committed to creating a culture of safety and wellness in the workplace.

Personal vulnerability may be an area of interest to focus on in future pursuits into the complex experiences of crisis responders. For example, there may be a distinct difference for crisis responders who work in remote areas, such as on Aboriginal reserves. Circumstances such as having personal experiential meaning toward the topic of youth suicide could impact the coping styles of workers. It may also be constructive to examine crisis responders working in a small enough community to have a personal connection to the client or personal history in relation to the clientele. The healing that a smaller community would undergo after a youth

suicide could show emotions that are closer to the surface reflecting on a unique experience of encountering grief.

Finally, a full heuristic study, or collective case study approach including other participants as the next step in the research is recommended to augment the discovery of knowledge in the current study. The primary researcher suggests a period of incubation for herself or for others after reading this document to allow for some period of reflection as required after the immediate awareness that comes from being exposed to new information. Perhaps a study including several interviews with other crisis responders to youth suicide could enhance the current study by showing similarities, differences, and even uncover other themes not unearthed during the present self-case study

### **Implications for Practice**

Crisis responders are confronted with demands of family members to help explain suicidal behaviour. As well, other service providers rely on them to take full responsibility for crisis situations as they work through the crisis plan given to families and youth treatment homes. The well-being of crisis workers hangs in the balance of high pressured interactions over which they have little control. Based on the findings of the present study, anticipating the common features of how crisis responders face high stress circumstances could be the key to more thorough training for those situations. For instance, increased role play in training exercises, especially those that consider communication and resources outside of the crisis worker and the client, will allow for crisis responders to practice so that they are prepared for the degree of responsibility they will undertake during that time.

In relating to the trauma, crisis responders are asked to focus their attention on the people immediately impacted by the youth suicide. While they are also a part of the group of people in

the impacted zone, they are expected to advance the situation without addressing any possible emotions they may be experiencing in the moment. As a result, it is difficult to know how they process this information. The normal emotion associated with the traumatic event is ignored in order to sustain the situation for others. This empathetic response referred to as vicarious trauma is evident in reports about nurses and other professionals (Elwood et al., 2010). While caring for others, they become emotionally drained and can later endure adverse effects by their efforts.

In an effort to further extend current knowledge, and offer insight into the significance of the topic, CSDT is useful as a theoretical guide in understanding the findings of the present study. The themes that resulted from the present research indicated that the crisis responder's approach to working with youth was impacted, but also their ideas pertaining to connecting with others in their personal life. A youth suicide is a tragedy, but also an unexpected termination as such without the resolve typically involved when terminating a therapeutic relationship. The crisis responder is expected to separate themselves from the experience of a youth terminating their life, as well as any bond they may have had with the crisis response team.

This abrupt break that occurs for crisis responders can impact the manner in which they connect with youth in future efforts to address suicidal behaviours. Prevention and intervention efforts occurring at the organizational level can support a dynamic on the front lines that assists workers in processing these events appropriately. Determining the most suitable level of support which is needed to promote wellness at work depends on resources and how they are distributed. Enhancing the understanding of vicarious trauma for crisis responders can provide a healthier workforce that is adequately trained and prepared to offer proficient client care.

### **Conclusion**

In conclusion, comprehending the experiences of crisis responders will improve the body of research that directs clinical practice. More specifically, youth suicide is a sensitive subject that relies on the stability and emotional health of professional supports. Further information is needed regarding what factors contribute to burnout, and specifically for workers who have shifted from working from within an institutionalization model towards more community-based programs. Including crisis responder's experiences will contribute to the promotion of healthy ways to minimize vicarious trauma. Furthermore it will identify variables that can assist programs in hiring, training, and retaining competent dedicated workers.

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**Appendices****Appendix A1**

Table 1

Completed Suicide per 100,000 persons

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Total population		Aboriginal
Males 15-24	24	126
Females 15-24	4	35

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*Note.* Adapted from "Suicide Death Rates by Age Group: First Nations and Canadian Populations, 1989-1993" by Canadian Institute for Child Health, 2000, *Canada's Children: A CICH Profile* (3<sup>rd</sup> ed.) (chap.6), p. 33.



**Appendix A2**

Table 2

Completed Suicide Rates Manitoba per 100,000\*

Aboriginal On Reserve		Aboriginal On Reserve	Aboriginal Off Reserve
15-19	9.6	88.6	51.7
20-24	14.5	83.9	59.5

*Note.* Adapted from "Suicide among Manitoba's aboriginal people, 1988 to 1994" by Malchy, B., Enns, M., Young, T., & Cox, B., 1997, In *Canadian Medical Association*, 156(8), p. 1133-1138.

## Appendix B

### Questionnaire

Proposed research questionnaire for crisis responders who had experienced youth suicide during their time working with a mobile crisis team in Canada. Developed by Despina Tzotzolis.

- 1) What has your experience as a crisis responder to youth suicide been like?
- 2) Is there anything that continues to stay with you to this day about youth suicide?
- 3) Are there any positive effects for you as a person professionally or personally having been a crisis response worker addressing youth suicidality?
- 4) Are there any negative effects for you as a person professionally or personally having been a crisis responder to youth suicide?
- 5) Did experiencing youth suicide change the way in which you did/do your job?
- 6) Do you have anything else you would like to add regarding your experience with youth suicide?

## Appendix C

### Song Lyrics/Audio

Song written and translated from the original Greek by Despina Tzotzolis (2012).

Audio available at <https://archive.org/details/TheHurtChildSings>

#### *The Hurt Child Sings*

Through the heavy rain  
I was left outside your window  
Draw closer, come  
To really see me

A bright day  
Appears  
For me

A bright day  
Appears  
For me

Now I am left  
Unaided  
And unmoving  
And you are not here  
To protect me

A bright day  
Appears  
For me

## **Appendix D**

### **Personal Journal Excerpts** by Despina Tzotzolis

#### **March '09**

The job is not only tough because we are making decisions about whether a youth needs protection from them self but also we consider a variety of contributing factors to the client's situation. What is the impact on the other family members and what subsequent support is needed? Also does child and family services need to be involved if there is a presenting child protection matter. We may attend a crisis call because mom was having difficulty trying to wake her kid and getting them to school and then after discussions realize the youth is depressed; sleeping too much, isolating, feeling low self-worth. All of a sudden the priority becomes suicide prevention and not so much about failing grades.

#### **January '10**

When team members are confronted with chaos it is our job to slow things down and relate to others in a calm manner and when we struggle with that we welcome a clinical consult with our coordinators. Also we tend to have faith that our team members have handled a situation analogous to the way we would have. The process looks like taking a quick look at the file if one exists from that last time we visited just to get a sense of the outcome as it may be one option to resolve the current crisis at hand. Many times the team is addressing the same type of crisis and typical questions directed toward the client are "has anything changed from the last time the crisis team was here?" or "how was the situation resolved the last time you contacted us?" We are always encouraged by management to take a curious stance rather than a judgmental stance especially when addressing our "frequent flyers" those families which have contacted the crisis team several times. Also management continues to remind team members that crisis is

“self-defined” what may not seem to be that important to me personally, could be considered an “intolerable loss” to a client. It feels good that I can go to my managers with *some* questions about how to handle things. But I want them to see me as competent because that helps me believe in myself in those moments of doubt. It's just not possible to share the really deep fears about the work I'm doing.

### **May '11**

An influential and experienced psychiatrist conducting an interactive all staff meeting bluntly told the group that no matter what we do as professionals we cannot prevent someone from committing suicide. She placed a gentle disclaimer before her statement telling us that our job is important and not to be discouraged. Finally she said, “If they really want to do it they will”. Some co-worker's sounded offended when the psychiatrist said that. I remember the group debrief later that day there was a split in the group as some still believed they could prevent someone from completing suicide with appropriate interventions. I remember very vividly something else. When that respectable psychiatrist told us there was nothing that could stop someone committed to the idea that suicide was their only option; in that small pocket of time she shared that particular information I felt relieved that if a *client* completed suicide it would not be my fault.

### **Aug '11**

Postal strike is finally over and the pictures from the hospital photographer came today. My beautiful baby boy, I cannot live without you. I see twinkles in your eye, we are connecting already... All babies start off that way I'm sure of it, a bright future ahead of them with possibilities... or does the diathesis stress model take over, more specifically is it all predetermined being male, Aboriginal, history of depression/suicide in family and other risk

markers seal the fate of a child who will eventually kill themselves...like a Shakespearean tragedy...there is nothing we can do to prevent the fatal outcome...

### **March '13**

The workshop I went to was filled with people from all disciplines learning the same thing, we did role plays, watched videos, and listened to the speaker describe a person-centered directive approach to eliciting change. The techniques could be used to help resolve ambivalence or a resolution to suicidal thinking among other harmful behaviours. The speaker reviewed some of the difficulties of working with at risk populations, and that their readiness for change sometimes lies in the skill of the helper, specifically their ability to collaborate and guide the process of change for their client. Also he spoke about the type of affection we have for our clients and described this to us by talking about the different definitions of love. They are rooted in the Greek language; *phileo*- friendship, *eros*- romance, *agape*- unconditional, and *storge* which he was told by a participant in a previous workshop he held was the kind of love you might have for your addiction. This did not sit well with me as I am familiar with the Greek language and remembered this word meaning something else. On our lunch break I called my mother who was at my home babysitting. She's been staying with me while I gradually transition back to work, helping me with the baby. She told me that *storge agape* was the kind of love you have for your child. "A protective love?", I asked? She said it was exactly that...at that moment I felt an intense connection to the word, and to my thoughts about the youth I have worked with.

## Appendix E

### Media

Manitoba's government is spending \$8 million over four years on a youth suicide prevention strategy.

The strategy pays particular attention to northern Manitoba, where the suicide rate among aboriginal youths is reaching epidemic proportions, said Ron Evans, grand chief of the Assembly of Manitoba Chiefs.

The strategy includes a crisis stabilization unit in Thompson and mobile units to provide treatment for youths in remote communities.

Kitching, Chris. (2008, December 15). Province to spend \$8M to prevent youth suicides.

*Winnipeg Sun*. Retrieved from <http://www.winnipegsun.com>

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It's hard to know what to do in the face of suicide, especially when it's a young person. But a suicide pact? With 30 kids? What can you do about that?

The truth is, we know a lot about suicide and indigenous youth. We know that people become suicidal when the pain of life overwhelms them. We know that in the case of indigenous youth, that pain stems from a long history of colonialism and its impacts: the lack of cultural continuity, of opportunity, of a stable home life, of hope for the future. But we also know how to support indigenous youth and reduce the risk of suicide.

Suicide pacts are a cry for help. They are an attempt for individuals who feel lost and alone to gain a sense of community. Unfortunately, they gain that community at the ultimate price. We know that the solutions lie with strengthening our families and culture in order to increase self-esteem. We know that we need to talk to the youth

themselves for the solutions.

Many people know that suicide statistics for aboriginal youth are up to six times higher than the national average.

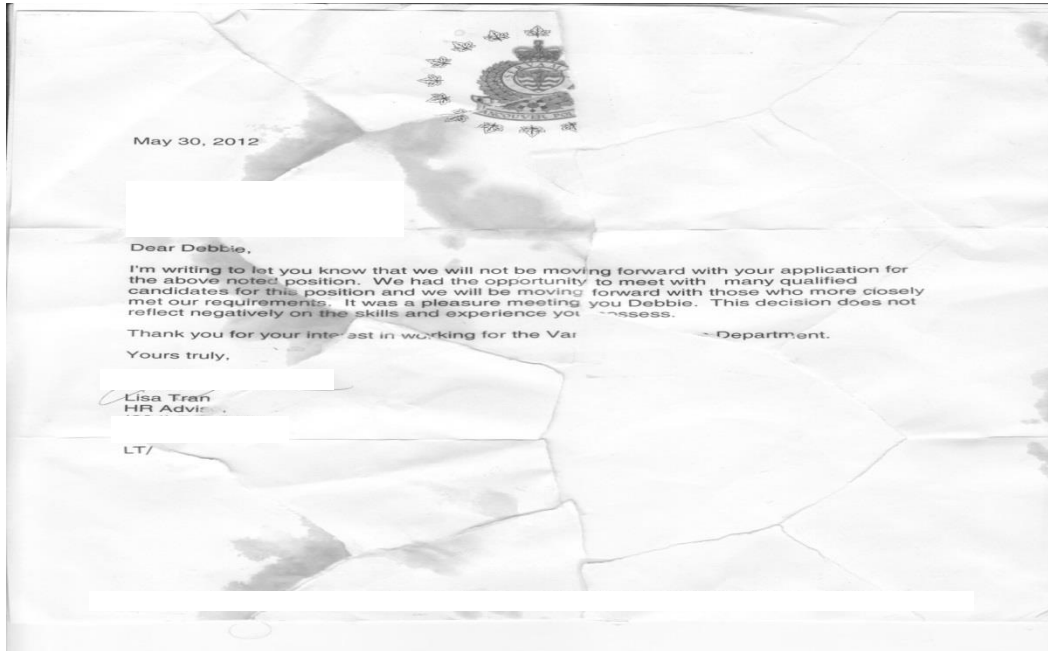
Thira, S., & McCormick, R. (2012, December 18). Opinion: Are Aboriginal teens dying to belong?. *The Vancouver Sun*. Retrieved from <http://www.vancouversun.com>



**Appendix F**

**Vancouver Police Department Rejection Letter**

(Personal communication, May 30, 2012)



[Transcription]

“Dear Debbie,

I'm writing to let you know that we will not be moving forward with your application for the above noted position. We had the opportunity to meet with many qualified candidates for this position and we will be moving forward with those who more closely met our requirements. It was a pleasure meeting you Debbie. This decision does not reflect negatively on the skills and experience you possess.

Thank you for your interest in working for the Vancouver Police Department.”

### Appendix G

#### Consent Form for Ethics Approval

Multiple sources of evidence will be accessed for analysis. The data gathered for heuristic review and process are the personal memories, diary entries, personal suicide and trauma debriefing training materials, previous academic course work and class notes, articles referring to youth suicide and crisis response, and excerpts from media. Access to the data will only be available to the primary researcher and will not be shared with either the Faculty of Human Ecology or the Faculty of Graduate Studies. All precautions will be taken to protect the identities of all persons influencing the heuristic research design and application. The data obtained through this process will be securely stored and destroyed upon completion of the project.

There is risk being that as the primary researcher/sole participant, I may suffer from some discomfort while disclosing my thoughts, feelings and experiences on the topics discussed during the heuristic process. Contact information for the office of the University of Manitoba Ombudsman and the office of Student Advocacy is known to me should I feel I require assistance in addressing any detrimental effects resulting from participation in the project. Complaints, conflicts and assistance can be accessed through these offices in confidence.

There will be no academic credit or remunerations provided to me as the sole participant in the project.

**My signature on this form indicates my self-commitment in participating in the research project.**

Principal researcher:

Despina Tzotzolis

Telephone:

Supervising Professor:

Dr. Caroline Piotrowski

Telephone:  
or email

**This research has been approved by the [appropriate REB]. If I have any questions about this project I may contact any of the above-named persons or the Human Ethics Secretariat at [redacted]. A copy of this consent form will be kept for my records and reference.**

I give my informed consent to participate in this research project:

\_\_\_\_\_  
Primary Researcher/Sole Participant's Signature

Jan 1, 13  
\_\_\_\_\_  
Date

\_\_\_\_\_  
Thesis Supervisor's Signature

Jan 2013  
\_\_\_\_\_  
Date

## Appendix H

## Ethics Approval Certificate



Human Ethics

## APPROVAL CERTIFICATE

June 13, 2013

**TO:** Despina Tzotzolis (Advisor C. Piotrowski)  
Principal Investigator

**FROM:** Susan Frohlick, Chair  
Joint-Faculty Research Ethics Board (JFREB)

**Re:** Protocol #J2013:064  
"A Crisis Responder's Experience with Youth Suicide - A Case Study Approach"

Please be advised that your above-referenced protocol has received human ethics approval by the **Joint-Faculty Research Ethics Board**, which is organized and operates according to the Tri-Council Policy Statement (2). **This approval is valid for one year only.**

Any significant changes of the protocol and/or informed consent form should be reported to the Human Ethics Secretariat in advance of implementation of such changes.

**Please note:**

- If you have funds pending human ethics approval, please mail/e-mail/fax (261-0325) a copy of this Approval (identifying the related UM Project Number) to the Research Grants Officer in ORS in order to initiate fund setup. (How to find your UM Project Number: <http://umanitoba.ca/research/ors/mrt-faq.html#pr0>)
- If you have received multi-year funding for this research, responsibility lies with you to apply for and obtain Renewal Approval at the expiry of the initial one-year approval; otherwise the account will be locked.

The Research Quality Management Office may request to review research documentation from this project to demonstrate compliance with this approved protocol and the University of Manitoba *Ethics of Research Involving Humans*.

**The Research Ethics Board requests a final report for your study** (available at: [http://umanitoba.ca/research/orec/ethics/human\\_ethics\\_REB\\_forms\\_guidelines.html](http://umanitoba.ca/research/orec/ethics/human_ethics_REB_forms_guidelines.html)) **in order to be in compliance with Tri-Council Guidelines.**