Canadian Journal of Counselling and Psychotherapy /
Revue canadienne de counseling et de psychothérapie
ISSN 0826-3893 Vol. 56 No. 2 © 2022 Pages 164–187
https://doi.org/10.47634/cjcp.v56i2.72243

Counselling Youth Who Are at Risk for Suicide: Working the Tensions
Counseling auprès de jeunes présentant des risques suicidaires : Désamorcer les tensions

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ABSTRACT
The purpose of this qualitative study was to examine how counsellors narrate their experiences of assessing and counselling youth who are at risk for suicide, the challenges and opportunities they face, and the conditions that support them in working in a relational, ethical, and useful way. Our analysis focused on how counsellors described their experiences working with youth who are at risk for suicide, the prevailing discourses and institutional requirements shaping their accounts of their practice, and some of the potential effects of these ways of thinking, talking, and relating. Our findings show some of the specific ways that counsellors "work the tensions" in their therapeutic encounters with youth who are at risk for suicide. This involves compliance and critique as well as artful reinterpretation. We hope to make a useful contribution to a growing body of practice-based evidence that recognizes the value of flexible, relational, and reflexive approaches to counselling youth who are at risk for suicide.

RÉSUMÉ
L'objectif de cette étude qualitative est d'examiner comment les conseillers racontent leurs expériences d'évaluation et de counseling auprès de jeunes présentant des risques suicidaires, les défis et possibilités qui s'offrent à eux, et les conditions qui les aident à adopter une approche relationnelle, éthique, et utile. Notre analyse a examiné comment les conseillers décrivaient leurs expériences de travail auprès de jeunes présentant des risques suicidaires, les discours dominants et les exigences institutionnelles qui influencent les compte rendus de leur pratique, et certains effets possibles de ces manières de penser, de parler, et d'entrer en relation. Nos conclusions révèlent certaines façons précises par lesquelles les conseillers « désamorcent les tensions » dans leurs échanges thérapeutiques avec des jeunes présentant des risques suicidaires.

L'acquiescement et la critique ainsi qu'une habile réinterprétation en font partie. Nous espérons apporter une contribution utile à une somme grandissante de données fondées sur la pratique qui reconnaissent la valeur des approches souples, relationnelles, et réflexives pour le counseling auprès de jeunes présentant des risques suicidaires.

> Researcher: How do you find that youth respond to these ways of working? What are the effects of these tools, frameworks, and practices on the young people that you are seeing and directly engaging with?
>
> Counsellor: Are you asking if we were just to do the [name of organization] screen assessment, what the impact would be? Or what is the impact of the way that we actually do it?

We open this article with an excerpt from a transcript of a focus group with counsellors as a way to show that there are official ways of doing things and then there is "the way we actually do it." This is not meant to suggest that counsellors are somehow ignoring clinical standards or bypassing required protocols, nor is it meant to imply that "the way we actually do it" offers a pure version of the truth or gives us direct access to an objective social reality. Rather, this excerpt illuminates the discursive nature of counselling and research. It shows that people's responses to questions represent performative, social accomplishments that are negotiated through interactive processes (Lester et al., 2018). The excerpt also makes visible the collaboratively produced nature of research by revealing the active presence of the researcher in shaping the conversation that unfolds.

Counselling and qualitative research are both social practices whose meanings are worked out through interaction and through drawing on available institutional and cultural resources (Strong & Smoliak, 2018). Given our particular interests in how language, discourse, and relational processes shape the ways that counsellors narrate and enact their practices, our qualitative study is theoretically grounded in a social constructionist approach (Miller & Strong, 2008; Strong & Smoliak, 2018; Willig, 2019). The work of counselling youth who are at risk for suicide takes place amid dominant and contradictory discourses about suicide and its prevention. This produces different understandings of the roles and responsibilities of counsellors, which in turn require careful navigation of multiple professional, relational, and ethical tensions. For example, if a counsellor understands that it is their responsibility to keep a client alive at any cost, this could lead to increasingly directive or anxiety-driven responses. A suicidal act may be averted, but the therapeutic relationship may be irrevocably damaged. This is a familiar ethical dilemma for many counsellors engaged in this work.

The Rise of the Biomedical, Technological Paradigm

Counsellors who work in publicly funded, community-based mental health treatment centres routinely encounter youth who are at risk for suicidal behaviour

alongside other presenting concerns such as family conflict, trauma, relationship problems, loss, self-harm, and substance use. In recent decades, there has been a proliferation of suicide risk assessment tools, protocols, and treatment guidelines, all of which have been designed to assist counsellors and health care providers in their work with potentially suicidal clients (Bernert et al., 2014; Perlman et al., 2011). Very few of these clinical tools or practice frameworks focus specifically on youth (Courtney et al., 2019).

Most clinical guidelines or practice standards for working with individuals who are at risk for suicide include some variation on the following: counsellors identify potential suicide risk, assess clients according to known risk factors for suicide, plan for safety, obtain consent to speak with significant others in the client's support network, implement treatment plans according to risk level, restrict access to the lethal means of suicide, document risk levels and treatment plans, and provide caring contact follow-up (National Action Alliance for Suicide Prevention, 2018; Roush et al., 2018). In the few instances in which the particular needs of young people who are at risk for suicide are addressed, there is a strong emphasis placed on collaboration, youth engagement, treatment flexibility, and active family involvement (White, 2014; Busby et al., 2020; Jobes et al., 2019).

Cultivating a strong therapeutic alliance based on collaboration, trust, and empathy is well-understood to be one of the most important aspects of working with individuals who may be contemplating suicide (Michel & Jobes, 2011; Jobes, 2020). This is consistent with the "common factors" approach to psychotherapy (Wampold, 2015), whereby outcomes are understood to be influenced most strongly by the quality of the therapeutic alliance and by other non-specific factors such as client variables, external therapeutic events, and hope/expectancy about the treatment (Wampold & Imel, 2015).

Most counselling services in Canada are funded and administered through formal health systems. This often means that biomedical and technological orientations provide the primary organizing frameworks through which suicidal despair and professional counselling are understood, potentially displacing more collaborative, relational, or responsive approaches (Bracken et al., 2012; Strong et al., 2017). We see clear evidence of this medicalized logic in the National Action Alliance for Suicide Prevention's (2018) *Recommended Standard of Care for People With Suicide Risk*:

> The evidence is clear that it is possible to identify most individuals with greatly elevated risk, allowing us to provide targeted, effective supports during the period where their risk remains high. This is similar to identifying risk factors for heart disease so that something can be done about it.… (p. 3)

While often taken for granted in a medicalized paradigm, thinking about suicide risk as if it is "disease-like and caused by underlying biomedical and psychic

conditions" (Miller & Strong, 2008, p. 610) is not natural or required. In recent decades, a number of authors within the counselling and suicidology fields have expressed concerns with the uncritical acceptance of standardized and medicalized approaches to understanding and responding to suicidal despair (Espeland et al., 2021; Hjelmeland & Knizek, 2020; Marsh, 2020).

Limitations of Standardized and Medicalized Approaches

Standardized suicide risk assessment protocols typically predetermine ways of thinking about (or knowing) suicide, which may be at odds with counsellors' commitments to working in a more curious, open, relational, collaborative, and responsive way (Espeland et al., 2021; Strong & Smoliak, 2018). As Strong et al. (2017) observe, a medicalized approach to professional counselling is becoming increasingly common, reflecting an underlying "diagnose and treat logic" (p. 163) whereby the use of DSM-V categories, evidence-based practices, and biomedical understandings of problems are often taken for granted. Similarly, many traditional suicide prevention risk assessment frameworks tend to be based on individual-level theorizing, categorical thinking, biomedical framings, and "psychocentric approaches" (Marsh, 2020; Rimke & Brock, 2012). These in turn generate solutions that emphasize individual responsibility, self-management, and the role of professional expertise, obscuring the role of social, historical, and political structures that contribute to distress (Button & Marsh, 2020; Reynolds, 2016).

Standardized approaches to suicide risk assessment can offer a useful structure to counsellors seeking to assess potential risk systematically, but they cannot accommodate nuances, contradictions, ambiguity, or emergent meanings easily. By directing counsellors' attention to known risk factors for suicide, standardized risk assessment frameworks can potentially leave other significant factors insufficiently explored. This has led Sommers-Flanagan (2018) to state that "without taking time to understand how individual patients think about suicide, it is difficult to know whether the presence or absence of specific factors are operating to increase or decrease suicide risk" (pp. 34–35). Many contemporary approaches address some of the limitations of standardized suicide risk assessments by balancing information gathering with relationship building and by placing a stronger emphasis on collaboration, conversation, and context (Jobes, 2020; Michel & Jobes, 2011).

In the section that follows, we situate the issue of youth suicide within the current context in Canada. We summarize the current state of knowledge and highlight some of the unique and valuable insights that qualitative researchers can offer to our understanding of counselling those who are at risk for suicide. We describe the study that we undertook in 2019–2020 with counsellors who work with youth who are at risk for suicide in the province of British Columbia. We present the key findings from our study and conclude with a set of recommendations for future research and practice.

The Challenge of Youth Suicide

A total of 173 Canadian youth aged 15 to 19 died by suicide in the year 2020, representing a rate of 8.2 per 100,000 (Statistics Canada, 2021). There are typically three male youth suicides for every female youth suicide (Statistics Canada, 2021). Suicide is one of the leading causes of death among children and youth in British Columbia (BC), exceeding deaths due to motor vehicle fatalities or overdoses (BC Coroners Service, 2020). There were 111 suicides in that province among those aged 10 to 18 between 2013 and 2018, according to a recent provincial review (BC Coroners Service, 2020). While approximately 6% of the BC population identifies as Aboriginal (including First Nations, Métis, and Inuit; Statistics Canada, 2017), Indigenous youth accounted for 23% of all youth suicides in BC during this period.

Non-fatal suicidal behaviours and self-harm are also serious concerns. According to the most recent BC Adolescent Health Survey (McCreary Centre Society, 2019), 17% of students in Grades 7 to 12 seriously considered killing themselves in the year prior to taking the survey. Moreover, 5% of the youth surveyed reported that they had made a suicide attempt in the preceding year. A total of 17% of students reported that they had engaged in self-harming behaviours without intending to kill themselves in the preceding year, whereas 47% of non-binary youth had self-harmed in the preceding year. We can see from these reports that youth who are marginalized (e.g., 2SLGBTQIA+ or Indigenous youth) are at elevated risks for suicide and self-harm. They face unique stressors related to racism, colonialism, heteronormativity, and bi/trans/homophobia, and these forms of structural discrimination need to be taken into account when considering counselling responses.

Understanding and Responding to Youth Suicide

Youth suicide and suicidal behaviours are multiple, dynamic, complex, and contextually situated. They are shaped by neurobiological, psychological, social, cultural, historical, economic, and political factors. Comprehensive, multi-pronged, community-based, and developmentally informed approaches to youth suicide prevention are typically recommended (Busby et al., 2020; Robinson et al., 2018). Skill-based, problem-solving treatment approaches such as Dialectical Behavior Therapy-Adolescents (DBT-A) show promise in reducing suicidal behaviours among youth (Busby et al., 2020; Jobes et al., 2019). However, according to several systematic reviews (Bennett et al., 2015; Glenn et al., 2015; Robinson et al., 2018), there continues to be a paucity of high-quality evidence on effective treatments for preventing suicide among youth, and many questions remain. Recent studies have also suggested that current scientific evidence does not support the use of suicide risk assessment instruments to predict future suicidal acts (Runeson et al., 2017).

There is a great deal of debate and contestation surrounding the study and the practice of youth suicide prevention, owing in part to ongoing epistemological, ethical, and socio-political debates in the field of suicidology regarding the nature of knowledge, the politics of evidence, and the conceptualization of suicide itself (Fitzpatrick, 2020; Hjelmeland & Knizek, 2020; Marsh, 2020; White, 2020). There has been a growing push over the last 10 years to consider a broader, more diverse range of approaches for preventing and studying suicide, especially since rates of suicide are not declining but are actually on the rise in many parts of the world, including the United States (Curtin et al., 2016). Service users, persons with lived experience of suicide, scholars, practitioners, policy-makers, artists, and activists have been collectively calling for the mobilization of multiple forms of knowledge that would enable a broader range of practices and responses to be considered (Hom et al., 2021; Rossouw et al., 2011; White et al., 2016).

Unique Insights From Qualitative Research

With its close attention to language, context, history, and relational meaning-making, qualitative research can illuminate how counsellors navigate the challenges of providing therapeutic care to persons who are at risk for suicide (White, 2015; Willig, 2019). For example, Rossouw et al. (2011) conducted a phenomenological study of therapists' experiences of working with suicidal clients in New Zealand. The authors identified three themes based on their interviews with therapists: shock and surprise; strong feelings of responsibility, fear, and guilt; and being unfamiliar, referring to therapists' confrontation with the ultimate unknowability of others, which was intensified when working with suicidal clients. They suggest that the "phenomenological mode" of understanding and relating to clients may offset the dominant "scientific mode" that characterizes mainstream mental health services. Instead of responding to the suicidal person with the "voice of the already known," they recommend a stance of invitation and openness, with a focus on meaning (p. 8).

Podlogar et al.'s (2020) grounded theory study from Slovenia highlights the multiple ethical and professional tensions that mental health practitioners routinely have to balance when working with suicidal clients. Their analysis resulted in the creation of a theoretical model that represents how therapists work to achieve dynamic balance across six key areas: understanding suicide, the role of the alliance, attitudes, emotional response, responsibility, and the focus of the therapeutic work. Within each of these categories, psychotherapists were faced with finding a dynamic balance between potentially opposing tensions. The authors suggest that the focus on achieving a dynamic balance across these broad areas is of particular salience when working with clients who are at risk for suicide.

A study from Sweden involved asking suicide prevention experts how nurses working in a psychiatric outpatient clinic with young people might identify and

support youth who "struggle with living" (Omerov et al., 2020). The interviews with experts were synthesized into three main themes. First, working with youth who are contemplating suicide is necessary but demanding and requires a bold form of engagement. Second, there is a need to acknowledge warning signs. Third, the development of a trusting relationship that draws on the expertise of both the practitioner and the young person is considered essential.

An exploratory Canadian study (Dubue & Hanson, 2020) based on interpretative phenomenology sought to gain a better understanding of psychologists' experiences conducting suicide risk assessments. Findings suggested that psychologists value integrative approaches to risk assessment where client collaboration and information gathering are woven together in the spirit of a therapeutic assessment. Their study highlighted several tensions that psychologists encounter as they try to strike the right balance between respecting client autonomy and providing responsible care. Dealing with outside pressures such as regulating bodies and professional codes of ethics can generate anxiety and strain among psychologists as they try to address multiple interests and ethical obligations competently. The authors recommend that both graduate students and practising psychologists would benefit from learning about more contemporary approaches to suicide risk assessment that are not based solely on information gathering. While not necessarily focused on youth, these alternative risk assessment frameworks emphasize collaboration, therapeutic engagement, and trust building (Jobes, 2020; Sommers-Flanagan, 2018).

Espeland et al. (2021) examined risk assessment practices in Norway by interviewing individuals who were responsible for implementing national suicide prevention guidelines and action plans. Their findings suggest that standardized risk assessment approaches can easily become impersonal and objectifying, creating ambivalence in counsellors and suicide prevention practitioners. They also found that the strict emphasis on following procedures had the potentially undesirable effect of privileging the needs of the system and of the practitioner over those of the client, which was antithetical to more relational approaches to suicide prevention.

While not focused on suicide specifically, the Canadian study undertaken by Strong et al. (2017) is relevant for the way it explored some of the tensions and complexities experienced by counselling students as they attempted to navigate working in increasingly medicalized spaces. These researchers mapped the multiple discourses that counselling students frequently encounter in their field placements, including those that are relational, evidence based, pluralistic, multicultural, focused on health management, and person-centred. Each of these discourse positions carries its own assumptions, values, and understandings of human despair that in turn invite different therapeutic responses. This exposure to competing discourses can create dilemmas for new counsellors as they attempt to work in the midst of these discursive landscapes.

Present Study

The preceding studies all provide important insights, and yet a number of issues remain unexplored, providing a strong rationale for our study. First, most of the recent qualitative research has focused on adult clients in non-Canadian contexts. Second, counsellor accounts of work with persons who are at risk for suicide rarely draw from a constructionist methodology where the focus is on highlighting how dominant institutional narratives strongly influence how practices can be thought, spoken, and enacted. Third, the qualitative studies undertaken to date do not typically show how counsellors collaborate with others through dialogue to make meaning and to co-construct knowledge. By focusing our attention on counsellors' accounts of practice with Canadian youth and by drawing on a constructionist methodology to highlight the role of socially generated meanings, our study makes a novel contribution.

For this study, we sought to gain a better understanding of the practical ways that counsellors working in publicly funded, community-based mental health treatment settings in BC accomplish the work of assessing and counselling youth (aged 13 to 19) who are at risk for suicide. We wanted to know more about the conversational practices counsellors relied on to support young people in staying alive and about the conditions and the practices that sustain them in their work. More specifically, we were interested in exploring how counsellors do this work under conditions of increased accountability, medicalization, standardization, and risk management (Espeland et al., 2021; Strong et al., 2017). We received ethical approval to proceed with this study from the University of Victoria's human research ethics board. The study took place between November 2019 and December 2020. Two main questions guided our study: (1) How do counsellors narrate and make sense of their experiences working in a professional counselling context with youth who are at risk for suicide? (2) What do these counsellors' accounts reveal about what makes this work the most useful, hopeful, affirmative, and life enhancing for the young people they work with?

Method

Participant Recruitment and Data Collection

Third-party recruitment was used to invite counsellors from two clinical teams/sites to participate in the study. A poster was circulated by an administrative assistant to counselling staff working at two clinical teams located within two urban centres in the province of BC. We let counsellors know we were interested in learning more about their experiences working with youth who are at risk for suicide and told them about the opportunity to participate in a 1.5-hour group dialogue with other counsellors on their team about the unique challenges and opportunities found in this work. It was made clear to all participants that their

participation was strictly voluntary. Counsellors were advised that their clinical supervisors would not know who had participated in the research study.

Focus Groups

The rationale for using a group format was threefold: (a) to reduce the isolation, anxiety, and fear of blame that often accompanies therapeutic work with clients who are at risk for suicide (Awenat et al., 2017); (b) to explore the potential of a practice-oriented group conversation for facilitating professional learning; and (c) to elicit socially shared, tacit knowledge through "collective sense-making" that includes the active contributions of the researcher (Ryan et al., 2014, p. 331). The primary aim of the focus group conversation was to elicit stories about and detailed descriptions of counsellors' experiences of working with suicidal youth in a professional, therapeutic context.

Four counsellors (two men and two women) from the first site agreed to participate in a face-to-face focus group in the fall of 2019. Three counsellors (one man and two women) from the second site agreed to participate in a virtual focus group in the spring of 2020. All seven counsellors worked exclusively with youth and ranged in their levels of experience; all but one had been trained at the master's level. The Covid-19 global pandemic of 2020 hampered our recruitment efforts and meant that we could not meet in person for the second focus group. In the end, we conducted two 1.5-hour focus groups with counsellors who work at two clinical sites in BC cities with youth who are at risk for suicide. The first focus group was also graphically recorded, which allowed emerging ideas and themes to be represented graphically through images in real time.

Constructionist Approach to Analysis

Conversations among members of both focus groups were audio-recorded and transcribed. A social constructionist approach was used to read the data, with a strong focus on identifying how social processes—including language, categories, and prevailing discourses—shape counsellors' accounts of practice (Potter & Hepburn, 2008). We are using the term discourse to refer to "texts and talk as part of social practices" (Potter & Hepburn, 2008, p. 276). It is a medium for action (more as a verb than as a noun) in which "versions of the world are constructed and made urgent or reworked as trivial and irrelevant" (p. 275). We focused attention on both what was said and how it was expressed. We wanted to gain a better understanding of how specific ways of talking shape how counsellors experience themselves, the young people they work with, and the broader social world that we all inhabit. In short, we were concerned with the relationships between language, meaning-making, and the implications for practice (Willig, 2019).

Informed by our constructionist sensibilities and theoretical commitments, we relied on the flexible and reflexive approach to thematic analysis developed by Clarke and Braun (2018) to organize and interpret the focus group data. In this

approach, there is a strong emphasis on researcher subjectivity, reflexivity, and the situated and contextual nature of meaning-making. Themes are active creations of the researchers based on their theoretical orientations. In our case, the data were analyzed thematically to address our research questions, which were focused on how counsellors narrated and made sense of their practices when working with youth who are at risk for suicide. Close attention was paid to how counsellors assigned meaning and drew on dominant discourses to work up accounts of social reality in their conversations with each other and with the researcher (Miller & Strong, 2008). We also attempted to identify some of the counsellors' preferred practices and discourses for guiding their therapeutic engagements with young people.

In reflexive thematic analysis, themes are patterns of shared meaning that are organized around a central concept and are the active creations of the researchers (Braun et al., 2019; Clarke & Braun, 2018). All members of the research team were actively involved in reading the transcripts, and several meetings were held to share our responses and emerging understandings with each other. The first author took primary responsibility for the overall analysis, while the second and third authors raised questions, offered unique insights, and helped refine the preliminary themes. We used annotations and colour-coding to mark up the transcripts with our initial impressions. We were particularly interested in how counsellors conceptualized and justified their approaches to working with youth who are at risk for suicide. Guided by our research questions and by our theoretical framework, we paid close attention to counsellors' preferred descriptions and practices, in order to gain a better understanding of what made the work most hopeful and useful. Following an iterative process of multiple readings and team discussions of the transcripts and the graphic recording, we went on to identify potential patterns in the data and began constructing preliminary themes and organizing concepts that responded to our particular research questions. For example, the concept of "working the tensions" seemed to capture best the idea that counselling young people who are at risk for suicide involves discursive dexterity and an ability to navigate multiple ethical, relational, and professional tensions. From there, we went on to identify two broad themes and a series of sub-themes. We attempted to highlight the unique ways that counsellors made sense of this work, which included showing contradictory interpretations and co-constructed meanings that arose through the focus group conversations. The final step in our analytic process involved soliciting feedback from participants. Specifically, the first author shared the preliminary themes with all participants and asked if they had any further input. One participant provided some additional commentary, which resulted in the further refinement of one of the themes.

Positioning Ourselves as Researchers/Practitioners

We are three white, straight, cisgender, middle-class, educated professionals. We are painfully aware that our work takes place on stolen Indigenous lands,

specifically Lekwungen territory and the territory of the Songhees First Nation. We recognize that our whiteness typically goes unmarked and provides the unspoken normative centre against which members of Black, Indigenous, and racialized groups are rendered Other. We understand that the world has largely been created for our benefit and comfort as white people. Access to these unearned benefits is built into the systems, structures, and policies that govern all of our lives. By making these inequitable social arrangements explicit, not only do we make visible our ethics and politics, but also, we show how this racism and this heteronormativity are highly relevant to understanding suicide and its prevention. Specifically, youth who are Black, Indigenous, racialized, queer, or transgender face unique stressors as a result of living in a world that stigmatizes, marginalizes, and/or misgenders them (Bochicchio et al., 2022; White, 2021). We recognize further that counselling and therapy are never neutral and that many mainstream evidence-based mental health practices are based on the experiences of western, white, European populations (Gone, 2015). In short, we are mindful of the formal knowledge base and the professional practice obligations that flow from it, *and* we recognize the value of less certain, more contextually contingent, and occasionally subversive or disruptive knowledge (Nairn, 2004; Rossouw et al., 2011).

Results

In listening to counsellors' accounts and conversational exchanges about their work with youth who are at risk for suicide, we heard standard accounts of practice that typically were expressed in a straightforward way, encapsulated in tidy narratives and procedural language. We also heard accounts of counselling practice that were less official and that invoked more philosophical, metaphorical, and poetic language such as "presence," "being," "art," and "existence." We share excerpts from our conversational exchanges with counsellors (whose names have all been changed to maintain their anonymity) that exemplify the concept of "working the tensions," and we have organized these excerpts under two broad themes: (1) compliance and critique and (2) artful shifts and conversational openings.

Compliance and Critique

Counsellors are well-versed in the institutional requirements for assessing and responding to youth who are at risk for suicide. Emmett describes it this way:

> We are trained in suicide risk assessment. We are engaging in a conversation, so that is the filter, but it is like an interview process around assessing risk. Is there a plan? What is the intensity around that? Are there available means? Is there planning? Who else knows? What is all that? We are having an internal dialogue—"Is this low, medium, high?" Regardless, around that kind of risk analysis that we make, we are consulting with our coordinator around that

> risk assessment, be it low, medium, or high. We are collaborating and consulting around a plan to move towards next, based on that suicide risk assessment. It could mean various levels of intervention based on the assessed risk.

Performing Accountability

In this account, we see the actual effects of being professionally "trained in suicide risk assessment." It means being systematic with a series of set questions, placing persons into categories, and developing interventions to move forward based on the counsellor's analysis and expertise. This is consistent with most evidence-based suicide risk assessment guidelines that convey a linear and procedural logic that starts with risk identification, moves to risk formulation, and proceeds to targeted treatment planning that aligns with the level of risk (Cukrowicz et al., 2004). This systematized, categorical, and methodical approach to seeing people is often taken for granted. As Hall and White (2005) note concerning the use of categories as hallmarks of professional practice,

> Underpinning much professional work is the need to process people in terms of institutional categories: pre-defined formulations and routes which enable simple assessment, decision-making and disposal.… Such categories are not often explicitly established in professional encounters, but more usually hinted at, negotiated or resisted. (pp. 386–87)

This way of thinking is expressed by another counsellor, Marina: "The checklist starts going off in your head." Meanwhile, Colin helps us to understand that counsellors not only have to follow the rules but also have to be seen following the rules. All of this can be achieved with great efficiency:

> My goal is to get this done before the hour is out and get everything checked off, book another appointment, write that on the form so I can tell [clinical supervisor] that "I have another appointment; yes, I gave them the crisis line card." I can do all my notes and then if anything happens, I have done what I am supposed to do.… I just want to get it done and out of the way. I try to make it useful. I don't steamroll the person, but I completely take over—"This is what I have got to do."

In Colin's account, "get[ting] everything checked off" means writing it down in a particular way so that if ever there is a client suicide, his practice will not be called into question. He and the organization will be absolved of any responsibility should there ever be a practice audit or a coroner's inquest (the unspoken and imagined audiences of the clinical record, highlighting the social nature of this type of documentation). Colin's comments highlight the ways that counsellors are keenly aware of the scrutiny they are under and of the need to have their

paperwork in order. The sense of being pressured to "get it done and out of the way" is not necessarily inherent to the suicide risk assessment process itself, but rather, it reflects the contemporary reality of working within a complex medicalized system that is governed by licensing, accrediting, and regulatory bodies that exert their own pressures on counsellors, supervisors, youth, and families (Strong et al., 2017). Anticipating the possibility that questions could be raised about his thoroughness in assessing a client's safety, Colin actively voices how he will speak to his supervisor using words and phrases that convey a definitive, checklist approach: "I have another appointment; yes, I gave them the crisis line card," a carefully crafted statement designed to establish his professional competency, show his compliance with the rules, and deflect blame. Counsellors in our study understood acutely the need to perform a particular form of accountability (Potter & Hepburn, 2008) in case "anything happens"—a euphemistic way of referring to a young person's suicide.

Cracks in the Standard Approach

Alongside these official accounts of practice in which accountability and compliance are social realities that are actively being constructed, the counsellors also expressed potential concerns with the standard approach, giving rise to a tension to be worked out. For example, Benjamin makes the following point: "The process is kind of set, and you might be pushed down the stream and your client might be left behind." In other words, the standard suicide risk assessment practice requires counsellors to work in a "set" way. It has an unstoppable momentum, irrespective of whether it is meeting the needs of the client. As one example of this, Marina offers the following thoughts:

> I have an example of one client who feels that she has been involved in lots of services, but she feels that she can't talk about it because the response is always so hyperactive—"We have to do this—we have to get Emergency Services involved." It has led her to say, "Well, I can't really talk about it." … [The client] said an amazing thing: "Can I just talk about it without you doing that? Can we do the helpful part?"

Counsellors also occasionally viewed the standardized protocol as a step to get through, on the way to "the helpful part," as expressed here by Colin: "Get that stuff out of the way. Then I can actually have a more meaningful conversation. I try to understand what it means, talking about death generally. More conceptually … just the idea of death is normal."

Maureen offers her perspective on this process:

> When you get into this, what comes up right away is "risk assessment." Which then becomes pretty objectifying, pathologizing. You are kind of the expert on

> it, rather than really being in a relationship with someone. Also, the context of it becomes "Are you suicidal or not? Are you at risk or not?" rather than "Hey—what is life like for you?" And there is a whole bunch of information that is missed.… You have to take over and lead it at that point. There is a bunch of things that you have to do, and you are going to administer … which in a way kind of reinforces the illness—"Something is wrong with me; I can't look after myself."

In these excerpts, we see how some standard practices position counsellors as authorities who "take over." They are set up to administer expertise rather than to facilitate a generative, curious, open-ended, collaborative exploration. This unspoken professional expectation can leave young people in the position of being objectified and pathologized or subject to a hyperactive emergency response. Counsellors in our study raised important questions about standard or traditional approaches and critiqued the potential negative effects of such approaches. They found interesting and creative ways to resist this type of authoritative or hyperactive positioning. We see evidence of this in the following discussion regarding the institutional requirement to ask clients about suicide directly.

Slowing Down and Attending to Context

> Corinne: I think there is a little bit of intensity in asking that question ["Are you having thoughts of suicide?"] within a few minutes of meeting.… That is not certainly the first conversation I want to have with youth. I'm much more interested in slowing the process down and start building a relationship before we start talking about where they are at in terms of their suicidal thoughts and thinking.
>
> Val: I really agree with what Corinne is saying. I find that it is a bit of a balance. Of course, it is important to continuously assess for suicide when we are working with individuals, but having such … expectations that we ask the questions that directly can really get in the way of our clinical judgment and the way we would engage with somebody. It wasn't actually until I came to [name of organization] where it was required that you ask so blatantly, when there [are] no other indicators of going in that direction.… I don't believe you have to ask the question to get the answer. If someone is suicidal they will answer how they want to answer.… It is not just the question that is the screen, but we put so much weight on *the* question.
>
> Researcher: Why do you think it is required to ask this question, as you put it, "so blatantly"? What is behind that? What are your hunches about that requirement?
>
> Val: I think it is liability. It is a way that [name of organization], or any organization, pretends to protect themselves from a possible suicide when a person is in care or in service with [name of organization].

This concern about centring the interests of the organization over those of the client is consistent with the observations of Espeland et al. (2021), who noted that a fear of liability creates the conditions under which professionals become overly concerned with their own self-protection. It also resonates with the study undertaken by Rossouw et al. (2011), who found that "the authorities' anxious emphasis on the administrative and documented evidence related to the [suicide-related] cases [made it seem] that the institution's priority was to ensure that it could put forward a defence against possible culpability" (p. 1). At the same time, counsellors found ways to ask questions about suicide that were grounded in the particular life contexts of their clients, as exemplified by Emmett:

> I'm okay with incorporating that [question about suicide] as part of my first conversation with someone. Not right away, like a robot without context—but I have managed to figure out a way for me that I am able to weave it in. Sometimes it seems an appropriate place, sometimes not so much. For me, I think it is important, because I have had experiences where I haven't asked and I have walked away, and some issue has come up where a particular person was suicidal or thinking about that, and it was my anxiety that got in the way of me asking.… I do think it is a liability thing and I think there is also, like, sometimes if we don't ask, we won't know.

Counsellors who work in publicly funded community mental health settings are typically situated in institutional contexts that place a lot of emphasis on complying with administrative procedures and organizational protocols as an important practice of accountability. Exemplifying the concept of "working the tensions," the counsellors we spoke to found ways to comply with institutional expectations *while also* exercising their clinical judgment. This included asking critical questions about whom the rules were serving and considering carefully the potential effects of these practices on the young people who had sought their help. As we discovered, counsellors can set the pace and timing of when, how, and why they are asking questions. They can continue to build trust and to strengthen the therapeutic relationship as part of the overall assessment process (Jobes et al., 2019) without falling prey to acting "like a robot without context." In the next section, we elaborate on the concept of working the tensions by showing how counsellors draw on conversational practices to shift away from a narrow procedural orientation to this work.

Artful Shifts and Conversational Openings

Counsellors rely heavily on the use of dialogue to create possibilities for new understandings and to mobilize action toward the client's preferred future. It is the primary means through which counsellors and clients achieve joint understanding,

and it is "through dialogue [that] speakers work out new understandings and ways of going forward together" (Strong et al., 2008, p. 389).

Conceptualizations of Suicide

For example, Benjamin describes his efforts to conceptualize suicide in a more contextualized way by "trying to acknowledge it as a response to what is going on for them in that moment.… When that is effective, there is often a physical release and we are able to shift the conversation." In a similar vein, Marina highlights her efforts to contextualize suicidal despair as an understandable response to the young person's current context: "I validate their thoughts of wanting to die based on the context of their life. I think it is important to talk about that." To the researcher's question of why she thought that approach was important, Marina responded,

> You maybe feel that something is wrong with you and a lot of people will act like something is wrong with you if you are thinking of dying. You are "looking for attention." I think it is important to say, "There is nothing wrong with you. If I was living in this context, I might actually feel like dying, too, when it is really hopeless." … I can think of one youth of mine, they live in poverty, there [are] often financial and food insecurities. She has sort of depression and often has ongoing [suicidal] thoughts at different times. There is this whole thing that happened last year where their [electricity] got shut off when it was cold. She felt like dying. I think it had a lot to do with that.… The safety plan should be "turn the [electricity] back on."

Maureen then jumps into the conversation to say, "I think I do a lot of work to really sit in the darkness, too." This position of sitting alongside the client, not jumping too quickly to solutions, and bravely and patiently holding the space offers a good example of a non-anxious and daring form of engagement (Omerov et al., 2020).

In these accounts, we see the artful and flexible ways that counsellors draw on different conversational moves, relational sensibilities, and ethical and political stances for understanding and responding to suicide. Benjamin and Marina make sense of suicidal despair, so to speak, by framing it as a *response* to a challenging or unjust context, consistent with social justice and response-based practices (Richardson, 2016). For Maureen, sitting in the darkness alongside the young person is an ethical and relational response. It communicates to the young person that asking how (or whether) to live is a question worthy of further exploration and deserving of time, patience, and care.

Conceptualizations of Counselling

The notion of art comes up as a way to conceptualize this conversational work in the following focus group exchange.

Corinne: It is an art. At what point and how do we bring that conversation up in our initial assessment?

Researcher: I'm interested to hear some of the stories of how this unfolds and the "art" that you all bring to it within these institutional requirements.

Val: When I start working with families and youth right off the bat, that is the place that I'm starting at: "How can we open up this dialogue?" If it's a youth that is in front of me, "How can we open up this dialogue to include adults in your life, preferably parents, caregivers, around all sorts of risk?" … It is a shift away from what we are talking about in terms of doing the [suicide] screening, which I am absolutely still doing, of course, with everybody that I am working with, but shifting to a different philosophy around how we have these conversations in general.

Researcher: If you were to give a name to that shift away from the screening, what would you call this new way of practising?

Val: The word that comes to mind is "opening": creating openness, creating connection in the family unit.

Researcher: Corinne, what would you say you bring to this work that feels like the "artful" nature of the work when working with young people at risk for suicide?

Corinne: When you first asked that question, it made me think back to starting this work 10 years ago. I think my response was "What do I do with this?" Now the question I hold is "How can I *be* with this?" … If I can be curious and be present with the person and really understand—"How is this helping you? How is this helping you cope?"—…then we start to shift the conversation: "What is the pain? Tell me about that stuff." And then it is "Can I just be with that?… Can I hang out and be with you in whatever is so painful in your life that you want to leave?" And then it is really through that process and being with—and being curious and starting to understand—I think things can start to open up and we can start to have a different conversation.

What we hear in these accounts is the importance of creating openings for young people and their families to be seen and recognized in their own unique contexts. We see the different ways that counsellors offer possibilities for young people to stay engaged with life, through creative and ethical conversations rooted in care, responsiveness, justice, and curiosity. This is artful and relational work.

Discussion

Our analysis focused on how counsellors described their experiences working with youth who are at risk for suicide, the prevailing discourses and institutional requirements shaping their practice accounts, and some of the potential effects of these ways of thinking, talking, and relating. As others have noted, many

counsellors express a strong sense of ambivalence toward standardized suicide assessment and risk management practices (Espeland et al., 2021), which can be experienced as highly procedural, in keeping with a "Mental Health Administration Discourse" (Strong et al., 2017, p. 173).

Our findings suggest that counselling youth who are at risk for suicide can never be captured adequately through a standardized risk management approach, despite the ease with which counsellors are able to articulate this orientation. In response to our research question about how counsellors narrate and make sense of their practices engaging with youth who are at risk for suicide, we generated the concept of "working the tensions." This concept captured the patterned ways that counsellors conceptualized their practices with youth who are at risk for suicide as a series of ongoing tensions to be worked out at multiple levels, involving both compliance and critique. It involves fluid conversational practices and discursive shifts that are always standard and emergent, institutionally mandated and creatively responsive, procedural and artful, known and unknown. We contend that this is a more honest and realistic way of thinking about practice that not only challenges overly simplistic technological models but also makes space for the inevitable tensions and contradictions that arise in this work.

"Working the tensions" was quite subtle at times, such as when counsellors sought simply to "slow[] the process down" or when they tacitly understood that they needed to complete their paperwork in a way that displayed their accountability so that they could move on to "more meaningful conversation[s]." Each of these discursive strategies holds something in common with what Strong et al. (2017) identified as "navigable tensions" (p. 177) or what Podlogar et al. (2020) referred to as finding a "dynamic balance." These moves can also be likened to the concept of a "doubled practice," which involves "working within/against the dominant, contesting borders [and] tracing complicity" (Lather, 2017, p. 127).

Limitations

There are some limitations to this qualitative study that are important to acknowledge. First, even though many of the findings align with those of previous qualitative investigations that document some of the challenges experienced by counsellors who work with youth who are at risk for suicide, it is worth reiterating that the qualitative findings presented here are based on a unique local practice context, which means they cannot simply be exported to all other mental health settings in a straightforward way. At the same time, we do believe that our findings can inform and extend current practice and policy debates about improving care for suicidal persons (Fitzpatrick & River, 2017). Second, because of the Covid-19 pandemic, we were forced to conduct our second focus group online, using a video conferencing platform. This may have altered what participants shared in the focus group and how they did so. Third, by inviting participants to engage in a practice-oriented group conversation with their professional peers, we may

have inadvertently excluded counsellors who held more extreme, less socially desirable, or divergent views. Finally, in this study, we did not have the opportunity to find out from young people themselves what *their* experience of the counselling process was, including whether it was helpful or hopeful.

Implications for Practice

There are some practical implications for future practice and research that these findings point to. First, what if counsellors were invited to consider their practices in response to more open-ended, process-oriented questions as a demonstration of their professional accountability? For example: "How did you collaborate with your client in the exploration of suicide and its alternatives? How did you manage to get alongside your client in spite of any fears or anxieties you may have had talking about death or suicide? How did you work the tensions between institutional requirements and forms of relational, responsive care?" These types of questions recognize the inherent tensions in the work and invite a focus on social and relational processes and on the institutional contexts of counselling. Asking such questions may provide a counterbalance to the current checkbox mentality that inadvertently generates fear and anxiety in counsellors and privileges the interests of the counsellor and of the institution. Second, the value of creating a safe conversational space for counsellors to explore and to reflect critically on their practices was evident in our transcripts. We were able to see the productive effects of the research questions, which reduced counsellor isolation and invited new ways of framing the work of conceptualizing suicide. This dialogical approach highlights the potential of a community of practice approach based on creative thinking and joint learning. Third, future research that includes the views of young people and families as well as transcripts of counselling sessions will make an important contribution to our field through the inclusion of more "conversational evidence" as a way of exemplifying dialogic and relational processes of therapeutic change (Strong et al., 2008). In closing, we hope that the idea of "working the tensions" can help counsellors understand more adequately how they think and work within and against dominant institutional narratives and find ways to engage in meaningful, collaborative, and life-sustaining work with young people.

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Funding for this study was in the form of an Island Health Collaborative research grant (2019).

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