The Phenomenology of Crises


Courtney Sen



A Clinical Research Project presented to the faculty of the Hawaiʻi School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements for the degree of Doctor of Psychology in Clinical Psychology.



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This Clinical Research Project by Courtney Sen, directed and approved by the candidate's Clinical Research Project Committee, was approved by the faculty of the Hawai'i School of Professional Psychology at Chaminade University of Honolulu in partial fulfillment of the requirements of the degree of Doctor of Psychology in Clinical Psychology.

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The Phenomenology of Crises


Courtney Sen

Hawai‘i School of Professional Psychology at Chaminade University of Honolulu – 2020

Research on psychological crises has expanded in recent years due to an increasing need for effective crisis intervention strategies. However, there remains a lack of theoretical agreement on the concept of a psychological crisis, how it is experienced, and how it develops. There is also limited research on those who perform crisis intervention. The purpose of this transcendental phenomenological study was to explore the experience of a crisis from the perspective of a crisis intervention team. Participants included a crisis mobile outreach therapist, a crisis line screener, and a crisis case manager. Individuals selected demonstrated commitment to crisis work for at least 10 years. Semi-structured interviews were conducted with each participant and constant comparative method was used. Results were presented in a descriptive portrait with a discussion of themes and patterns. Findings from this qualitative inquiry highlight the significance of phenomenology, or the individual experience, in crises and crisis intervention. Common characteristics and traits among the participants were identified as potential factors contributing to resilience and occupational longevity. Implications for treatment, crisis intervention, and supporting crisis workers are discussed.

Dedication

This is dedicated to those who devote their lives to helping people in crisis. Thank you for believing when others cannot. Thank you for sharing your hope and your light.

Acknowledgments

First, I would like to thank my committee chair and academic advisor, Dr. Joy Tanji. This research project would not have been possible without you. Thank you for believing in me, advocating for me, and sharing your wisdom and knowledge with me. To my committee member, Dr. Robert Anderson, thank you for contributing your time and energy to this project.

I would also like to thank my family and friends for all the encouragement throughout the years. This journey has not been easy, and your unconditional love and support kept me going. *Mahalo piha*.

Finally, I would like to express my sincere gratitude to the participants in this study. It has been an incredible opportunity to be able to hear your stories. Thank you for inviting me in and sharing your experiences with me. I am in awe of your resilience, selflessness, and compassion for others. You inspire me to continue to do this work.

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**CHAPTER I. INTRODUCTION**

A mental health crisis is generally understood by most people as a state in which a person is experiencing some type of distress, is overwhelmed, and unable to cope with the situation at hand with their resources available. The Merriam-Webster Dictionary defines *crisis* as "an emotionally significant event or radical change of status in a person's life; the decisive moment; an unstable or crucial time or state of affairs in which a decisive change is impending." The meaning of the word crisis has evolved over time, experiencing semantic drift as a result of linguistic, psychological, and sociocultural forces. Originally, *crisis* denoted "the turning point for better or worse in an acute disease or fever," however it now most commonly refers to "a difficult or dangerous situation that needs serious attention," and appears to have taken on a negative connotation (Crisis, n.d.). My interest in mental health crises stems from my work in crisis intervention, which has allowed me the opportunity to sit with a wide variety of people through some of their lowest moments, and offer emotional support and resources. When I explain my work to others, I often get a strong reaction. People express concern for my wellbeing and safety as a crisis therapist, and even personal discomfort at the idea of being with a stranger at a moment of emotional intensity and instability. I believe that these reactions, as well as semantic changes in the word *crisis*, reflect the Western culture that we live in today, a culture that is uncomfortable with distress and the expression of strong negative emotions.

As a crisis therapist, I often encounter patients who are seemingly desperate to escape, or to eliminate their distress and lessen the impact of the crisis immediately. It is rare when I encounter those who understand their crisis as a turning point or unavoidable state that they must endure, come to terms with, and can ultimately use as an opportunity for change. This striking difference in the perception and understanding of a crisis is something that I would like to better

understand, because it appears to lead to differences in resiliency and transformative growth. One way to elucidate these differences is to understand the experiences of those who dedicate their careers to supporting people in crisis, and have the ability to remain resilient in the face of emotional contagion. I believe that a greater understanding of resiliency in crisis workers could help to better train and support a field with high burnout, as well as better inform our treatment and aid those in crisis.

## Situating the Study

Qualitative researchers attempt to provide a contextual frame for their studies, or a way of conceptualizing the study and the community being investigated. This is necessary because the experience, or phenomenon, and the context are arguably inseparable; thus, it is necessary to understand how the context shapes the phenomenon and results. The contextual framework for a study involves examining the personal stake the researcher has in conducting the study, conducting a comprehensive review of the relevant literature, and articulating the problem inherent in the extant literature (Glesne, 2016). To situate a study, the researcher examines how a study is conditioned by his or her personal biases about what would be meaningful to study. In other words, the researcher's motives going into the research are acknowledged as a form of bias that poses some limits on the study (Rossman & Rallis, 2012).

My motives for studying crises stem from personal experiences working as a crisis therapist. I have found that people experience and cope differently with crises, and this is often influenced by existential, cultural, and religious beliefs and backgrounds. I believe it is a meaningful area to study because it can deepen our understanding of the phenomenology of crises and help inform crisis intervention teams and treatment. I acknowledge that my own biases have led me to choose this area of research, and recognize that my presence and assumptions will

impact the phenomenon I am studying. My motives for studying this topic also stem from personal beliefs. I tend to align with the humanistic theory of psychology, and this has steered me to focus on phenomenology; I believe that each human being has a unique experience, and is trustworthy and self-healing at the core. When peoples' resources are overwhelmed by contextual circumstances, they may experience the helplessness, powerlessness, defensiveness, and an inability to effectively direct their own lives that we often see during crises. The person will enter into a state of incongruence, or conflict between his or her self-perception and experiences of social reality. This is the theoretical orientation that I personally align with, and I acknowledge that my theoretical biases create a predetermined framework for this study, driving me to focus on the experience of incongruence when studying crises.

## Review of Literature

A review of literature provides a comprehensive review of the current theoretical and research knowledge relevant to the phenomenon being studied (Glesne, 2016). A review of literature frames the study and provides context, or a way of conceptualizing the study and the community that it is investigating. By doing so, it enhances the rigor and utility of a study, can help the researcher to assess whether the topic chosen is meaningful and has moral praxis, helps to focus or bound the study, and can inform research design and the development of interview questions (Glesne, 2016). Additionally, the review of literature examines the relationship of the study to prior theory and research. It helps the researcher attend to theoretical sensitivity; by becoming more familiar with extant knowledge, the researcher can more readily assess how the etic understanding of the phenomenon compares with emergent emic understanding during the study. This helps the researcher to know what is meaningful to ask and to focus on generating new knowledge for the purpose of building and refining theory.

Researchers study the phenomenon of crises across the world and from various disciplines including psychology, philosophy, sociology, biology, and anthropology. However, there is a lack of theoretical agreement on the definition of a psychological crisis, or how it is experienced and comes about. There is also a lack of research on the crisis workers and first responders who perform crisis intervention. I will review extant literature on crisis theory, suicide theory, and burnout and resilience in crisis workers in order to better understand the experience of crisis from multiple perspectives, and to further inform this qualitative inquiry.

**Crisis Theory: The Nature of Crisis**

*Defining Psychological Crises*

The phenomenon of personal psychological crises, while widely referred to in literature and practice, is surprisingly not well developed in a theoretical aspect. This is partly due to the complexity and multidisciplinary nature of the topic, studied by researchers in several fields of knowledge. Much of extant crisis literature focuses on intervention strategies and ways of giving aid and support, which is understandable considering the need to address the potentially severe outcomes of crises; however, little attention has been given to the development of theory. Crisis theories are often based on assumptions, clinical observations and implications found when mediating traumatic stress, rather than principles based on research that explain or predict the effects of crises on individuals. Although research in this area is expanding and has greatly informed crisis intervention, there is still a need for a comprehensive understanding of the nature of crises, as well as a need to mold these assumptions and clinical observations into theory (Myer & Moore, 2006).

Beyond the dictionary definition, the concept of crisis has no universal criteria. As stated previously, the morpheme *crisis* has experienced semantic drift over time. Researchers in

psychology have varying definitions and understandings of a psychological crisis. For example, some researchers argue that a psychological crisis develops rapidly, and some argue that it may be formed gradually. A crisis could be precipitated by stressors, internal conflicts, or a period of time during which a person faces obstacles. Some believe that the experience of a psychological crisis alters a person's value system, personal attitude, or the development of deviant attitudes (e.g., teenagers). Others believe that a crisis can lead to self-injurious behavior. Efimova and colleagues (2015) reviewed various worldwide scientific approaches to understanding crisis psychology and propose that the universal criterion for a psychological crisis appears to be mental tension and situation complexity. The researchers argue that a clash between a need and an objective obstacle results in a difficult situation; it is the unsuccessful attempts of overcoming the obstacle that leads to mental tension. The difficult situation and the ways in which it is handled (e.g., constructive overcoming, change in attitudes, self-injurious behavior or suicide, deviant behavior, etc.) are dependent upon objective and subjective characteristics presenting together to form an extremely negative emotional experience for an individual. Efimova and colleagues propose that a psychological crisis causes full or partial transformation of an adult's identity, and in the case of a teenager, it can alter personality formation and perception of the world. The researchers conclude that "crisis is a crisis of life, the critical moment and a turning point of a course of life" (Efimova et al., 2015, p. 248).

***Danger and Opportunity***

Stress, trauma, and crisis can be understood as different psychological states existing on a continuum (Dulmus & Hilarski, 2003). Stress is a universally human experience, however each individual experiences stress differently. *Stress* is the relationship between a person and the environment that is perceived by the person as taxing, exceeding his or her resources, and

endangering wellbeing (Lazarus, 1984). Essentially, it is the individual's subjective perception and interpretation more than an objective existence of a negative event or situation. Stress can lead to a traumatic outcome when a person's worldview is shattered and there is disruption in psychic equilibrium. This psychological experience includes helplessness, disconnection, powerlessness, loss of control, difficulty communicating, and chronic feelings of fear and vulnerability. On the end of the continuum, a psychological *crisis* is a state in which a person has experienced a traumatic event, has failed to cope and lessen the stress or trauma, and enters into a state of disequilibrium (Dulmus & Hilarski, 2003). The theory of crisis being a temporary disruption in homeostatic equilibrium is one of the more commonly accepted understandings of a psychological crisis, and I will refer to this theory when discussing crises in this literature review.

Parikh and Morris (2011) note that the crisis state is different from stress, as it has the potential to lead to adaptive or maladaptive end results. Individuals in a state of crisis can learn new skills and healthy coping behaviors, increase interpersonal connectedness, increase personal agency, and become more flexible; when these new developments are applied to future situations, it can increase an individual's adaptability. However, if the skills learned include irrational thoughts, reduction in interpersonal connectedness, decreased personal agency, and rigid personality traits, it could heighten the risk of future mental health problems. Therefore, a perceived crisis may or may not result in pathology, and an event seen as a crisis could be interpreted either as an event which may leave a person shattered, or ultimately be overcome and serve as a vehicle for change (Dulmus & Hilarski, 2003).

Albert (2017) explored positive self-transformation resulting from the experience and resolution of a mental health crisis through a qualitative study, which involved the interviewing

of participants who had experienced a crisis and a positive outcome following the crisis. The results indicated that crises manifest in a variety of psychosomatic, behavioral, emotional, mental, psychic, and spiritual ways, and have a remarkable and lasting impression on the psyche. Albert argued that a mental health crisis could be an antecedent to a psychospiritual growth process, which involves integrating the crisis into a meaningful experience. Crises are often viewed with negative and pathological associations, which prevent people from recognizing the potential benefits of the resolution and integration of these challenging events.

Transpersonal psychology views mental health crises as fundamental components of people's psychospiritual development, leading to a deepened or renewed sense of self and reality. Within this frame, treatment recommendations have called for greater acceptance, curiosity, and support of the crisis experience instead of the allopathic approach that is geared toward effectively reducing or eliminating symptoms. When participants in Albert's study accepted their condition and integrated it into a positive self-concept, this led to improved relational, vocational, and self-care strategies (Albert, 2017). The subjective perception of the crisis is therefore important in the experience of and healing from mental health crises.

**Suicide**

In the mental health field, crisis intervention protocol typically includes a thorough assessment of suicide and safety issues. Suicidality is pervasive in mental health crises and can have severe consequences for individuals, families, and communities. In the United States, the age-adjusted rate of suicide has been rising steadily over the past couple decades. According to the World Health Organization (2017), from 2000 to 2015 the rate of suicide increased 30% from 9.7 to 12.6 per 100,000 people. As general mortality declines with improved healthcare and public health measures, it is concerning that the rate of suicide has risen for all genders and ages

10-74 (Curtin et al., 2016). Suicide is a worldwide phenomenon affecting people of all ages, ethnicities, races, and income brackets. It is the second leading cause of death among 15-29 year olds globally and 78% of all recorded suicides occurred in low and middle-income countries in 2015. The World Health Organization (2017) estimates that for each adult who died by suicide, there may have been more than 20 others attempting. In my experience as a crisis worker, the majority of people we outreach have expressed thoughts of suicide at some point. Not all crises lead to suicidal ideations or behaviors, however, I believe that with the prevalence of suicide and safety concerns among those experiencing mental health crises it is imperative to understand suicide and suicide theory when exploring the concept of crisis.

### *Defining Suicide*

Generally speaking, suicide is the act of killing the self. Although this definition seems simplistic, suicide is a behavior specific to each individual with different motivators, circumstances, and anticipated gains. Edwin Shneidman (1985), a pioneer in the field of suicidology, conceptualized suicide in the Western context as "a conscious act of self-induced annihilation, best understood as a multidimensional malaise in a needful individual who defines an issue for which suicide is perceived as the best solution" (p. 203). Although the medical model is prominent in acute treatment settings and tends to pathologize behavior, suicide is not considered a disease. It is not a psychopathological entity in the Diagnostic and Statistical Manual of Mental Disorders, 5th Edition (DSM-5), and "suicidal behavior disorder" is listed as a condition in need of further study (American Psychiatric Association, 2013). Suicide occurs at the intersection of individual, relational, environmental, social, and cultural factors; the interplay of these elements is also sometimes referred to as the ecological model, which emphasizes the different levels (i.e., individual, relationships, community, and societal) that influence and lead to

behavior (Leong & Leach, 2008). Accordingly, I will examine suicide at various levels in order to provide a brief overview of this phenomenon.

### *Theories of Suicide*

**Sociology.** Emile Durkheim, a well-respected French sociologist, was one of the first to publish a comprehensive theory of suicide, conceptualizing suicide as a phenomenon that arises from societal pressures and influences (Durkheim, 1897). Instead of viewing suicide through a religious lens, as was common at this time, he argued that suicide is an act resulting from social and environmental factors. He categorized these factors in two domains: social integration (e.g., assimilation or social affiliation with society and others) and social regulation (e.g., society's influence on the emotions and motivations of individual members). Durkheim concluded that individuals may feel lacking in purpose and experience symptoms of depression when they are not integrated into society or do not have a clear role within a social group; this affective state, he argued, could then potentially lead to suicide.

Durkheim differentiated four types of suicide: anomic, fatalistic, altruistic, and egoistic. *Anomic suicide* takes place in the context of inadequate social regulation. For example, during an economic recession, individuals may experience changes in their current roles in society, leading to uncertainty and confusion. Too little social regulation may leave an individual feeling alienated from society, with little meaning to life. *Fatalistic suicide* takes place in societies with a high degree of social regulation; the person is in a situation, in the context of a hyperregulated social structure, from which they feel there is no escape (Holmes & Holmes, 2006). *Altruistic suicide* takes place in the context of a highly integrated society; in this case, individuals may perceive suicide as a form of societal contribution. On the other hand, *egoistic suicide* is the result of low social integration or excessive individualism (e.g., an individual with little social

support and few responsibilities or ties to kin). Durkheim's work examined individual deaths within the context of the greater society, however, in doing so his theory also minimized the individual factors leading to suicidal behavior. Nevertheless, his theory was significant in that it provided a foundation for future scientific research and inquiry into suicide (Stanley et al., 2016).

**Economics of Suicide.** Several economic theories have been derived from Durkheim's sociological perspective. Durkheim's work stresses the imbalance between means and need; in some respects, this is similar to an economic conceptualization and implies that suicidal behavior is driven by processes such as supply and demand. Economics is the study of resource allocation; it is concerned with decision-making and its consequences (Gunn & Lester, 2014). Recognizing that suicide is a behavior involving this economic process of decision-making, economists in recent years have developed models to better understand suicidal behavior.

Within the standard economic model, suicide is deemed a rational decision made when a person's perceived lifetime value falls below a certain threshold. Individuals who commit suicide are acting rationally by selecting the most desirable alternative, even if the chosen action results in death. This view is controversial when compared to the idea that suicides are the product of momentary lapses in reason, a theory maintained by some suicidologists. According to the economic model, decreases in perceived lifetime incomes should be associated with higher suicide rates (Gunn & Lester, 2014; Hamermesh & Soss, 1974; Koo & Cox, 2008). Empirical research in this area has been equivocal, however, and there is a need for further research delineating the ways in which economic factors mediate suicide.

Merzagora and colleagues (2016) examined almost 1,000 cases of suicide in Milan, and found that people with severe physical or psychological illnesses were three times more likely to commit suicide during an economic crisis. Differences in suicide rates before and during the

economic crisis were not found to be significantly associated with employment status or the interaction between variables of employment and health status. The lack of interaction between health and employment status suggests that having a serious illness in the midst of an economic crisis may increase suicide risk; the authors note that this may be due to budget cuts in public health care, which can lead to a reduction in the availability and quality of services. In such a context, suicide can be seen as the result of a calculation of the value of life (Merzagora et al., 2016). Although this model may only explain parts of the decision-making process involved in suicide and research on the economics of suicide is relatively sparse, it is a useful approach in analyzing behavior at an individual level as well as societal influences at the macroecological level.

**Anthropology.** Anthropologists argue that Durkheim's theory of suicide often appears to be inapplicable in different cultural contexts, especially in non-European societies. Anthropology offers valuable insight into suicide by studying the human experience of suicide and its role in various societies and cultures. Ethnographic studies exploring suicide in various parts of the world attempt to go beyond the limits of sociological approaches by understanding the emic experience of the informant. Staples and Widger (2012) argue that suicide can be understood as a kind of sociality or social relationship through which people create meaning in their lives. Cross-cultural studies on suicide have repeatedly demonstrated that suicide sometimes acts as a means of protest when other, more "direct" forms are not allowed by social convention. Suicide appears to be a kind of social action, communication, and protest; suicide can be reflective of dramatic social change in a society. Suicide also can be a means of escaping societal expectations or redefining identities. From an anthropological standpoint, the causes and consequences of suicidal behavior are relational; suicide occurs at the intersection of bodies and relationships, in

which the "self" and "other" provide some form of meaning but are ultimately fused together. Interestingly, those who kill themselves for the purpose of seeking meaning continue making meaning after their deaths, as their deaths inevitably affect those around them. Staples and Widger (2012) note that people often seek to limit the efficacy of suicide or their own responsibility for the suicide, and by doing so create new meanings of suicide. Anthropologists argue that suicide, therefore, does not merely begin with a "precipitating factor" and end with a "suicidal act," but extends into the pasts and futures of individuals and the social world around them. Staples and Widger (2012) propose that suicide both claims and rejects human sociality and, in a sense, it creates as much as it negates. Suicidal behavior creates and severs social relationships and is a way of experiencing, thinking about, and ultimately explaining and shaping the world around us: "we live by suicide as much as we might die by suicide" (p. 200).

**Biology.** In contrast, the biological perspective of suicide suggests suicidal behaviors are related to mental illness and neurochemical changes. Retrospective and psychological-autopsy studies have consistently shown a significant association between mental disorders and suicide, and it is estimated that up to 90% of people who commit suicide have a diagnosable mental disorder (Cavanagh et al., 2003). In a nation-wide survey, Nock et al. (2010) observed that anxiety, mood, impulse-control, and substance use disorders significantly predicted suicide attempts. Interestingly, depression was observed to be a predictor of suicidal ideation but was not always associated with suicide plans or attempts. Disorders characterized by severe anxiety, poor impulse control, and agitation (e.g., PTSD, conduct disorder, substance use disorder) were significant predictors of suicide attempts. These results suggest that there are distinct associations between mental illness and suicidal behavior, and highlight the need to further delineate suicidal ideations and behaviors.

The relationship between suicide and depressive symptoms has been long established. Substantial evidence suggests that depression is related to a deficiency in serotonin or diminished activity of serotonin pathways. Serotonergic circuits have also been found to mediate impulsivity, which is a risk factor for suicide. It is not yet known whether the biological makeup of depression differs from that of suicide, although there is growing evidence to suggest so. For example, several studies have linked alterations in the serotonergic system with suicidal behavior, driving researchers to examine the role of the serotonin transporter in regards to suicide. However, like many theories that attempt to delineate suicidal behaviors, findings have been inconclusive (Purselle & Nemeroff, 2003).

In addition to serotonergic systems, noradrenergic and dopaminergic neurotransmitter systems, signal transduction, and cellular morphology have also been identified as neurochemical correlates of suicidal behavior. Several studies have suggested that genes and the environment influence the function of serotonergic and noradrenergic systems. In the noradrenergic system, cortisol and the HPA (hypothalamic-pituitary-adrenal) axis are involved in the hormonal stress response system. Although results are equivocal, suicide appears related to hyperactivity of the HPA axis (Mann, 2003). For the purpose of this review, these correlates of suicidal behavior will not be discussed in depth; however this is a notable area of developing research.

It is clear that there is an underlining biological and genetic component of suicidality. In a study of a community-based sample of monozygotic and dizygotic twins, Statham et al. (1998) observed that genetic factors accounted for approximately 45% of the variance in suicidal thoughts and behavior. Their results also illuminated the ways in which psychiatric history, personality, genetic vulnerability, traumatic events, and sociocultural protective factors (e.g.,

Roman Catholic religious affiliation) are associated with suicidal ideations and attempts. The neurobiological viewpoint of suicide has been a significant contributor to suicide theory, however psychopathology and brain biology do not completely explain suicide as a phenomenon.

Kessler et al. (2005) examined suicide trends in the United States and concluded that despite a notable increase in the treatment of depression and other mental illnesses, no significant decreases occurred in suicidal behaviors during the 1990s (Kessler et al., 2005). Other randomized controlled trials find very small treatment effects in the reduction of suicidality amongst patients with various mental disorders, even with standardized regimens (Burns et al., 2005). These reports elucidate the complexity of the etiology of suicide, which extends past psychopathology and brain biology (Nock et al., 2010).

**Psychology.** Psychological approaches to understanding the suicidal mind have grown considerably since Sigmund Freud first investigated suicide and precipitated a change in the perspective on suicide, from a moral, philosophical, legal, or spiritual phenomenon to a clinical matter for which one should receive help rather than moral judgment (O'Connor, 2011). Systematic psychological research on suicide began with Edwin Shneidman, who founded the American Association of Suicidology in the 1950s. More recent developments have been driven by social learning theory and cognitive and behavioral models; several of these theories will be discussed below.

***Psychodynamic Theory.*** Psychodynamic theory aims to understand and explain the suicidal individual's intrapsychic world. The psychodynamic framework stresses the influence of human development, motivation, affect tolerance (i.e., ability to handle emotions), ego conflicts and deficits (i.e., identity conflicts), object relations (i.e., interpersonal relationships), fantasies,

psychopathology, and social context (The Suicide and Self-Destructive Behaviors Study Group, 2018). In *Mourning and Melancholia*, Freud (1917) explained suicide as unconscious anger directed at an object, with which the ego identifies and wishes to destroy: "The analysis of melancholia now shows that the ego can kill itself only if, owing to the return of the object cathexis, it can treat itself as an object—if it is able to direct against itself the hostility which relates to an object and which represents the ego's original reaction to objects in the external world" (p. 252).

Maltsberger (1986) explained suicide as the consequence of an affective state of crisis, involving intolerable psychic pain and subjective despair which negates the instinct to protect the self; suicide is driven by the need to end pain, destroy hated facets of the self, or to attack others through the self. Loss, failure, or distressing life events can aggravate internal struggles related to an individual's developmental vulnerability, as psychodynamic theory focuses on the ways in which disturbances in early attachment may have led to self-hatred and self-contempt in the suicidal individual. Maltsberger (2004) proposes that suicide is the potential outcome of following: psychic pain becomes increasingly intolerable, precipitating frantic efforts to ease the pain and resulting in affective-cognitive "flooding"; this may cause a loss of psychic control, and can ultimately lead to psychic collapse and impaired reality testing. Within the psychodynamic framework, conscious and unconscious fantasies are believed to be full of uncontained anger and dysphoria, which can cloud a person's sense of reality and judgment. Thus, some people in this emotional state may not recognize the reality and finality of death.

Kaslow et al. (1997) conducted an empirical study of suicidal behavior in a sample of psychiatric patients, examining four key psychodynamic concepts: self-directed aggression, object loss, ego functioning disturbance, and pathological object relations. Although they did not

find significant support for all four hypotheses, their results strongly supported the object-relational concept of suicidal behavior. Suicide attempters appeared to view relationships in a more negative light and were less emotionally involved in them; this was identified as impairment in object relations. These participants were more likely than those in the control group to expect harm from others and overwhelming pain in interpersonal relations. Those who attempted suicide were also significantly more likely to report loss throughout childhood as well as recent adulthood. These results illuminate the significance of the interpersonal, relational aspect of suicide, which is emphasized in psychodynamic theory. The psychodynamic theory of suicide is one of the earliest psychological theories that shaped the perception of suicide and laid the groundwork for further research. Many of the psychological theories of suicide that will be discussed in this review are rooted in psychodynamic theory.

*Stress-Diathesis Model.* Stress-diathesis refers to the relationship between a stressor (stress caused by life experiences) and a predisposition or vulnerability to behavior (diathesis). The theory suggests that a person with a vulnerability to suicidality (e.g., predisposition to depression) may experience a stressor (e.g., trauma), which could lead to suicidal behaviors. The stress-diathesis model highlights the distinction often made by psychologists between "state" and "trait" variables. *State factors* are those that describe the immediate psychological state of the individual, which responds to stressors. *Trait factors* are long-term, stable variables, such as personality features or a low level of serotonin in the central nervous system (Gunn & Lester, 2014). Both state and trait variables are important to consider when studying human behavior; similarly, the stress-diathesis model helps to better understand why most seemingly vulnerable individuals who are depressed or experience traumatic events do not go on to die by suicide.

Mann and colleagues (1999) examined factors contributing to suicidal behavior among psychiatric patients in a hospital setting. In their study, objective severity of depression or psychosis were not found to be predictors of suicide attempts; however, suicide attempters reported higher scores on subjective depression and suicidal ideation, as well as fewer reasons for living. Those who attempted suicide had greater rates of lifetime impulsivity and aggression, as well as history of substance abuse, family history of suicide, head injury, and history of childhood abuse. Mann and colleagues proposed that the risk for suicide is not determined merely by a mental disorder (the stressor), but also by a diathesis (e.g., suicidal ideation and impulsivity).

Another stress-diathesis hypothesis was developed by Williams and Pollock (2001), who propose the "cry of pain" (versus "cry for help") model. According to their model, suicide is the response (cry) to a situation in which an individual perceives defeat, no escape, and no rescue. Williams et al. identified attentional biases, or sensitivity to negative stimuli, which increase the risk of triggering the defeat response. An individual with poorer problem-solving skills may believe that they are unable to escape or avoid distressing problems or life events; when an individual perceives that attempts to solve current problems have been unsuccessful, he or she may feel powerless and trapped within the intolerable situation. This can lead to hopelessness and an inability to perceive positive outcomes or future opportunity for rescue. Williams and Pollock's model has clinical relevance in that it integrates the effects of life events as well as neurobiological factors. Components of their model (e.g., hopelessness, mental pain) can be studied using neurobiological research approaches, which is a beneficial contribution to the literature on the pathophysiology of suicide (van Heeringen, 2012).

***Strain Theory.*** Zhang's strain theory of suicide (2005), while not formally considered a stress-diathesis theory, also proposes that suicide occurs as a result of stressors. According to this theory, suicide is the consequence of psychological strains. A strain can be conceptualized as a push or pull in different directions, causing an individual to become frustrated, upset, angry, or in pain. Zhang compares the concept of strain to cognitive dissonance, as a strain (at its simplest) is psychological frustration or suffering that an individual must reduce, solve, or do away with. Zhang proposes four sources of psychological strain that may cause suicidal ideation: differential values (conflicting values or beliefs), reality versus aspiration (discrepancy between aspirations or goals and the reality that may prevent one from achieving them), relative deprivation (comparison of one's impoverished life with the perceived wealth of others), and deficient coping (inability to cope with stressful life events).

Mental disorders may strengthen the association between strain and suicide, while social integration, social regulation, and psychological factors (e.g., personality traits) may act as moderators between strain and suicide. Thus, assimilation or integration into a social group (e.g., family, school, religion, employment) may decrease risk of suicide, even in the face of a major strain (Zhang & Lester, 2008).

Zhang et al. (2017) recently tested the strain theory by examining the ways in which life satisfaction moderates suicide intent among medically serious suicide attempters (requiring medical treatment for an attempt) in rural China. Their results identified mental disorders, aspiration strain, and relative deprivation strain as significant risk factors for increased suicide intent. The researchers concluded that lower life satisfaction is associated with a stronger intent for suicide, and lower life satisfaction is influenced by perceived deprivation and gaps between reality and aspirations.

Another study by Zhang et al. (2017) compared psychological strain and suicidal ideation in college students in China and the United States. Results revealed that psychological strain can significantly predict suicidal ideation, independent of depression, anxiety, and stress, which were also positively related to suicidal ideation in both countries. These findings provided support for the strain theory of suicide, which focuses on the sources of psychological pain and the mechanisms by which the pain becomes intolerable and the situation hopeless.

***Escape Theory.*** Jean Baechler (1975) proposed an early escape theory of suicide. He theorized that suicide is an escape from aversive states, and viewed suicide as a rational means for solving problems. Baechler outlined a typology of suicide including escapist suicides, aggressive suicides, oblative suicides, and ludic suicides. Within the escapist suicides, he proposed that flight, grief, and punishment were motivations for suicidal behavior. Baechler viewed suicide as a solution to a problem; rather than pathologizing suicide, he drew attention to the fact that suicide can be a logical decision in an individual's mind. Escapist-flight suicide occurs when a threshold of suffering is reached and an individual decides to end an intolerable situation, escaping through suicide. As threshold and resilience varies from person to person, two individuals placed in an identical situation may choose very different outcomes. Baechler described grief-motivated suicide as a reaction to a specific loss (e.g., a loved one dies or leaves, personal illness, loss of social standing, betrayal of faith, loss of honor, loss of independence and freedom, death of a leader). Lastly, Baechler viewed punishment-motivated suicides as those that serve as a form of punishment or atonement for crime or personal failure (e.g., motivated by shame, guilt, etc.). While Baechler's work is arguably overly rationalistic and simplistic, viewing suicide as a form of escape was a noteworthy step away from pathologizing suicide, and served as a foundation for subsequent escape theories.

Baumeister (1990) expanded on Baechler's escape theory. He proposed that suicide is driven by the need to escape from undesirable self-awareness. This process, he argued, is caused by the following: (1) falling short of standards due to either recent problems or setbacks or unrealistic expectations; (2) negative internal attributions, low self-esteem, or self-blame; (3) an aversive state of self-awareness precipitated by comparison of the self with particular standards; (4) negative affect arising from the unfavorable comparison of self with standards; (5) cognitive deconstruction, through which an individual rejects and avoids meaningful thought in an attempt to escape negative affect; and (6) consequences of deconstruction, including disinhibition, absence of emotion, passivity, and dysfunctional cognitions. These consequences may contribute to a willingness to attempt suicide; therefore Baumeister proposed that suicide is precipitated by the desire to escape the discomfort of self-awareness. This wish to escape may quickly escalate to the contemplation and act of suicide. He noted that the steps in this model are a sequence of choices, which explains why suicide is a relatively rare outcome of disappointing or stressful life events.

Several studies have provided evidence for the escape theory, linking negative life events, perfectionism, and internal locus of control with suicidal behavior. Tang et al. (2013) conducted an experimental study among medical students, testing the hypothesis that individuals who blame themselves for failure are at greater risk for "implicit suicidal mind," or a state of mind in which an individual associates the self with death and suicide. Three randomly assigned groups included a failure-related priming, success-related priming, and control group.

After exposure to priming, the participants completed the death/suicide Implicit Association Test. Significant differences were observed between groups in accessibility to implicit suicidal mind, and experimental priming moderated locus of control. Priming failure

increased implicit suicidal mind, and priming success decreased implicit suicidal mind. In other words, students who were primed for failure were more likely to associate the self with death and suicide. The researchers propose that individuals are more likely to associate the self with death and suicide when they believe they will fail to attain an important goal. In addition, individuals with an internal locus of control (the belief that one has some control over life outcomes) showed greater implicit suicidal mind when primed with thoughts of failure. On the other hand, participants with an external locus of control (the belief that life outcomes are mostly determined by external forces) were unaffected by such priming. The researchers note that individuals with an internal locus of control tend to blame themselves when faced with negative or stressful life events (e.g., failure, not meeting expectations), which may lead to taking responsibility for failure, burdening the self, and desiring to escape. Overall, this study provides evidence for the escape theory and suggests that suicidal ideation and behaviors emerge from the need to escape negative self-awareness, often triggered by failure or inability to meet expectations.

*Interpersonal-Psychological Theory.* In recent years, Joiner's (2005) interpersonal-psychological theory of suicide has become one of the more well-known and accepted theories of suicide. According to this theory, the basis of suicidal desire is the perception of social alienation (thwarted belongingness) and encumbrance (perceived burdensomeness). Essentially, the suicidal person believes "I am hopelessly alienated" and "My death will be worth more than my life to others" (Joiner, 2005); suicidal desire is a necessary although insufficient cause for a suicide attempt, and if a person with a strong desire for suicide acquires the capability (or loses inhibitions) to attempt suicide, the risk of a serious suicide attempt is increased. Joiner argues that past exposure to physical pain may increase an individual's tolerance for the physical pain involved in self-harm; this habituation can be a risk factor for suicide. Therefore, the unmet need

to belong (e.g., due to social isolation) as well as perceptions of burdensomeness on family (e.g., due to family conflict, unemployment, physical illness) can lead to a desire for suicide. When this desire is met with the capability for suicide (e.g., increased physical pain tolerance and reduced fear of death), it may escalate to a lethal suicide attempt. The interpersonal theory helps to explain the rarity of lethal suicides among those who experience or are at risk for suicidal ideations and behaviors, as three conditions must be present simultaneously in order to result in successful suicide attempts (Van Orden et al., 2010).

Chu and colleagues (2017) conducted a systematic review of literature testing the interpersonal theory of suicide; they examined the interaction between interpersonal theory constructs and suicidal thoughts and behaviors. Their evaluation provided support for the interpersonal theory, as the perception of alienation (thwarted belongingness) and burdensomeness was significantly associated with suicidal ideation. In addition, the interaction between thwarted belongingness, perceived burdensomeness, and capability for suicide (ability to carry out a painful act of self-harm) was significantly related to a greater number of past suicide attempts. The researchers note that effect sizes for these interactions ranged from small to moderate. They suggest that the interpersonal theory's three constructs and their interaction do not appear to be better predictors of suicide than other often-studied risk factors (e.g., demographic variables, psychiatric diagnoses, social factors). The researchers do not discount this theory, however, as other suicide theories have had similar mixed results when tested. Thus, it is apparent that more stringent testing of suicide theories is an area warranting further research.

***Cognitive Theory.*** The feeling of hopelessness has been consistently identified as a predictor of suicide. Beck and Steer (1988) characterize hopelessness as pervasive negative and fatalistic expectations for the future, which can exist both at the trait level (e.g., a long-term

characteristic) and state level (e.g., a temporary feeling). In investigating the relationship between depression and suicide, Beck (1963) found that the cognitive distortions prominent in depression were not always relevant to suicidal behavior; he also believed that affective (emotional) states, were secondary. Beck noted a link between suicidal ideations and patients' perceptions of their situations as hopeless; consequently, the study of hopelessness (e.g., "It is never going to get better.") as a cause of suicide became an area of substantial research. Since then, a multitude of studies have reinforced this theory; hopelessness is seen by cognitive psychologists as the most relevant cognition to suicidal behavior. Beck suggested that trait hopelessness was only relevant to those who engage in premeditated suicidal actions; trait hopelessness is less relevant for impulsive suicidal actions, which are more likely to be driven by psychological states perceived to be unbearable. Beck et al. (1989) conducted a prospective study that followed a group of inpatients for five to 10 years, and found that measures of hopelessness were able to predict 90% of subsequent suicide fatalities. Therefore, it appears that depression and hopelessness are significant factors to consider for suicide prevention.

Menon et al. (2016) examined records of first time and repeat attempters of suicide at a hospital in South India. Neither first time nor repeat attempters differed significantly in sociodemographic characteristics, psychiatric morbidity, coping styles, level of stress, or overall functioning. Hopelessness, however, distinguished first time attempters from repeat attempters, independent of depression. The authors note that hopelessness could independently predict multiple suicide attempts even in the absence of clinical depression, and provide support for Beck's theory and the strain theory of suicide. They postulate that over time, psychological strain brought on by various pressures and life stressors can become overwhelming and lead to hopelessness. Cognitive hopelessness, in addition to enduring schemas of negative experiences,

memories, and self-evaluations are established and thus prone to activation by minimal triggers; consequently, hopelessness, when triggered, could quickly lead to a repeat suicide attempt. Since Beck's original theory, hopelessness has been widely accepted as one of the primary cognitive processes leading to suicidal behavior.

Cognitive deficits (lack of healthy forms of thinking) and cognitive distortions (dysfunctional thinking processes) have also been linked to suicidal ideation and behavior. Internal disorders (e.g., depression) are often associated with cognitive distortions, and externalizing disorders (e.g., conduct disorder) are often associated with cognitive deficits in addition to cognitive distortions. These deficits and distortions affect interpretations of stimuli, which many researchers argue can be a vulnerability for suicide.

Schotte and Clum (1987) examined samples of suicidal and nonsuicidal hospitalized patients, finding that suicidal patients had more deficits in personal and interpersonal problem solving (measured by requiring participants to find alternative solutions to problems and anticipate subsequent consequences), experienced higher levels of stress, and reported more hopelessness. Similar findings by Pollock and Williams (2004) indicated that those who attempted suicide had poorer problem-solving abilities than matched psychiatric controls, despite changes in mood. In a study aiming to integrate the cognitive distortion and deficit models, cognitive distortions were found to be directly associated with suicidal ideation, and cognitive deficits were indirectly related to suicide by association with cognitive distortions (Fazakas-DeHoog et al., 2017). The researchers suggested that deficiencies in problem solving can lead to higher levels of hopelessness and negative self-evaluations, which in turn may escalate to suicidal ideation.

*A Cognitive Model.* Wenzel and Beck (2008) proposed a cognitive model of suicidal behavior that conjoins theory, cognitive and behavioral correlates of suicide, and risk factors for suicide. Wenzel and Beck proposed that *dispositional vulnerability factors* are enduring, trait-like variables that may put an individual at risk for psychiatric illness and suicidal behavior. *Cognitive processes associated with psychiatric disturbance* are the maladaptive cognitions and information processing biases (e.g., ignoring positive feedback), which are associated with various psychiatric disorders and symptoms. *Cognitive processes associated with suicidal acts* are maladaptive thoughts and information-processing biases that Wenzel and Beck suggest are activated during a crisis (e.g., experiencing suicidal ideations or engaging in suicidal behavior). These cognitive processes may lead to suicidal ideations and behaviors; the point at which a person takes action depends on his or her threshold of tolerance for the overwhelming cognitions and emotions emerging. Similar to several of the diathesis-stress models discussed earlier, Wenzel and Beck proposed that life stress can activate cognitive processes associated with psychiatric disturbances and suicide. Their model serves as a solid guideline for understanding suicide from a cognitive perspective, and is a promising resource for clinicians treating patients with cognitive therapy.

**Suicidology.** Although risk factors such as depression, hopelessness, and stressful life events are acknowledged as significant predictors of suicidality, such risk factors do not appear to fully account for suicidality. Suicide is arguably intrapsychic; it goes beyond the experience of stress and pain, and includes the individual's perception of his or her ability to cope with the event or pain. Suicide is multifaceted and there is significant variability in suicidal behavior, such that it is almost impossible to predict. Therefore, as Leong and Leach (2008) explain, "[Suicidology] should be the study of the whole organism, not only the stress or pain. People do

not simply commit suicide because of pain, but because it is unbearable; they are mentally constricted; they have a mental/emotional disorder; they cannot cope, etc." (p. 24). Suicidologists believe that suicide is not only intrapsychic, however, but also interpersonal, as our actions and cognitions are greatly affected by our interpersonal relationships.

Edwin Shneidman, often considered the father of suicidology, developed the concept of *psychache*, or psychological pain. Shneidman (1993) proposed that psychache is a requisite precipitator for suicide, defining psychache as the chronic, nonsituation-specific "hurt, anguish, soreness, aching, psychological pain in the psyche, the mind" (p. 145). Unlike cognitive psychologists, he focused on the affective experience of psychache, giving less weight to cognitions or behaviors. Shneidman believed that the experience this painful affective state can become unbearable to the point where an individual seeks escape through suicide. He asserted that other predictors of suicide (e.g., depression and hopelessness) are secondary and relevant only through association with psychache. Several studies have supported the significance of psychache and relevance to suicidality. Troister and Holden (2012) conducted a two-year prospective study of psychache among high-risk undergraduates and found psychache to be the only significant predictor of suicidal ideation. In addition, psychache was the only factor that influenced the variation of change in future suicidal ideations. Results such as these support Shneidman's assertion that psychache is an important precipitant in suicidal behavior.

Shneidman (2005) viewed suicide not as a disease of the brain, but rather a product of extreme psychological pain and the belief that death will solve the problem of mental distress. This view frames suicide not as a desire for death, but rather as a method of escape from intolerable anguish and emotion. Shneidman viewed suicidal impulses phenomenologically, studying the inner world of the individual and focusing on the individual's unique affective

experience. Rather than understanding suicide as related to psychiatric disorders or biological irregularities, he stressed that suicide should be conceptualized in terms of psychological pain and unmet psychological needs. Shneidman's perspective encourages the acceptance of human suffering that occurs within the suicidal individual, rather than pathologizing the suffering. The argument is that suicide should be viewed as a phenomenon experienced within the individual; the suicidal person is then regarded as a unique individual whose personality and experiences lead to wishes for suicide (Pompili, 2010).

***Phenomenological Approach.*** Phenomenology is a philosophical discipline. In its most basic form, phenomenology aims to objectively study subjective topics, such as consciousness and the judgments, perceptions, and emotions that make up the conscious experience. Phenomenology involves systematic reflection in order to identify the properties and structures of an individual's experience. Subjective experiences are the foundations of suicidology. Suicidology explores the phenomenology of suicide; the emphasis is on the unique suffering experienced by the subject and the subject's inability to stand it, thus believing that death is a solution.

Pompili (2010) proposed that suicide is a consequence of fractures with oneself, others, and nature, coupled with the inability to experience feelings related to well-being and appreciation. Some individuals experience this fracture deeply, and such an experience is not necessarily related to mental disorders such as depression; Pompili noted that it is possible for an individual to be profoundly depressed, yet hopeful and seeking solutions apart from death. It is difficult to develop models of suicide due to the complexity of this phenomenon, and the fact that many key features of suicide are not easily identifiable. The lack of helpful models of suicide is reflected by the nation's increasing suicide rate despite tremendous efforts in this field.

**Integrative.** Despite its multifaceted nature, suicidal behaviors are common in virtually all regions of the world (Gureje et al., 2011). In the search for "psychological universals," Norenzayen and Heine (2005) asserted that there are common human characteristics that underlie our physical, social, and psychological being. In other words, humans share universal psychological building blocks, indiscriminate of geographical or historical contexts. Norenzayen and Heine proposed that the social, cognitive, or psychological differences we observe in humans are products of biological evolution and culture. Thus, although specific social and cultural factors are important to consider when examining suicide, the process through which individuals reach suicidal ideations and behaviors appears relatively consistent cross-culturally. Therefore, there is value in integrating current theories for a more comprehensive understanding of the phenomenon of suicide; future research and practice should include cultural considerations. Several integrative models of suicide have emerged in recent years, and a few will be discussed here.

The Suicide and Self-Destructive Behaviors Study Group (2018) recently published an integrative psychodynamic model of suicide. This model integrates psychodynamic, interpersonal, and cognitive-behavioral theories of suicide and is set within a psychodynamic framework. The researchers argue that the individual contemplating suicide is influenced by the interaction of various social, biological, and intrapsychic contexts; thus, assessing the suicidal individual in these various contexts can provide a more comprehensive analysis. This model begins with the stress-diathesis concept, as it examines underlying developmental vulnerabilities, which may be triggered through various precipitating events. The theory of thwarted belongingness is then considered, assessing for social experiences and availability of social support. The capacity to bear an affective state is then assessed, with attention to Maltsberger's

(1986) affective flooding and Wenzel and Beck's (2008) suicide schemas. Subsequently, protective factors (barriers to suicide) as well as accelerants (exacerbating factors or symptoms) are assessed, followed by cognitions (e.g., perfectionism, hopelessness, all-or-nothing thinking, etc.). The individual's conscious plan for suicide as well as suicide fantasies are assessed in order to assess for risk and lethality; lastly, attentional fixation (i.e. tunnel vision) on suicide is examined, as this dissociative state that accompanies suicidal warning signs may activate pathways of thought and action leading toward the goal of suicide.

This integrative psychodynamic model is helpful in that it combines empirically supported models from multiple theoretical perspectives with clinical experience; the goal is to be theoretical sound while individually specific. Such models serve as useful tools when evaluating and assessing suicide risk, which is the first step in suicide intervention.

Zhang (2016) developed the original strain theory of suicide and recently integrated the strain theory with the interpersonal theory of suicide. Referred to as the two-factor model, Zhang's updated theory focuses on psychological strains cultivated in a social structure, and the ways in which negative life events, social disconnectedness, and high capability escalate the progression from ideation to behavior. The two-factor model of suicide is advantageous in that it encompasses the causes of suicidal ideation (strain theory, Factor I) and the major risk factors for those who already have suicide in mind (interpersonal theory, Factor II). These risk factors include social disconnectedness, capability, hopelessness, and mental disorders. The interpersonal theory provides a basis for the secondary level of prevention (early diagnosis and prompt treatment) of suicide in selective and high-risk populations, and the strain theory offers a basis for the primary level of prevention (preventing the onset of suicide) in the general

population. Although Zhang's revised two-factor theory has yet to be extensively tested, it provides a helpful framework for understanding suicide and developing prevention measures.

Smith and Cukrowicz (2010) proposed a functional model of the acquired capability for suicide, drawing from the interpersonal theory of suicide. The researchers expand on the acquired capability for suicide by integrating a diathesis-stress model in order to account for diatheses associated with the acquired capability for suicide (e.g., genetic vulnerabilities). Under this model, an individual is at greater risk for developing the capability for suicide when a greater number of specific diatheses are experienced, and this individual will require fewer severe diathesis-expressing events. Joiner's original interpersonal theory explains the acquired capability for suicide as an ongoing build up to the point at which an individual crosses an inhibitory threshold and becomes capable of suicide. However, Smith and Cukrowicz argue that an individual can develop the short-term capability for suicide in the moment via intoxication, psychosis, dissociative states, mania and so forth. Essentially, Smith and Cukrowicz expand the interpersonal theory by further exploring genetic vulnerabilities and the influence of provocative life events, while integrating relatively time-stable factors and short-term factors.

Lee et al. (2016) examined the model developed by Smith and Cukrowicz within a Korean community, and found their results to support the functional model of the acquired capability for suicide. Short-term enhancers for the acquired capability for suicide had direct effects on suicide attempts. Lee et al. note that preventing suicide should thus have different interventions between those who have specific suicide plans and others who have drug addictions, psychotic episodes, or manic episodes.

**Cultural Context**

Culture can be described as the shared skills, knowledge, and way of life within a society or group; it gives a collective and its individual members a sense of identity and belonging. Culture is one's meaning, even in death or suicide; many researchers argue that culture cannot be ignored when studying topics such as suicide, which have a large social and relational component (Leong & Leach, 2008).

For example, an important question to cognitive psychologists is whether the cognitions that reinforce suicidal behavior and motivations are universal. Considering the diversity of sociopolitical environments, cultures, and histories across the globe, one can assume that underlying social cognitions that drive the dynamics of the mind are equally as diverse. Social and cultural factors are recognized as fundamental drivers of cognitive processes; an individual's socio-cultural environment and social cognitive processes are arguable inextricable. Cultural practices and beliefs are also known to influence cognitive processes, as they help to perpetuate those practice and beliefs (Nisbett & Norenzayan, 2002). Furthermore, early anthropologists believed that culture influences the development of an individual's worldview, cognitive processes, and reasoning (Wundt, 1916).

Revisiting Durkheim's sociological theory as well as the anthropological theory of suicide, it is clear that social context is significant in regards to suicide. Many social scientists studying suicide recognize that suicide is a social act; when examining suicide under an ethnographic lens, it is no longer limited to social and pathological risk factors. Rather, suicide appears to be a social relationship in its own right, through which people in some cultures create and establish meaning in their own lives. For example, Malinowski (1949) observed that acts of suicidal behavior in the Trobriand Islands, when performed under certain conditions with

particular methods, were perceived as complaints or challenges to others in dispute. By attempting or successfully committing suicide, the blame was then transferred to others, and the suicidal individual's kin would be compelled to seek revenge. Suicide has been observed to serve as a social mechanism in some societies, and in this context appears less relevant to psychopathology or neurology (Staples & Widger, 2012). Therefore, if we are to understand suicide for the sake of improving psychological treatment and intervention strategies, the diverse structural contexts and conditions from which suicidal behaviors arise must be further examined. For the purpose of this review, specific cultural beliefs and differences in regards to suicide will not be examined in depth, however diversity is an area of research in need of further exploration.

*Attitudes Toward Suicide*

In a valuable cross-national study, Eskin and colleagues (2016) compared university students' attitudes toward suicide and suicidal persons. Twelve countries were chosen, belonging to four culture zones identified by previous research studies: Confucian, Islamic, English speaking, and Catholic. Their findings showed Muslim countries (e.g., Tunisia, Turkey, Iran, and Palestine) to have the lowest suicide acceptance scores; samples from Austria, the UK, Japan, and Saudi Arabia had the highest suicide acceptance scores. Interestingly, four of the five samples with the highest suicide acceptance scores (Austria, UK, Japan, and Saudi Arabia) were either from countries with high suicide rates (Austria and Japan) or the participants reported significantly more suicidal ideation or attempts. Except for the Turkish sample, students from Japan and Muslim countries believed most that suicide was a behavior that should be hidden. The researchers noted that this phenomenon is indicative of social stigma; it reflects Japan's high suicide rate and Muslim Arab countries' tendencies to underreport or misclassify suicides.

Students from the USA, Italy, the UK, Jordan, and Austria, on the other hand, were the most accepting of open communication about psychological problems.

Attitudes to suicidal individuals were also investigated, as the researchers argued that these attitudes are important indicators of social integration and support (e.g., willingness to help a suicidal friend). Samples from Turkey, the USA, Italy, and Tunisia had the highest social acceptance scores, while samples from Japan, Saudi Arabia, Palestine, and Jordan had the lowest social acceptance scores. Interestingly, the lowest scores on social acceptance, helping, and emotional involvement factors and the highest scores on the disclosure disapproval factor were obtained by samples from countries with high suicide rates or more suicide ideation and attempts reported. Consistent with previous findings, suicide acceptance was found to be inversely correlated with social acceptance of suicidal people; the researchers noted that perceiving suicide as an acceptable option but rejecting those who engage in suicidal behavior may be problematic, as the person in this situation is more open to committing suicide but hesitant to seek help due to anticipated stigma. Being in this type of trap could lead to hopelessness and helplessness and have dire consequences. Results also indicated that those with no history of suicidal ideation or attempts were more likely to have internal barriers against suicide, or life-sustaining attitudes; thus, examining attitudes toward suicide may have clinical significance in the assessment of suicide risk. This research study highlights the significance of cultural variations in attitudes to suicide and suicidal individuals, and it is evident that an individual's diverse social context (i.e. race, ethnicity, religion, sexuality, and gender) is a key component of suicidality (Eskin et al., 2016).

**Suicide and Crisis**

Suicide is a complex, multifaceted behavior, and the theories explored highlight the importance of individual differences among each case. It is imperative that intervening clinicians fully understand the individual's experience of their inner world, as well as the social context, beyond psychological risk factors. For the purpose of developing effective treatment practices and protocols, it is crucial to have a solid theoretical foundation. The field of clinical psychology has made significant advances in suicide theory, and integrative theories are increasingly comprehensive.

Although research on suicide theory has expanded in recent years, these efforts do not appear to have resulted in significant reductions in suicide rates thus far. This is perhaps due to a lack of empirically supported interventions for suicide prevention, as there are gaps in research evaluating the effectiveness of employed suicide prevention and treatment programs. In addition, there is a scarcity of treatment development and evaluation research as well as inadequate research methodology in many of the studies that are conducted (Linehan, 2008).

The disease model of suicidal behavior has been the most prominent theory driving suicide interventions, however there is limited evidence to suggest that this model has led to effective prevention and intervention protocols. Interventions targeting mental disorders do not appear to result in significant reductions in suicide attempts or fatalities. For example, the hospitalization of suicidal individuals has not been proven to be an effective intervention method, and yet it is a standard of care in the field (Linehan, 2008).

Suicidology is a relatively young field of study, however, and significant progress has been made in better understanding suicide as a phenomenon, as well as developing assessment

and treatment models. In studying the phenomenology of crises, we may be able to better understand why suicide occurs, and what leads a person in crisis to choose either life or death.

**The Crisis Worker Experience**

As previously stated, differences in the perception of a crisis and the perceived outcome of a traumatic event is an area that has not been extensively researched. Although we know that stress, crisis, and trauma are ultimately determined by perception, the different ways in which people experience crises and the multiple meanings they attribute to these events are not well understood. Another way of understanding these variances is to investigate the experience of the crisis worker or therapist who supports people in crises, witnesses these differences in perception and resiliency, and has likely found ways of maintaining his or her own psychic equilibrium when confronting another's emotional spillover. In a way, these workers serve as models for resiliency in the face of crises, and can shed light on the factors that optimize helping capacity. To this date, there are few studies focusing on the experience of the crisis worker, who is often a paraprofessional and even a volunteer in the case of suicide hotlines. As previously discussed, a crisis leads to the failure of an individual's usual coping mechanisms and induces a state of heightened vigilance; an individual in crisis is therefore more open to intervention, and it is often during a crisis that individuals are motivated to seek help, sometimes for the first time. The crisis worker thus plays an important role in crisis intervention, and a relatively brief intervention could have a significant impact; a collaborative intervention using problem solving and mobilization of resources could encourage an individual in crisis to take advantage of the opportunity for growth presented by crises (Kalafat et al., 2007). Therefore, I believe it is important to understand the experience of crisis workers and the people who undertake these jobs

in order to better support crisis workers, improve and inform crisis intervention, and assist individuals in crisis.

**Understandings of Crises**

In a qualitative study, Morton (2010) explored the relationship between emotion and the experience of a mental health crisis, particularly in the context of crisis resolution services and mental health services. Morton notes that existing research on the nature of a crisis is rare. In her study, findings showed that there was seldom one major life event that had led people into crisis, and crises were not the result of poor coping ability, but rather coping capabilities being overloaded. Mental health staff indicated during interviews that they were under the impression that individuals could no longer contain a range of feelings associated with various difficulties (i.e. loss, relationship problems, trauma, and social problems), and these emotions spilled over into something with which they sought help. These individuals' experiences were thus significant but not described as solely connected to mental illness or relapse, even when there was a previous formal diagnosis. Morton (2010) concluded that it is the un-containable emotions that cause a person in crisis to reach out for help; she noted that emotional crises do not discriminate and can be experienced by anyone.

Tobitt and Kamboj (2011) conducted a qualitative inquiry among crisis resolution or home treatment team members in order to better conceptualize the phenomenon of crises and to understand the experience of crisis work. The researchers note that the concept of "crisis" remains ambiguous and is poorly delineated in mental health settings. This study was done in the United Kingdom and obtained a sample of multidisciplinary professionals in crisis work (i.e., nursing, social work, psychiatry, clinical psychology, and occupational therapy). Several themes emerged in the participants' responses. A crisis was described to include functional disruption (a

temporary loss of normal functioning), risk of harm (to self and/or others), a need for additional support (supports in place had failed and outside sources of support were needed), extreme mental distress (heightened, painful emotion), and a potential need for hospitalization for further stabilization. Many of the participants noted that a crisis refers to a temporary disruption to functioning and does not include longstanding or mild "crises" (Tobitt & Kamboj, 2011).

The researchers also identified themes in respondents' accounts in their understanding of the concept of crisis as it occurs. Many respondents mentioned the idea that people can experience similar situations and yet only some enter into a state of crisis; the researchers call this effect differential vulnerability, and respondents attributed this to variations in peoples' appraisal of and tolerance for stress. Respondents postulated that these variations arise from different developmental histories, especially problematic attachment in relationships, traumatic life events, social adversity, and being sheltered from opportunities to learn to cope. Some respondents identified crises as opportunities to reflect on current life circumstances, make changes, and learn how to prevent or minimize future crises. The respondents noted that not all clients saw their crisis as a catalyst for change, especially those who were repeated service users. Some respondents also observed that crises could either elicit change and action or a lack of motivation and resistance to engage (Tobitt & Kamboj, 2011).

Themes also emerged in relation to respondents' understanding of how crises originate. These included life stress ranging from everyday stresses to major life events, biochemical crisis (e.g., imbalance in brain biochemistry resulting from medication issues or "natural" factors), systemic crisis affecting the wider system to which they belong and vice versa, past memory triggered (e.g., distressing memories triggered by current events), cultural influences on crisis (e.g., pressures of modern life, societal expectations, media representations, and consumer ethos;

culture shapes perceptions of what crisis is and the "quick fix" crisis resolution), and concealed origin of crisis (sometimes the origin of the crisis was concealed from the worker at first and became apparent later in work). Again, respondents noted that differential vulnerability was a part of these contributing factors and there are significant differences across individuals (Tobitt & Kamboj, 2011).

**Occupational Stress and Resilience**

*Occupational Stress*

Crisis workers and other mental health professionals are dedicated to providing services to vulnerable populations in a context which inevitably involves listening and being exposed to an individual's pain and suffering. The experience of the crisis worker is unique in that the client being serviced is often in a state of disequilibrium, traumatization, heightened distress, and affective lability.

The day-to-day exposure to clients in crisis and the distress they experience can lead to occupational stress and become emotionally taxing. This may result in the experience of conditions such as secondary traumatic stress (experiencing symptoms of PTSD due to engaging in an empathic relationship with an individual suffering from a traumatic experience), vicarious traumatization (an alteration in one's thoughts and beliefs about the world such as safety, trust, and control due to engaging in an empathic relationship with an individual suffering from a traumatic experience), compassion fatigue (cumulative emotional and physical fatigue resulting from the continued use of empathy with individuals who are suffering), and professional burnout. Professional burnout is a state of physical, emotional, psychological, and spiritual fatigue resulting from chronic exposure to demanding situations or populations that are vulnerable or suffering. The act of burning out is a state that progresses over time, and can be

caused by emotional exhaustion, depersonalization (e.g., detached responses to clients or coworkers) or cynicism, and reduction in personal accomplishment (e.g., feeling inadequate when clients do not respond to treatment despite efforts to help) (Newell & MacNeil, 2010).

*Resilience*

Traditionally, resilience literature focused on childhood and adolescent development. However, in recent years resilience studies have expanded to include adulthood, particularly in the face of loss or potential trauma (Pietrantoni & Prati, 2008). *Resilience* can be defined as the ability of adults, who are exposed to a potentially disruptive event or crisis, to maintain relatively stable, healthy levels of psychological and physical functioning. Resilience is more than the absence of psychopathology; resilient individuals may experience disruptions in normal functioning but go on to exhibit healthy functioning, the capacity for renewed experiences, and positive emotions over time (Bonanno, 2004). More recently, research in resilience has been applied to first responders, or those whose jobs entail being first on the scene of an emergency (e.g., firefighters, paramedics, police officers). Burnout and compassion fatigue have been studied in first responders due to the demanding nature of the job and an accompanying high turnover rate.

A quantitative study by Pietrantoni and Prati (2008) analyzed questionnaires sent out to first responders and found that first responders experience a good level of satisfaction and low level of burnout and compassion fatigue as results of their jobs; their research showed that most first responders surveyed were not affected by traumatic stress or burnout syndrome despite exposure to critical incidents. Thus, the researchers conclude that first responders likely rely on personal and social resources in order to cope with critical incident stress. Such resources include a feeling of belonging to the community in which they live and work, as well as self-efficacy or

confidence in job-performance abilities; these factors appear to give first responders a sense of control and meaning in their jobs.

Burnett and Wahl (2015) investigated the relationship between compassion fatigue, burnout, compassion satisfaction, and resilience among disaster behavioral health and emergency preparedness response professionals in Michigan. According to their findings, 72% of participants were evaluated to be at significant risk for compassion fatigue, while 20% of participants reported problems associated with burnout, such as feelings of hopelessness, exhaustion, or lack of confidence in job-performance abilities and self-efficacy. Only 22% of participants had scores indicative of high resilience, and resilience was found to have a significant negative correlation with compassion fatigue and burnout.

A significant positive correlation was found between compassion satisfaction and resilience. Additionally, less than half of the participants had subscale scores indicative of compassion satisfaction, or the fulfillment gained from the act of helping. Overall, the majority of participants possessed adequate skills for adapting to change and managing adversity. The researchers conclude from their findings that resilience appears to play an important role in mediating the effects between compassion fatigue and burnout (Burnett & Wahl, 2015).

Menon et al. (2015) conducted a study analyzing the effects that changes in job tasks had on crisis resolution and home treatment team (CRHT) staff in the United Kingdom. The original CRHT clinicians engaged in in-home crisis intervention with clients. However, after organizational changes, the CRHT clinicians no longer did community and in-home outreaches and found that their roles changed significantly. Menon and colleagues found that contact with colleagues, direct service with patients, and a variety of work were rewarding to staff members. Themes of suicide and violence were most linked with stress, with clinicians reporting self-doubt

when faced with difficult clinical decisions. In addition, CRHT staff indicated that previously being able to work intensively with people in their own homes was a large part of their job satisfaction; the loss of this opportunity led to an inability to observe the impact they had on the patient, and staff felt that they functioned merely as "filters." The researchers hypothesize that CRHT staff loss the felt impact of the therapeutic intervention, which mitigates the felt impact of the trauma, and found their work to be less rewarding.

Menon and colleagues note that a crisis clinician who works with patients in a state of extreme distress and helplessness enters into a position in which they must provide "containment." A clinician creates a "container" or holding space for undigested thoughts and feelings, which can become available for reflection when the clinician makes meaningful contact with a patient, takes on their traumatic experience, and helps them to make sense of it. The researchers hypothesize from a psychodynamic perspective that clinicians deprived of their therapeutic function may experience a loss due to an inability to engage in an occupation that perhaps serves to gratify needs, replicate significant childhood experiences, and actualize occupational dreams or expectations (Menon et al., 2015).

**Summary**

The concepts of psychological crises and suicide are complex and multifaceted. As a result, there is little theoretical cohesiveness about the nature, causes, and effects of these phenomena. Although research on suicide and crisis theory has greatly expanded in recent years, these efforts do not appear to have resulted in comparable reductions in suicide rates thus far. Much of the existing literature focuses on crisis intervention in order to develop effective assessment and treatment methods and protocols, however there is arguably a need for theoretical grounding. In addition, there are gaps in research identifying characteristics in crisis

workers that promote resilience, allow them to thrive and be effective in their jobs, and enable them to create a container or holding space for individuals experiencing extreme distress.

## Statement of the Problem

The statement of a problem in a qualitative study provides a rationale for doing the proposed study; this statement is based on an observation of gaps in current literature. It is important to generate this statement because it provides direction and purpose for the research, showing how exploration of these omissions or under-representations in research will enhance current theory and practice (Glesne, 2016). In doing so, it provides moral praxis or ethical reasons for conducting the study, as it identifies the cost or impact of these omissions in literature and the value of gaining this knowledge.

Research on psychological crises and suicide has expanded in recent years due to an increasing need for effective crisis intervention strategies. However, there remains a lack of theoretical agreement on the concept of a psychological crisis, how it is experienced, and how it develops; the same applies to the phenomenon of suicide. There are also gaps in research on those who perform crisis intervention. While there is existing literature on resilience and burnout in first responders, there are few studies examining resilience in crisis therapists or mental health workers. Pietrantoni and Prati's study (2008) is one of several quantitative studies which have identified factors contributing to resilience in first responders; however, the researchers note that resilience is a multidimensional construct that should be examined with both qualitative and quantitative techniques. Due to the experiential nature of crisis intervention, conducting a qualitative study with mental health crisis workers would help to illuminate another viewpoint of crisis and resilience. Having this knowledge could help with the training and support of crisis intervention teams, as well as add to a lacking area of intervention: that which focuses on the

promotion of resilience factors rather than the treatment and pathologizing of negative health symptoms.

## Purpose of the Study

A qualitative study's statement of purpose identifies the phenomenon of interest to the researcher, the unit of analysis (participants), the methodological approach that will be used, how the findings will be presented, and a provisional definition of the phenomenon (Creswell, 2008, as cited in Rossman & Rallis, 2012). The purpose of a study in qualitative research refers to its utility, or credibility to potential users. It provides a framework for conducting the study while preserving the right to make some field decisions. It also focuses on the experience of the participants, or the emic perspective (Rossman & Rallis, 2012).

The purpose of this study is to explore the experience of a crisis from the perception of a crisis intervention team, including a crisis mobile outreach therapist, a crisis line screener, and a crisis case manager, using a transcendental phenomenological design. Investigating the experiences of those who support people in mental health crises can help us to better understand factors that optimize helping capacity, as well as ways of supporting crisis workers, improving crisis intervention, and assisting individuals in crisis. The result will be a descriptive portrait and discussion of themes and patterns. At this stage in the research, *crisi*s will be provisionally defined as a state in which a person has experienced a traumatic event, has failed to cope and lessen the stress or trauma, and enters into a state of disequilibrium.

## Research Questions

A research question identifies the overall intent of a study. It focuses and highlights what a researcher's work seeks to explore and understand. Research questions help to identify the boundaries or perimeter of a study. Qualitative research questions are open ended and

nondirectional, focusing on perception, meaning, and process in order to generate or refine

theory. This contrasts with quantitative research, which implies cause and effect or suggests

measurement.

The four general categories of questions used to organize a transcendental

phenomenological inquiry include: descriptive questions (explore participants' perceptions of

what the phenomenon is), experiential questions (explore the participants' perceptions of their

experiences when engaged in the phenomenon), process questions (explore how the phenomenon

changes over time and how meanings evolve), and meaning questions (explore significance and

meaning ascribed to a phenomenon) (Moustakas, 1994).

My research aims to explore the following questions:

1.  How do crisis workers describe a mental health crisis?

2.  What is the crisis worker's experience of a crisis?

3.  How do crisis workers' perceptions of crises develop and evolve over time? How do

    crisis workers remain resilient while being present with a client, in the face of emotional

    contagion?

4.  What makes this work meaningful to the crisis therapist?

## Grand Tour Questions

Grand tour questions are questions used to facilitate participant sharing of experiences;

these are typically open-ended questions that translate research questions into conversation

questions, inviting participants to share their phenomenological field, or to give them a "grand

tour" of their experiences. Grand tour questions capture the greatest breadth and depth possible

of participants' experiences in a particular context (Spradley, 1979).

The initial grand tour questions for this study included the following:

1. How would you define a mental health crisis? Has your definition or perception of a mental health crisis changed from when you first started this work?

2. What seems to be most helpful to clients when doing crisis intervention?

3. What led you to doing crisis intervention and what do you enjoy most about this work?

4. What is the most difficult part of being a full-time crisis worker?

5. Tell me about one of the most memorable and/or meaningful calls you've been on. Why was it memorable or meaningful to you?

6. How do you maintain your own emotional stability when working with patients who are in a state of crisis? (What have you experienced in life and in your work that has allowed you to find longevity in this field?)

7. If you could have any other job, regardless of financial compensation, what would it be?

8. What is your dream vacation?

## Significance of the Study

The significance of a study in qualitative inquiry refers to the hopes and aspirations for a study; it identifies the major stakeholders of the study, and how these people might benefit from and be affected by the findings. Identifying the significance of a study is important because it enhances utility and ethical rigor of a study (Glesne, 2016). Conversely, in quantitative research the significance of the study often articulates an aspirational statement and refers to how statistically likely it is that the results will contradict the null hypothesis.

The findings of my study will benefit those who conduct crisis intervention, individuals experiencing crises, and organizations hiring crisis workers. Crisis and first-responder work is a field with high occupational stress and burnout, as it can be physically and psychologically

demanding. Knowing what factors allow a person to successfully provide crisis intervention will

help identify the characteristics that lead to resiliency in a person, both in the helper position and

in the person receiving treatment. In addition, it will allow organizations to better train and equip

their workers to provide quality crisis intervention services. Lastly, understanding what traits

allow a person to provide a holding space for a person in an emotional crisis can shed light on

how people experience crises and can better cope with stress.

# CHAPTER II. APPROACH

[This chapter presents the proposed field method. Chapter III presents an account of the emergent field method; documentation of field learning and methodological refinements made to better capture the participants' stories with emic accuracy.]

## Rationale for Use of Qualitative Methodology

Qualitative inquiry focuses on understanding; it is an interpretive science in search of meaning rather than an experimental science in search of laws, as is the goal of quantitative inquiry. Qualitative inquiry emphasizes phenomenology, or the science of the individual's personal experience and perspective. It aims to transform data into information that can be used for the benefit of various fields of learning. While quantitative inquiry aims to predict, control, describe, confirm, and test hypotheses, qualitative inquiry aims to understand, describe, discover, and generate hypotheses. Qualitative research can benefit from small, nonrandom, theoretical, and purposive samples in a naturalistic environment. It is flexible, evolving, and builds theories (Glesne, 2016).

There are four main uses for qualitative research: instrumental, enlightenment, symbolic, and emancipatory. Qualitative research can be used for instrumental purposes by applying the methodology to a particular problem. In instrumental research, findings are developed into knowledge with the planned intent to implement these findings into practice; usually this perspective is linear and involves a rational decision-making process, clear goals for research, direct attainment of these goals, and access to relevant research. Qualitative research can be used for enlightenment, or to provide the user with knowledge. Sometimes a specific research goal is not designated, and rather the researcher chooses to provide knowledge which can be used for various purposes. Accumulated knowledge can challenge existing beliefs, build insights, and enhance general understandings of practice. Qualitative research can also be used symbolically,

to provide new ways of expressing phenomena. Findings offer symbolic explanations, making complex, ambiguous experiences or beliefs comprehensible and communicable. Qualitative inquiries may also help crystallize beliefs or values, and facilitate a shift in public perceptions. Lastly, qualitative inquiry can be emancipatory, meaning that the knowledge it generates has the potential to be transformative and alter some aspect of society. Thus, research may empower participants' daily lives; participants may take actions on the basis of what they discover about themselves during a study that empowers them and changes oppressive structures and practices (Rossman & Rallis, 2017).

This qualitative inquiry can most likely be used for enlightenment purposes, or to provide the user with knowledge that can be used for various purposes. My hope is that this study can challenge existing beliefs, build insights, and enhance general understandings of crisis intervention and practice.

**Specific Methodology**

Qualitative inquiries may be conducted using one of the following approaches: biographical, case study, phenomenological, ethnographic, grounded theory, and action research (Glesne, 2016). This study will utilize a transcendental phenomenological approach. Phenomenological studies examine the meanings ascribed to the lived experiences of several individuals with respect to a concept or social phenomenon. Transcendental phenomenological studies are a postmodern variant of the original phenomenological approach, that places a greater emphasis on bracketing or managing preconceptions, utilizing a semi-structured approach to inquiry, and developing universal structures based on what people experience and how they experience it (Moustakas, 1994). The transcendental phenomenological method attempts to

manage potential prejudgments or biases, and requires the researcher to observe phenomena openly, understand meanings, and self-reflect.

This method is applicable to my study because I am studying the emic rather than consensual experiences of participants in the study; this requires epoché, or a review of my own biases or preconceptions, and a semi-structured approach to inquiry. My role is to develop a way of understanding and structuring the emergent reflections of another person's experiences, considering what each participant is experiencing and how (Moustakas, 1994).

<div align="center">

**Role of the Researcher**

</div>

**Intersubjectivity**

In qualitative research, it is assumed that the subjectivities of both participants and researchers affect one another and that one cannot separate the knower from the known. This assumption is referred to as the assumption of intersubjectivity (Glesne, 2016). Despite acknowledgment of intersubjectivity as the nature of reality, the qualitative researcher's aim and responsibility is to capture the reality of the other. This is challenging given the filters and positionality of the researcher (Glesne, 2016; Moustakas, 1994). Qualitative researchers address reliability and validity issues by being reflexive and striving to make their purposes explicit; this involves self-examination in field journals, documenting their research procedures and processes, and taking on a participant-observer role in research (Glesne, 2016).

**Participant Observation**

Qualitative researchers attempt to position themselves along a continuum between pure participant and pure observer; they attempt to be both engaged and detached. A pure participant role requires a researcher to be both an investigator and a functioning member of the community under study. This allows a researcher to better understand the contextual evidence, as he or she

becomes part of the experience; however, this is disadvantageous in that the researcher may

begin to assume that his or her experiences are congruent with those of the participants. A full

observer role requires a researcher to be an observer rather than a member of the community

under study. This allows a researcher to maintain some objective distance between themselves

and the participants of the study, but involves a certain amount of deception, which presents

ethical challenges. Qualitative researchers choose to be participant observers in order to capture

the heart of each participant's story while interacting in ways that are sensitive, respectful, and

congruent with their positionality in the given context (Glesne, 2016; Rossman & Rallis, 2017).

## Ethical Considerations

The four general categories of ethical theory that inform qualitative inquiries include: the

ethics of consequences, ethics of rights and responsibilities, ethics of social justice, and ethics of

care. The ethics of consequences include utilitarian ethics and teleological ethics. Utilitarian

ethics is result-oriented, encouraging actions that produce the greatest benefit to the greatest

number of people. Teleological ethics orient action or activity toward a goal or target that is

assumed to be intrinsically good (e.g., truth and knowledge). In both instances, the assumption is

that the end therefore justifies the means. The ethics of rights and responsibilities considers the

fundamental rights of an individual and the obligations or responsibilities to protect those rights.

Each participant is seen as a valued being and is not to be viewed as a means to an end. The

ethics of social justice, also known as critical ethics, requires the researcher to make a positive

contribution to the well-being of those researched; this commitment to participant well-being

takes precedence over obligations to the wider community. The critical ethnographer's role may

therefore involve advocacy to a particular group. The ethics of care, also known as covenantal

ethics, is most important to qualitative inquiries and involves an obligation to host societies, the

public, students, sponsors, colleagues, and one's professional discipline. It acknowledges the mutual indebtedness between collaborating parties. Because the relationships between all parties are significant especially in qualitative studies, the ethics of care and its promise of fidelity is necessary to consider (Rossman & Rallis, 2012).

**Informed Consent**

Obtaining informed consent from participants is crucial in order to conduct research in an ethical manner. Researchers must ensure that participants are not deceived about the study and participate voluntarily. Participants are as fully informed as possible about the study's purpose and audience, understand what their agreement to participation entails, give consent willingly, and understand that they are not bound to the study and may withdraw at any time without consequences or prejudice (Rossman & Rallis, 2017). Informed consent will also include the identities of the researcher's clinical research project (CRP) committee who will provide instructional support throughout the study and a description of their roles. The researcher's CRP chair will serve as the primary debriefer and peer examiner. The informed consent also will clarify the role relationship between the researcher and participants (e.g., role of researcher as participant-observer) and specify the boundaries and structure of the relationship.

A two-part informed consent protocol will be utilized in this study, giving participants authority over their involvement throughout the entire process. The initial informed consent will a brief presentation of what the study is about, an outline what is being asked of an individual participating in the study, possible benefits and risks of participation, and their rights as a participant. In addition, the initial informed consent will discuss how participants will be supported should they experience discomfort or distress during the study. In such instances, the researcher will stop the interview, turn off the recording device, and spend some time debriefing

the participant in order to decide what the best course of action might be. Anything discussed while the recording device is turned off will not be included in the study unless repeated on the record at a later time. The focus during these breaks in the interview will be the participant's welfare. A Participant Information Form and an Emergency Contact Form will be completed by the participant to aid him or her in the event of an emergency. As this research study covers sensitive topics and may evoke strong emotions or uncomfortable memories for participants, a Community Resource List also will be provided to address any potential need for support and to reinforce ethical sensitivity. Throughout this process, the researcher and participant will continually collaborate and be aware of various experiences that could arise during the study.

The final informed consent will allow participants an opportunity to review and edit their contributions, making sure that the researcher's portrayal of their story is accurate and providing them an opportunity to ultimately decide what information they are comfortable releasing. The two-part informed consent protocol acknowledges participants' ownership of their stories and narratives, and interpretive authority. The two-part informed consent protocol supports greater methodological transparency and is part of the researcher's covenantal responsibility to the participants.

## Audio Recording

The informed consent will also notify participants that audio recordings of our conversations will be made, and I will take notes for the purpose of maintaining accuracy. During the interview, I will explicitly state when I am turning the audio recording device on and off. The participant may request that a part of the interview not be taped, and this request will be met; no data from off-tape conversations will be used. Again, in these instances, I will notify the participant when I have turned the audio recording device on and off.

**Security of Data**

All data should be safely secured to protect the participants' privacy. This study will utilize a double-lock system and data will only remain accessible for the duration of the study by myself, the transcriptionist, and my research advisor/research committee chair, Dr. Joy Tanji, who will serve as my primary peer debriefer and peer examiner.

I will keep a field methods journal to document and reflect upon each meeting. This journal, in addition to tapes and transcripts, will be redacted and stored in a locked box within a locked filing cabinet to which only I have the key. Electronic data will be encrypted in a password-protected document, stored on a password-protected data storage device in a lock box to which only I have the key.

When handing off audio files to the transcriptionist to review, the audio file will be password-protected on a password-protected storage device and never saved to a computer desktop or hard drive. I will send passwords to my transcriptionist and research advisor in a separate encrypted email. In addition, when the transcriptionist and research advisor are not working on materials, data will be stored in a double-lock system determined by myself. I will keep data sanitized until the very end of the study, in which a participant may determine that he or she would like recognition.

At the conclusion of member check, all data will be secured and kept for at least three years, until July 31, 2023. This is so I can more readily respond to any queries from other researchers. After three years the participants may decide if they would like the originals returned to them or destroyed.

**Participant Rights**

In qualitative inquiry, the agency, self-determination, and participation of the participant in the analysis and reconstruction of their social world, as well as collaboration in the process and products, are priorities. As a result, the qualitative researcher has the ethical responsibility to protect those being researched and to ensure that their research does not harm the safety, dignity, or privacy of the people with whom they work. This is done to make a positive contribution to the well-being of those being researched, to provide informed consent and maintain privacy when requested, and to avoid exploitation of those involved in the study (American Anthropological Association, 1998). The participant must be given autonomy and fidelity in the study, as the participant is ultimately the owner of his or her story. Participants have the right to waive or decline questions, to defer questions until a later time, and to speak off record when requested. As previously stated, the participant has the freedom to withdraw from the study at any time without cause or concern about potential consequences.

**Interpretive Authority**

Qualitative researchers must remain true to each participant's story and be aware of their voice and privilege in the study. Participants will be directly involved in the review and editing process and will have the right to review and edit any materials, including the narrative write-up, if they believe it is incorrect or sensitive in nature. This is done to enhance the emic accuracy of my portrayal of his or her interpretations of these experiences.

**Ownership and Proprietorship**

Qualitative inquiry is a collaborative process between the researcher and participant, with joint proprietorship and shared benefits for both parties. Researchers and participants are co-

owners of the products of research, and participants will be provided with a copy of the study's findings if desired.

**Confidentiality and Anonymity**

Finally, qualitative researchers must constantly be mindful of the rights of the participants and limits of confidentiality. Researchers have an ethical obligation to those with whom they work and must prioritize the safety, dignity, and privacy of participants. In addition to protecting any confidential information obtained, researchers must explicitly discuss the limits of confidentiality with participants and disclose confidential information only with appropriate consent. Any reports of suicidal or homicidal intent that appear to be imminent or any reports of abuse of children, elders, or individuals with mental or physical disabilities will be reported to the proper civil or legal authorities (American Psychological Association, 2017). My research supervisor, Dr. Joy Tanji, will also be notified. Confidentiality may also have to be broken if the materials from this study are subpoenaed by a court of law. In the case that the participant discloses intent to harm himself or herself or others, I will contact my CRP committee and appropriate measures will be taken to ensure the participant's safety and the safety of others.

The participant has the right to remain anonymous and have any identifying information removed, as well as the right to decline anonymity. The possible impact of these choices must be presented to participants with an explicit explanation that despite their best efforts, anonymity cannot always be guaranteed, nor can recognition from a study. Should participants decide that they would like to change the status of their anonymity at any time, this request will be met. Limits of the participant's confidentiality will also be explicitly discussed.

**Purposive Sampling and Bounding of the Study**

Purposive sampling involves selecting participants who can help to capture the complexity of the social phenomenon being studied, rather than assessing the distribution of or normative aspects of those experiences. Essentially, it entails selecting participants who have phenomenological insights gained through direct knowledge and experience of the phenomenon. This provides information-rich cases, which is helpful when trying to generate theory that captures the breadth and depth of experiences rather than the normative or average experience (Glesne, 2016).

For this project, maximum variation sampling will be used. This case selection strategy involves the selection of exemplar cases along a continuum of experiences. For this study, I will be selecting individuals with a demonstrated commitment to crisis work for at least 10 years. I plan to select individuals who provide crisis intervention in the following contexts: 1) one crisis mobile outreach therapist, 2) one crisis line screener, and 3) one crisis case manager. A crisis mobile outreach therapist provides crisis intervention and lethality assessments in the community, and is dispatched by the crisis line screener; a crisis line screener takes the initial call, conducts triage and provides therapeutic support over the phone, then dispatches a mobile outreach therapist if needed; a crisis case manager is referred by the mobile outreach therapist and provides case management and crisis support services for up to 30 days. Each position provides support to a person in crisis, although by different means and in different contexts. Selecting these participants will help to capture a more comprehensive understanding of the crisis worker's experience and provide a greater breadth and depth of insight into the phenomenology of crises.

**Data Collection and Analysis**

**Pre-Entry**

Before entering the field, a qualitative researcher needs to prepare before interacting with participants. This preparation is called pre-entry.

*Gatekeepers*

During pre-entry, the researcher identifies informants and gatekeepers who can assist with entry. Gatekeepers and informants provide access to potential participants, and in this way they facilitate entry into the site. A researcher's relationship with gatekeepers and informants is important, and could impact one's access to the phenomenon and its participants. The gatekeepers and informants protect the safety of the participants from outsiders; ethics must be thoroughly considered (Glesne, 2016). In this study, working with gatekeepers was not absolutely necessary due to my current immersion in the field as a crisis therapist who frequently comes into contact with the various positions being investigated.

*Role Management*

It is important for the qualitative researcher to be aware of possible role management issues that may arise. The researcher's role is to be, as described previously, a participant-observer and a learner. Role management issues can occur when the distinction between roles is more challenging to distinguish; for example, a qualitative researcher may begin to take on a therapeutic role during the interview (Moustakas, 1994). In this study, my role as both a field researcher and a co-worker is complex. I will help participants distinguish between my roles by reminding them that I am a researcher first and foremost in this situation; it may be beneficial to ask questions that encourage basic explanations of concepts well known in this field in order to reinforce the idea that I am learning from their experience. In addition, it will be helpful to

consult with my research supervisor (who will serve as my peer examiner and debriefer) consistently before entering the field and when examining results as a researcher in order to minimize biases.

***Cultural Protocols***

The researcher also considers the cultural context to be sensitive and respectful of cultural protocols. Having an awareness of communication styles, social norms, and how the community is structured could greatly help with entry. Being mindful of the cultural context is also an ethical responsibility, for the researcher must ensure that participants are not unintentionally harmed by the entry of outsiders.

In this study, I will be interviewing co-workers and colleagues who also work in crisis intervention. Although we have different job positions, we come in contact with the same clients in varying settings and capacities. Our jobs are highly independent, however consultation is encouraged and part of the culture due to the critical and sensitive nature of the work we do. There are some cultural protocols in this field that I keep in mind when interacting with colleagues. For example, dark humor and sarcasm are often socially acceptable in this field and used as a way of relieving stress, building bonds, and demonstrating understanding and resiliency. Clinical jargon is also used in order to communicate clearly and directly; in a field in which many of our clients are in life-or-death situations, there is little room for ambiguity or confusion. In addition, being mindful of the social hierarchy and respecting all colleagues regardless of position is necessary and expected. Some of these cultural patterns will likely emerge and be documented as part of this study.

*Review of Biases*

A review of biases is also a critical aspect of pre-entry, as lacking an awareness of one's biases could greatly affect the research outcome and could even be potentially damaging to the participants (Moustakas, 1994). An important part of qualitative research involves reviewing biases that the researcher may have, which could negatively impact or compromise the rigor of a study.

**Theoretical or Professional Biases.** Theoretical or professional biases can take place when the researcher's theoretical orientation influences perception, values, and the prioritization of certain types of information. A qualitative researcher trained in psychology may also find it difficult to maintain the role of a learner, and role confusion can take place when the researcher begins to play the role of a therapist (Moustakas, 1994).

I personally tend to lean toward the person-centered theoretical orientation; this orientation values the inner wisdom of the client and uses a nondirective exploration of the client's story. This could potentially create a bias going into my study, because it might be easier to slip into the role of a nondirective therapist while attempting to be a participant-observer. If I begin to play the role of the therapist, it might become more difficult for me to access the information I am seeking, and would prevent me from having an objective view of my participant's experience. I can address this bias by reminding myself during the interview that I am not conducting therapy; I can also make sure to debrief with my research supervisor (who will serve as my debriefer and peer examiner) between interviews, to discuss things like role confusion.

I also might go into the interview listening more closely for signals of conditions of worth, which the person-centered frame identifies as a contributor to the client's present

experience. Additionally, I might have a tendency to keep the participant speaking about the present, as person-centered theory values presence and the here-and-now. I have some questions prepared that are more reflective and historical, and these questions can help me to embrace the entirety of my participant's story. I can address this bias by remaining curious about the participant's entire experience, past and present, and reminding myself during the interview that I am not conducting therapy. I can also make sure to debrief with my research advisor (who will be serving as my debriefer and peer examiner) between interviews, to discuss things like biases, countertransference, and difficulties that arose during the interview.

**Methodological Biases.** There are also methodological biases in qualitative research. These include biases that stem from previous experiences in research. For example, I have received more training in quantitative methodology and am more comfortable with the process of designing and conducting research studies to test the veracity of a theory. This type of research puts the researcher in the expert role and explores relationships between variables rather than trying to understand the phenomena or person's experience (Moustakas, 1994). I may have a tendency to try to gather information that supports my hypotheses, or listen for patterns that are more common or familiar to me. I can monitor and challenge this bias by asking open-ended questions and reminding myself to go into the interview with an open mind and without an agenda. I can also debrief with my research advisor (who will be serving as my peer examiner and debriefer) between interviews to see what I was missing during the interview.

Because I have been trained under a positivist paradigm, I may also have a tendency to search for an objective reality against which I can find truth; for example, while hearing my participant's story I may listen more closely when she speaks about concepts which are more concrete and familiar. I may also ask questions that explore correlations and causal hypotheses

rather than explore her story as a whole. Again, I can try to counteract this bias by asking more open-ended questions and listening more closely when her story sounds unfamiliar or confusing to me. I can also debrief with my research advisor (who will be serving as my peer examiner and debriefer) between interviews to see what I was missing during the interview.

**Personal Biases.** Lastly, there are personal biases that can affect qualitative research. My own understanding of the world is based on how I was socialized and my own life experiences. One bias that I need to keep in check is my bias of being a crisis worker. Due to the fact that I am interviewing other crisis workers, this could potentially cause me to go into the interview with my own personal ideas and assumptions about my participants' experiences, which would affect my ability to gather information fully and accurately. I can address this bias by making sure I constantly check that I am in an observer role and am not the expert on the crisis worker experience, for it is ultimately about their experiences, not mine. I can also get assistance from my research advisor (who will be serving as my peer debriefer and examiner) who does not share this role of a crisis therapist, and review my data with them to remove as many biases as possible when analyzing and coding data.

Another bias that I need to be mindful of is my own assumptions of what a crisis is and how it should be handled, based on my own personal life experiences. This bias could affect the way I listen to and comprehend their stories. I can address this bias similarly, by checking in with myself during the interview to make sure that I am being as objective as possible and not trying to be the expert on their experiences.  I can also go over my own biases with my research advisor (who will be serving as my peer examiner and debriefer) to minimize the influence of my preconceptions on my understanding of the participants' stories.

**Entry**

Entry in qualitative inquiry is an ongoing process that begins prior to the interviewer entering the field and collecting and analyzing data. Entry requires consideration of relationships, culture, role management, recruitment of participants, and informed consent. Entry is a process of building relationships with participants so that the researcher may gain emic understanding of the participants' experiences. It is important for the researcher to be authentic and transparent about the methods of research in order to establish trust and alliance (Rossman & Rallis, 2017).

*Gatekeepers*

Gatekeepers, as previously mentioned, are the qualitative researcher's access to participants. Entry involves establishing initial alliances with gatekeepers, informants, and participants. In this study gatekeepers will not be used due to my existing immersion in the field.

*Role Management*

Since I am conducting backyard research, research in a setting familiar to me, role management issues will be especially important for me to monitor. I will need to establish a new relationship or role with each participant, one that places me in the role of the learner rather than colleague, in order to elicit their unique perspectives rather than a culturally rehearsed response to my questions.

*Cultural Protocols*

Qualitative studies are essentially cultural studies, and must be entered with respect and sensitivity. The researcher is there to learn and gain a phenomenological and emic understanding of the participant's experience and perception (Glesne, 2016).

***Informed Consent Protocol***

Informed consent is a significant part of entry and is crucial for the ethical conduct of research. This study utilizes a two-part informed consent process. The initial informed consent provides participants with an overview of the research study, what is being asked of them, the risks and benefits of participation, their rights, and limits of confidentiality. I will explain my role as a researcher and remind participants that they may withdraw from the study at any time without being required to reveal the cause of their withdrawal and without concerns of negative consequences.

The participants also will be notified that all conversations will be taped and any data collected will be secured and remain confidential to protect their privacy. As previously stated, audio files will be saved in a password-protected file on a secure storage device and stored in a locked filing cabinet. The transcriptionist will only have access to the sanitized data when completing transcription duties.

The final consent and release of information protocol allows each participant to check the researcher's work and to add, redact, or modify anything that they believe is too sensitive, poses a risk to them, or does not capture their story with accuracy. The participants will be asked to review transcripts, analyses, and write-ups of their personal narratives, including any quotes used to illustrate various themes that emerged during the interviews. The informed consent is a two-part process because in the beginning the participant does not yet know what they will share and has not had the opportunity to review how their experiences and interpretations will be portrayed. The final informed consent also reviews the nature and intent of the study, participant rights, and provides the participant with the opportunity to acknowledge his or her contribution to the study.

*Immersion*

Immersion involves staying out in the field for a prolonged period of time and collecting data several times. It allows the researcher to differentiate between what is part of the phenomenon and what is a local aberration or artifact of current events. It also deepens entry and allows for the gathering and testing of more data, which strengthens the integrity, validity, and reliability of the data (Rossman & Rallis, 2017).

**Constant Comparative Method**

The constant comparison method is a method for analyzing data in order to generate a theory. Constant comparative analysis involves simultaneous data collection and analysis, and is used in qualitative research because it allows the researcher to address the unexpected in the field, or to modify data-gathering strategies as needed. This allows the researcher to stay near to the participant's experience.

*Security of Data*

To protect participant confidentiality, all data gathered, including audio recordings and transcripts, will be locked in a file box in a locked office to which only the researcher can access. Electronic documents will be encrypted or password protected and saved on a secure data storage device that will be locked in a file box when not in use; materials will be redacted to remove personal or identifiable data (e.g., names) in order to maintain confidentiality and minimize any risk to participants.

The transcriptionist, my research advisor (who will be serving as my primary peer debriefer and peer examiner), and my research committee member will only have access to these materials when performing their duties related to the research study. They will also protect these documents while in their possession by utilizing the same double-lock system. Passwords will be

sent to the transcriptionist and my research advisor in separate encrypted emails in order to access electronic files. Additionally, the research field journal will not contain any identifiable information and will use a pseudonym in place of the participant's name. Overall, the qualitative researcher has the ethical responsibility to protect those being researched, thus maintaining privacy of the participants is crucial.

### *Audiotaping of Interviews*

All interviews will be taped on an audio recording device. Participants may request to speak off-tape at any time and off-tape conversations will not be used for the study. To maintain transparency during the interview, I will explicitly notify the participant when I am turning the audio recording device on and off.

### *Semi-Structured Interviews*

A constant comparative analysis process begins with a semi-structured interview, in which the researcher asks open-ended questions in order to elicit authentic, honest stories. Other questions can cover experience or behavior, opinion or values, feelings, knowledge, sensory, and background or demographics. This approach to interviewing facilitates staying near to the participant's emergent story. Although the researcher may want to ask questions that are linked to the foci of the study, these questions often emerge from the researcher's conceptual framework or theoretical biases. While there may be some overlap in the prevailing themes of the researcher's conceptual frame and the participants' phenomenology, it is important for the researcher to use his or her questions as a starting point, but to remain closer to the participant's openings as the study unfolds. This is done in order to inform pace as well as direction, since the intent of a qualitative inquiry is to uncover previously overlooked aspects of participant's phenomenological experiences rather than to confirm biases in the extant literature.

*Macroanalysis*

During the constant comparative analysis process, the researcher attempts to analyze the emerging data before returning to the field. The researcher may choose to conduct a preliminary macroanalysis of the data prior to returning to the field. Macroanalysis is considered a data management strategy rather than coding per se. It allows the researcher to conduct transcription and microanalysis on a lag while allowing the researcher to return to the field more quickly in order to remain immersed in the phenomenon throughout the data collection and analysis process. The disadvantage of relying on macroanalysis, however, is that the researcher will not have a nuanced understanding of what is emerging in the study, compromising the depth and breadth of the study (Glesne, 2016).

There are two strategies for conducting macroanalysis: coding by document and generating running code. Coding by document takes place immediately upon completing an interview and involves the researcher writing down what he or she believes to be the salient themes emerging in the conversation. The researcher then meets with the debriefer to discuss emergent dimensions and properties, or themes and subthemes, and to brainstorm possible methodological adjustments for the next interview. Running code is a more systematic form of coding by document. It involves listening to an interview tape and jotting down phrases that capture the emerging and changing themes of the interview. The list of codes can then be clustered to gain a provisional sense of what is being uncovered by the participant and to identify areas in which the interviewer could follow up and explore more deeply in the next round (Glesne, 2016).

*Transcription and Auditing*

Following each interview, qualitative researchers generate verbatim transcripts of their focused conversations with participants. The transcriber or auditor will check all transcriptions against the audiotape for accuracy and revise accordingly. For this research study, I will be transcribing all tapes. If a transcriptionist is hired, though, he or she will have access to the tape for the duration of transcription duties. All tapes will be sanitized and the participant's identity will remain confidential.

*Debriefing*

Debriefing includes meeting with a peer debriefer who provides methodological consultation before, during, and after data collections in the field (Glesne, 2016). The researcher meets with the debriefer on a weekly or biweekly basis to discuss his or her emerging observations, conceptualizations, and methodological challenges. The debriefer provides backup for the researcher's own internal reflexive process of questioning inferences, exploring alternative plausible hypotheses, and brainstorming methodological refinements meant to address problems encountered in the field (Shenton, 2004). A peer debriefer functions as a source of catharsis, a researcher's analyst, a methodological consultant, and to help with brainstorming and testing hypotheses about emerging content and processes. Having a peer debriefer is not absolutely necessary, however it can be very helpful and can enhance validity by improving reflexive and methodological rigor by challenging the researcher's biases. Joy Tanji, Ph.D., will be my peer debriefer in this study to assist with my reflexive process and provide methodological consultation.

*Microanalysis*

In micro-level coding, the researcher looks at smaller divisions of the data in order to capture his or her conceptualization of the phenomenon in more detail.

**Phenomenological Reduction.** The first level of coding, or phenomenological reduction, involves deconstruction of text data into smaller meaning units (Moustakas, 1994). During this process, the researcher reviews the transcription and begins to label or name what he or she thinks may be captured in that piece of data.

**Imaginative Variation.** The next level of coding involves clustering of the smaller meaning units into categories; clustering categories into larger categories, and clustering smaller meaning units within categories into subcategories. In phenomenological method, this is referred to as imaginative variation (Moustakas, 1994).

**Process Coding.** Process coding is a specific type of imaginative variation. It involves identification of sequences or cycles characterizing the phenomenon of interest (Strauss & Corbin, 1998). The intent of this process is to capture the central aspects of the phenomenon under study with clarity and specificity; in this process the more literal, identifiable, and idiographic components of the story are often removed. The codes are then translated back into the human story and shared with the participants during member check to ensure that the researcher is capturing each participant's story.

**Synthesis.** Over time, the clusters of categories become higher order categories, and a larger or essential story emerges with greater clarity. Basically, the textural-structural analysis converges toward an understanding of the essence of the phenomenon. This process is referred to as synthesis in phenomenological method (Moustakas, 1994).

*Peer Examination*

After coding takes place, the peer examiner encourages curious elaboration, clarification, and exploration of the coding strategy being employed by the participant-observer. The peer examiner checks the fit between the data units and codes assigned to them. The peer examiner examines the fit between the larger categories and smaller subcategories or meaning units subsumed under the categorical codes. A peer examiner's purpose is to make sure that the coding structure is integrated into a rich and unified sense of the emerging core concept, theme, or meaning of the study. Peer examination enhances the methodological rigor of the study and enhances the internal validity of a study (Glesne, 2016). Joy Tanji, Ph.D., will be my peer examiner and assist in reviewing my transcript analysis.

*Generating the Narrative*

A narrative presentation of qualitative data is essentially the researcher's interpretation of the participant's story, written simultaneously with the data analysis process. The researcher strives to portray the experiences of the participant with emic accuracy, attempting to understand the world of the participant and translate the text of their lives into a meaningful account. The researcher acts as a translator and interpreter, drawing upon his or her own experiences, knowledge, theoretical dispositions, and the collected data to arrive at their understandings of other worlds. The form and substance of the researcher's final write-up is shaped by factors such as the experiential nature of the research process, the context, and projected audience; the goal is to educate and connect with the audiences, while maintaining fidelity to the research respondents and presenting their story with respect and dignity (Glesne, 2016).

*Member Checking*

Member checking is a process of participant inclusion in the research process, in which the participants in the study are asked to review the researcher's work and asked to provide feedback regarding the accuracy of the researcher's portrayal of the participant's experiences of the phenomenon in question. During this review, the participant is given the opportunity to retract, add, or edit his or her contributions to the study and to discuss information he or she feels may be highly sensitive. The participant may also identify information that he or she feels could potentially reveal his or her identity. The most common approach to member checking involves asking the participant to review documents and write-ups, and this can also act as an opportunity for thanking the participant and seeking a final consent for release of information. Member checking is a process that also can help to enhance the internal validity of a study (Glesne, 2016).

## Methods of Verification

Methods of verification serve to enhance the methodological rigor, or trustworthiness, of a qualitative study (Shenton, 2004). The trustworthiness of a study can generally be measured in terms of validity and reliability. Validity in qualitative research is associated with the emic accuracy of the findings; reliability refers to the analytical generalizability of the findings, or the transferability and comparability of the findings to other similar studies (Shenton, 2004).

**Validity**

A qualitative study's validity depends on its credibility and confirmability. If the study is credible, it means that the participants' lived experiences have been captured with as much fidelity as possible; this is also referred to as emic accuracy. In such a study, the findings are congruent with the participants' reality and accurately portray the experiences and ideas of the informants rather than the characteristics and preferences of the researcher (Glesne, 2016).

Validity is accomplished by using methods of verification that support confirmability of the findings, including strategies that manage the researcher's subjectivity in the study (Shenton, 2004). Methods of verification that strengthen the validity of a qualitative study include: entry, relational ethics, role management, epoché, methodological consultation, member checking, and methodological transparency. During my study, I will apply each of these methods of verification to enhance validity.

### *Entry*

In qualitative inquiry, entry is an ongoing process that builds a trusting relationship or rapport between the researcher and participants. It is important to maintain a trusting relationship with participants in order to better understand and accurately capture their experiences and stories. Proper entry enhances participants' authentic sharing of their experiences and in doing so enhances the validity of the data (Glesne, 2016). In this study, I have already established initial rapport with my participants, as they are co-workers and colleagues of mine. During the study, however, I will need to maintain rapport while transitioning roles from co-worker to researcher; I plan to do so by remaining transparent about research methods in order to gain trust as a researcher, and allowing participants to feel comfortable and open in sharing their stories. It will be necessary for me to remind participants of the steps I will take to protect anonymity and confidentiality, and minimize any potential risks involved, especially in regards to their employment.

### *Relational Ethics*

Relational ethics are ethical principles focusing on the balancing of power or relational fairness in the researcher-participant relationship. In qualitative research, critical and covenantal ethical principles are highlighted as they promote shared power and a collaborative process, joint

ownership of research products, and interpretive authority for participants. Critical ethical principles or the ethics of social justice and emphasize the management of power differentials. Covenantal ethical principles are the ethics of caring and fidelity. They emphasize an awareness of the implications of uncovering information in a study and minimizing negative consequences that may incur as a result of participation in a research study. Essentially, critical and covenantal ethical principles emphasize an awareness of the impact that the research is having on the participants (Rossman & Rallis, 2017). Adhering to relational ethical principles enhances validity as it facilitates trust and authenticity in the exchanges between the researcher and participants. When the researcher demonstrates commitment to fidelity and the empowerment of participants, the participants are more likely to trust the researcher and share what is most meaningful to them.

### Role Management

In qualitative inquiry, both oral and written consent are usually obtained prior to entering the field. It is preferred that the researcher explicitly state his or her role, intention, and purpose, and clearly articulate the conceptual framework of the study. Should deception be involved, it is important to consider the potential impact and ethical implications of deceiving participants. Gatekeepers should be involved in role management, as gatekeepers often hold a formal position with authority and may grant or withhold permission (Glesne, 2016; Rossman & Rallis, 2017). In this study, role management will include obtaining fully informed consent and maintaining transparency as a researcher. I will not be using gatekeepers or deception due to my current immersion in the field, and it is important that I be clear about my role as a researcher versus a co-worker and convey that my purpose is to learn from participants and understand their unique experiences apart from my own. The quality and fidelity of the relationship between researcher

and participant determines the quality of the data obtained; thus, by maintaining rapport and fidelity I can enhance the validity of the data I gather.

*Epoché*

Epoché refers to the qualitative researcher's reflexivity process, which includes critical reflection on the ways in which the researcher, participants, setting, and research procedures interact and influence each other (Glesne, 2016). This is important when trying to step into the participant's world and when trying to understand a phenomenon in terms of its own inherent system of meaning. Epoché enhances the validity of a study by increasing the emic accuracy, or quality, of the data.

**Review of Biases.** Qualitative inquiry acknowledges the intersubjectivity of the research, or the fact that the researcher and participants inevitably shape the experiences and perspectives of each other. The review of biases discusses theoretical or professional, methodological, and personal biases of the researcher that may impact the rigor of the study. This includes the acknowledgment of initial biases that the researcher is aware of, a discussion of how these biases may impact the study, and possible solutions that address the minimizing or challenging of these biases (Glesne, 2016). It will be important for me to review biases and examine potential ways in which my own filters are affecting my understanding of the participants' experiences, especially given my own experiences in the field. The review of biases therefore enhances the methodological rigor of a study and enhances validity by helping the researcher to capture the participant's story with emic accuracy.

*Peer Debriefing*

A peer debriefer is a peer who assists the researcher in monitoring methodological rigor and provides ongoing feedback. Peer debriefing offers methodological consultation before,

during, and after data collection, and enhances validity by increasing reflexive and methodological rigor. I will be engaging in regular meetings with my peer debriefer, Joy Tanji, Ph.D., in order to discuss emerging observations, conceptualizations, and methodological challenges. My peer debriefer will help me to challenge my biases, explore alternative plausible hypotheses, and brainstorm methodological refinements to address problems encountered in the field (Shenton, 2004).

### *Peer Examination*

The peer examiner also assists the researcher by supporting curious elaboration, clarification, and exploration of the coding strategy (LeCompte & Preissle, 2003). The peer examiner closely examines the fit between the field data and emerging codes or propositions. Peer examination will help to enhance the rigor of data analysis in my study. It will also enhance validity as it captures and portrays the participant's experiences more authentically by using the language of the participant (Glesne, 2016). Joy Tanji, Ph.D. will assist me as a peer examiner.

### *Member Checking*

A member check allows the participants to verify the accuracy of transcripts and to discuss concerns regarding disclosures they wish to edit, especially in the final narrative write-up. This involvement gives participants the opportunity to own their own stories and participate as co-owners of any research materials. Member checking may also involve checking the accuracy of the emerging data analysis. I plan to utilize member checking in order to enhance validity by allowing participants the opportunity to provide input into the process of data collection and analysis. When participants are able to correct or edit materials this also helps to maintain emic accuracy in the data and provide participants with interpretive authority in the study (Glesne, 2016).

*Methodological Transparency*

Methodological transparency includes the documentation of emergent field methods. The researcher includes an emergent method chapter discussing methodological discoveries, problems encountered in the field and how they were addressed, and the outcome of methodological refinements or changes (Shenton, 2004). The documentation of emergent field methods enhances validity by keeping the researcher honest and aware of various factors impacting methodological rigor. Methodological transparency allows readers to better examine research findings in relation to the reflexive rigor operationalized in the study. By being as transparent as possible, I plan to create an environment in which I can maximize corrective feedback on the accuracy of my methodology and interpretations (Glesne, 2016).

**Reliability**

Reliability in qualitative research refers to its analytical generalizability. To be considered analytically generalizable, a study must be theoretically saturated, so that the results reflect universal themes—not just the idiographic themes of the participants. If a study's thematic findings are transferable, then they are more likely to be meaningful to other participants in other similar contexts (LeCompte & Preissle, 2003). This is assessed by examining the rigor with which the following methods of verification have been applied: entry, relational ethics, role management, epoché, review of biases, purposive sampling (e.g., number and diversity of participants, bounding and delimitations of the study, number of experiences and perspectives gained), consultation with peers, constant comparative method, immersion (e.g., number and length of data collection sessions, amount of time spent in the field collecting data), presentation of the integrated coding list generated during the study, and the dependability or comparability of the methodology used , and methodological transparency (Glesne, 2016).

*Entry*

Substantial rapport with participants usually elicits a more authentic and detailed story and facilitates theoretical saturation, thereby enhancing the reliability of the data. Again, although I am already immersed in the participants' environment, it will be necessary for me to maintain rapport with my participants as I step into the role of the researcher.

*Relational Ethics*

As previously stated, relational ethics in qualitative research include adhering to critical and covenantal ethical principles, which focus on relational fairness and balancing power in the relationship between the researcher and participants. Relational ethics enhances reliability by increasing the sense of safety and fidelity in a study; this enhances analytical generalizability by supporting the sharing of thick, rich, and authentic disclosures by participants (Rossman & Rallis, 2017). In this study it will be important that I adhere to relational ethics, especially when discussing possibly distressing and sensitive topics with participants, and also considering that I have prior professional relationships with my participants.

*Role Management*

As discussed previously, role management in this study will include obtaining fully informed consent and maintaining transparency about research methods, my purpose and intentions, and my role as a researcher. Role management contributes to the overall sense of safety, authenticity, and fidelity conveyed to participants; as a result, role management enhances theoretical saturation by encouraging participants to share their stories openly and in detail (Glesne, 2016; Rossman & Rallis, 2017). I plan to utilize appropriate role management practices in order to enhance the reliability of the data I am gathering, and to minimize any potential risk or harm to participants.

*Epoché*

Epoché or reflexive appraisal by the researcher allows the researcher to better capture the nuances of the phenomenon being studied and contributes to methodological transparency. Methodological transparency increases methodological rigor and helps in the replications of studies (LeCompte & Preissle, 2003; Shenton, 2004). Therefore, epoché can enhance reliability in this study by helping to achieve theoretical saturation.

**Review of Biases.** The review of biases is another strategy used to enhance reliability. The review of biases discusses theoretical or professional, methodological, and personal biases of the researcher that may impact the rigor of the study (Glesne, 2016). Throughout this study I will continuously review my personal, professional, methodological, and theoretical biases in order to maintain awareness of how my own filters influence entry and access to greater immersion and understanding of the phenomenon.

*Purposive Sampling*

Purposive sampling is a technique often used in qualitative research, as it allows for the selection of information-rich cases for an in-depth study of a phenomenon. This involves identifying and selecting individuals who are especially knowledgeable or experienced with the phenomenon being studied. My study will include participants who work with patients in crisis in various settings (e.g., crisis line, crisis mobile outreach, crisis case management), and have been working their jobs for over ten years. Purposive sampling strengthens the reliability of the data, as it enhances analytical generalizability through the strategic selection of participants with thick, rich, and varied experiences (Glesne, 2016).

*Peer Debriefing*

Peer debriefing also enhances the analytical generalizability of the study by adding methodological rigor to the constant comparative analysis process. As data is collected and analyzed, the peer debriefer explores the impact of emerging biases on the researcher's understanding of the data, then challenges the researcher to examine the data with a different lens. This process enhances reliability, as it broadens and deepens data collection and ultimately leads to saturation of the study's findings (Shenton, 2004).

*Peer Examination*

Peer examination also enhances reliability in a study by increasing the rigor of the constant comparative analysis process and therefore increasing the analytical generalizability of the data. My peer examiner will help me to broaden and deepen my coding structure and my understanding of the phenomenon in subsequent rounds.

*Member Checking*

Member checking gives participants the opportunity to provide input and verify accuracy of transcripts and research materials. I plan to utilize member checking to enhance the reliability of my study. Member checking enhances analytical generalizability by challenging the researcher to stay very close to the language of participants; this allows the researcher to better analyze subtle nuances in participants' lived experiences (Shenton, 2004).

*Constant Comparative Analysis*

Constant comparative analysis involves repeated cycles of data collection and analysis, allowing the researcher to test emerging hypotheses and refine overall accuracy of emic portrayal over time. Constant comparative analysis enhances reliability as it deepens the data and strengthens analytical generalizability (Strauss & Corbin, 1998). I plan to utilize this form of

analysis in order to gain a more comprehensive understanding of the crisis worker's experience and form hypotheses about the phenomenology of crises.

### *Immersion*

Immersion enhances reliability, as it contributes to the robustness of the findings; the more time spent in the field, the more the researcher can learn about the phenomenon from multiple vantage points and achieve theoretical saturation. As the researcher interacts with participants over an extended period of time, the researcher gains access to increasing depth, breadth, and detail with respect to participants' experiences (Rossman & Rallis, 2017).

### *Methodological Transparency*

The documentation of emergent field methods can also enhance the reliability of this study by increasing the generalizability of the data. Methodological transparency will help me to maintain presence and attention to the details of the emergent methodology and findings. Documentation of emergent field methods increases the reflexive rigor of the constant comparison analysis process and helps the researcher reach saturation in the codes or dimensions and properties of the phenomenon emerging in the field data (Shenton, 2004).

### Utility

In qualitative research, utility helps assess the rigor of studies in keeping with covenantal ethics. Utility assesses whether a study enhances or refines our current knowledge or understanding of the phenomenon being researched, whether the findings address the statement of the problem, and whether the results are readily utilizable. One criterion for assessing utility is fairness; a study with this utility provides a balanced presentation of the multiple realities in a situation and reveals the complexity and multiple perspectives held by each participant. Another criterion is ontological authenticity, or a more sophisticated understanding of the phenomenon

being studied that uncovers a new conceptualization or way of understanding the phenomenon.

Utility may also be assessed by examining the educative authenticity of the findings, by

considering whether the study enhances understanding of the phenomenon and provides a new

appreciation of current understandings. Utility may further be assessed by examining the

catalytic authenticity of the study, by considering whether the study's findings have the capacity

to support new courses of action and presents findings in a way that can be readily used in an

applied setting to intervene in constructive ways. Lastly, tactical authenticity offers potential

benefits to all concerned (LeCompte & Preissle, 1993).

This study seeks a better understanding of the experiences of a crisis worker by

comparing the breadth of different experiences of crises. My goal is to deepen current

understandings of suicide, provide insight and application to underrepresented populations, and

to add to suicide knowledge and theory. In this way, my study aims to have utility of ontological

authenticity and educative authenticity. It also will hopefully offer potential benefits for the

mental health treatment of those in crises and loved ones of those experiencing crises, as well as

benefit those who provide crisis intervention.

# CHAPTER III. EMERGENT FIELD METHODS

[The following chapter describes and discusses how the method proposed in Chapter II was refined in order to better support staying closer to the participants' emic stories as they unfolded.]

## Pre-Entry

### Gatekeepers

Gatekeepers facilitate entry into the site and provide the researcher access to potential participants. In this study, working with gatekeepers was not necessary due to my current immersion in the field as a crisis mobile outreach worker. Having worked in the field for four years, I knew of the participants and had heard about their work from other colleagues and clients. I was aware that these three participants had been in their positions longest amongst their colleagues, and this initially put them on my radar. As I interviewed the crisis mobile outreach worker for my initial methodological pilot study, I asked her if she had any suggestions for a crisis line screener and a crisis case manager to interview. She mentioned the names of the other two participants that I had been considering, which further solidified my desire to interview them.

### Role Management

Prior to entering the field, I recognized that it would be challenging to manage my roles as both a researcher and a colleague. Being the learner rather than an expert or colleague was something that I had to be very intentional about. Prior to conducting interviews, I addressed role management concerns with my peer debriefer, who helped me to prepare for interviews and formulate a list of questions that would help to elicit unique perspectives rather than culturally rehearsed responses.

**Cultural Protocols**

Cultural protocols were not too concerning for me during pre-entry, for I was already accustomed to the cultural patterns and social norms in the field of crisis intervention. However, I was aware of the fact that speaking the lingo and adhering to cultural protocols could bring me closer to the crisis worker role and away from my primary role as a researcher. It was helpful for me to prepare for interviews by discussing role management with my peer debriefer, as cultural protocols were understood and adhered to in my role as a crisis worker.

**Review of Biases**

An important part of qualitative research involves reviewing biases that the researcher may have, which could negatively impact or compromise the rigor of a study. A lack of awareness of one's biases could greatly affect research outcomes and even be damaging to participants. This section discusses how theoretical, methodological, and personal biases may have impacted the study, and how these biases were addressed.

*Theoretical Biases*

I tend to align with the person-centered theoretical orientation. This orientation values the inner wisdom of the client and uses a nondirective exploration of the client's story. My concern was that my tendency to be nondirective would make it more difficult for me to access the information I was seeking and prevent me from having an objective view of my participants' experiences. This was not a challenge that came up for me, though, and I found that nondirectiveness actually allowed me to gather more information in a way that felt closer to the participants' experiences.

I also anticipated the possibility that I would go into the interview focusing on present rather than past experiences and listening as a person-centered therapist would for conditions of

worth. Having some interview questions that were more reflective and historical helped me to hear more of the entirety of my participants' stories. I also managed theoretical biases by engaging in peer debriefing before and after interviews to discuss biases, countertransference, and other difficulties that arose during the interview.

### *Methodological Biases*

Due to having more training in quantitative methodology, I was aware of the possibility that I would have a tendency to try to gather information that supports my hypotheses, or listen for patterns that are more common or familiar to me. I noticed during one of the interviews that I began listening for information that fit into one of the emerging themes that I had observed with a different participant. In order to manage this bias I made sure to stick to my list of questions and continue asking open-ended follow-up questions. Debriefing before and after interviews was also helpful in reviewing methodological biases. My peer debriefer also assisted me with generating additional open-ended follow-up questions.

### *Personal Biases*

Personal biases were more challenging for me to manage due to my own experiences as a crisis worker. As a result, I had to be very intentional about putting my researcher role first when going into my interviews. Peer debriefing both before and after interviews was critical to address these biases, and I found that it helped me remain closer to the observer role. Additionally, discussing personal biases with my peer examiner helped me to limit my assumptions when analyzing and coding the data.

## Entry

### Gatekeepers

Due to my preexisting immersion in the field, gatekeepers were not utilized in this study.

**Role Management**

Throughout the interview process with my participants, there were two roles that I had to navigate: researcher and colleague. I approached the interviews and listened to participants' stories as a researcher, however I was also very aware of the fact that I was a colleague or former colleague to all the participants. I used my own experiences as a crisis worker to inform the questions that I asked, however it was difficult not to listen as a crisis worker as well. For example, I found myself feeling pulled to certain stories and had to ask myself whether my curiosity was based on the research questions that I had, or whether it was due to my own past experiences in crisis work and my ability to relate to their stories.

There were several times throughout the interviews when the participants noted that I likely had similar experiences, or used some clinical jargon that we often use in our work. These were moments when I had difficulty remaining in the researcher role. It was helpful to have participants define seemingly simple terms in order to avoid making assumptions about their experiences. At the same time, I believe that my role as a fellow crisis worker was advantageous because the participants felt comfortable sharing stories with someone who could relate to their experiences; this allowed me to gather rich data. Role management issues were addressed during my peer debriefings. I met weekly with my peer debriefer throughout the interview process in order to organize my thoughts, discuss emerging data, share my reactions to participants' stories, and examine biases influencing my research.

I had anticipated that maintaining my role as a researcher would be a significant challenge, especially since the researcher role is less familiar to me. In reflection, though, this did not prove to be as great a challenge as I had anticipated. This is likely because of the ways in

which the participants shared their stories; there was so much resilience, wisdom, and hope that I did not feel inclined to step into the helping role of the therapist.

**Cultural Protocols**

Due to my immersion in the field as a crisis worker, it was easier to recognize and navigate cultural protocols. One of the cultural patterns that emerged as anticipated was the use of dark humor and sarcasm. In crisis work, this type of humor is often used as a way of relieving stress, affiliating with colleagues, and demonstrating resilience. There were some moments when this type of humor was utilized by participants and my response as a crisis worker helped to maintain the flow of the interview; however, I was also intentional about limiting the use of this humor on my end in order to stay closer to my role of the researcher.

The use of clinical jargon was another cultural protocol that I encountered. As a researcher, I asked participants to define these terms so that I would not make assumptions about meaning. Again, weekly peer debriefing was helpful in managing any issues related to cultural protocols.

**Informed Consent Protocol**

Prior to conducting interviews, I had a telephone conversation with each participant about the research study, what was being asked of them, the risks and benefits of participation, their rights, and limits of confidentiality. I explained my role as a researcher and informed them that they would be able to withdraw from the study at any time without any concerns of negative consequences. I provided each participant with a community resource list that provided mental health resources in the event that they would need additional support. I also had each participant complete an emergency contact form for safety reasons. The participants were notified that all conversations would be taped and that any data collected would be secured and remain

confidential to protect their privacy. Each participant was given the opportunity to review the initial informed consent prior to meeting face-to-face and express any questions or concerns about the study.

The final consent and release of information was provided following member checks to allow participants to review any materials before making a final informed decision about releasing the information they had shared with me. I provided participants with my written narratives for approval and allowed them to add, redact, or modify anything they believed was too sensitive, posed a risk to them, or did not capture their story with accuracy. Each participant elected to use a pseudonym to protect confidentiality and anonymity. The final informed consent also reviewed the nature and intent of the study, as well as their rights as participant. Each participant expressed interest in the research topic and signed the informed consents.

## Immersion

Immersion involves staying out in the field for a prolonged period of time and collecting data several times. I was immersed in the field over the course of approximately six months. During this time, I was able to meet with each participant at least two times to gather information. This helped to strengthen the integrity, validity, and reliability of the data.

## Constant Comparative Method

### Interview Process

Initially, my intent was initially to interview each participant in person, however these plans were changed as a result of the COVID-19 pandemic. Due to the state-wide lockdown that took place, I unfortunately was not able to physically meet with every participant. My first interview with "Taylor" took place in November 2018 as part of a class assigned methodological pilot study designed to test my proposed field method. We met at a location of her choosing that

was private and secure. After she agreed to participate in this qualitative inquiry, Taylor was given the opportunity to review and edit her transcript from the first interview, and she approved the transcript to be used for this research study. Taylor's second interview took place over the phone due to the lockdown restrictions. I was able to meet with "John" for both interviews face-to-face at his office. Both of my interviews with "Aka" took place over the phone due to the lockdown restrictions.

Although I was not able to consistently meet with all participants in person, each semi-structured interview was thorough and lasted between one to two hours long. After each interview, I allowed for at least two weeks to review the audio recordings, transcribe, meet with my debriefer, and brainstorm follow-up questions. Meeting with my debriefer and reviewing the transcriptions were especially helpful between interviews.

Throughout the interview process, all participants appeared to appreciate the opportunity to reflect on their experiences as crisis workers. I had conversations with each participant both before and after the interviews to catch up or to get to know each other better, however these conversations were off the record. Although these conversations could not be used for data collection, they gave me a better understanding of each participant and their story, which I feel was helpful in writing their narratives. There were also a couple of incidents in which two of the participants had to pause to take the call. I turned off the recording to allow them privacy and because I often wanted to ask a clarifying question that was more appropriate off the record for privacy reasons.

**Peer Debriefing**

Peer debriefing occurred before and after each interview during my weekly meetings with my debriefer. These meetings were extremely helpful in discussing emerging observations and

themes, conceptualizations, and my own thoughts and reactions. My debriefer assisted me with my reflexive process. Together we explored plausible hypotheses, generated follow-up questions, and checked my biases. I found that these meetings helped me to go into each interview with more focus, confidence, and openness.

**Coding Process**

The coding process began informally with macroanalysis. Following each interview, I conducted coding by document and generating running code. I began with coding by document. After each interview, I wrote down general themes that I observed in the conversation. I then met with my debriefer to discuss themes and subthemes, and to brainstorm follow-up questions for the next interview. I also generated a running code by listening to the audio recordings and jotting down phrases that captured the emerging themes of the interview. I clustered these codes in order to getting a more detailed sense of what was being uncovered by the participant and to identify areas for follow-up before re-entering the field.

Following macroanalysis, I transcribed the audio recordings and audited the transcripts. Next, I conducted microanalysis by examining each participant's interviews and identifying axial and subaxial codes. I used low-inference coding with each participant's language, as it helped me to better portray the emic experiences of each participant. I organized the codes into a coding outline for each participant, and grouped the codes under emergent themes. This made it easier for me to process the coding for each participant as well as to compare the themes between participants. I also identified exemplar quotes that illustrated the axial and subaxial codes.

**Peer Examination**

I reviewed my axial and subaxial codes with my peer examiner, who helped me to challenge biases and adjust codes that did not seem to fully capture participants' experiences. We

then reviewed the coding outlines and discussed general themes for each participant, as well as similarities and differences between participants. My peer examiner's help was invaluable, as it assisted me in better understanding emergent themes and preparing for the narratives.

**Generating Narratives**

Prior to generating the narratives, I reviewed the coding outlines with my peer debriefer and discussed themes again in order to prepare me for writing the participants' stories. I wrote one narrative at a time, in the order in which I interviewed participants. Writing chronologically in this way helped me stylistically write as a storyteller who encountered and spent time with each participant along my research journey. Because of the immense respect and admiration I have for the participants, it was important to me that their stories come alive in my writing.

**Member Check**

During member check, I presented each participant with his or her final narrative to review. I gave them the opportunity to edit, remove, or add to the narrative. I also asked for feedback about the accuracy of my portrayal of their stories. Member checks were conducted by phone and email. All participants approved the narratives and indicated that it was close to their experiences. John and Taylor decided no edits were necessary, and Aka offered suggestions to make the narrative clearer.

Member checking also provided an opportunity to discuss some of the emergent themes with participants, and these discussions helped to deepen my understanding of their experiences. Because of the ongoing global crises throughout the duration of my study, we also discussed any changes that they had observed with clients or their jobs since our interviews. My conversations with John and Aka led to additional information that I incorporated into their narratives and into the discussion of data. Finally, I thanked the participants for their time and dedication to this

study. Each participant stated that they were happy to help and that they found it to be an interesting process. They also noted that they hoped their stories and this study would be helpful to others in the future. After approving the final narratives, all participants signed the final consent and release of information form.

# CHAPTER IV. FINDINGS

The objective of this study was to explore the experiences of crisis from the perspective of a crisis intervention team, including a crisis mobile outreach therapist, a crisis line screener, and a crisis case manager. Exploring the experiences of those who support people in mental health crises can help us better understand crises, factors that optimize helping capacity, and ways of supporting crisis workers. Additionally, it can help to improve crisis intervention and clinical practice. The results are presented in a narrative format to capture the unique experiences and stories of each participant. The participants are referred to by the pseudonyms they requested during our initial meeting.

## Taylor: Passion for Service

I met with Taylor over the course of two interviews in order to better understand her experiences as a crisis mobile outreach worker. My intention was to listen to her story as a researcher first, and allow my own crisis mobile outreach experience to help inform the initial questions that I asked.

### The Journey Begins

I was struck by the genuine love Taylor had for her job, even after over 14 years in her position, and also by how unexpectedly fitting the job was for her. Taylor's openness to varied life experiences led her Hawaiʻi, where she had initially hoped to work in the hotel industry doing event planning.

After some difficulty finding a job in this area, she ended up working for an organization that helped adults with mental disabilities find and maintain housing. Taylor discovered that she enjoyed working with this population, and this led her to the mental health field. Although Taylor had no formal mental health or counseling background, her passion for service,

adventure, and connection allowed her to thrive as a crisis worker. Taylor shared that she had never anticipated working in crisis intervention, however she had a natural propensity for counseling and helping others, as well as a curiosity about crises that kept her engaged in her work.

> I've always kind of, from a young age, been kind of interested in [counseling]—and why it is that people go to that extreme—why would somebody want to end their life? Because there's no re-do, there's no take-backs when it comes to actually killing yourself. And so I think from a very young age that I've always just been interested in that and trying to help people and it's just kind of carried on, and so I found like the perfect job.

**Experiences as a Crisis Worker**

*The Phenomenology of Crises*

Taylor described a *crisis* as an emotional state in which an individual is feeling overwhelmed and unable to tolerate the pain experienced with their resources available. She asserted that crises were defined by the individual's experience, thus what might be a crisis for one person might not be a crisis for another. Taylor shared that she has seen a wide variety of crises over the years, with the most common crises being suicidal, homicidal, relational, and addiction crises. She observed that a crisis appears to be a universal experience that most humans go through at some point in their lives.

> A crisis could be pretty much anything that the person's experiencing that's getting them out of sorts. I mean it could be anything from a break up to an animal dying, to thoughts of suicide, to thoughts of homicide. It could be any of those types of things, I mean really, it's what the person's feeling.

**Suicidal Crises.** Taylor noted that a crisis may lead to suicidality or self-harm when a person tries to escape the overwhelming pain they are experiencing. Taylor shared about her experiences working with youth in crisis, and the prevalence of self-harm. She explained that it is difficult for youth to have foresight and to grasp the severity and consequences of self-harm

and suicide. Youth have not experienced and coped with the many ups and downs of life, thus a

crisis can feel especially overwhelming for a young person. Taylor explained that experiencing

these ups and downs creates resilience and confidence in one's ability to cope with a crisis.

> I can see [youth] doing something that could cause a lot more harm and it's just because they don't have that kind of—they haven't been around long enough, is pretty much what it comes down to. Twelve, thirteen, fourteen years is such a short amount of time and everything affects them so strongly, so it's like if something bad happens their whole world is crumbling down. Whereas when you're an adult you could have ten things happening that are bad and you still know there's a tomorrow, there's a future.

**Homicidal Crises.** When asked about homicide in relation to suicide and crises, Taylor

stated that she does not often deal with homicidal cases. In her experience, a person who is

having thoughts of suicide appears more likely to reach out for help than a person having

thoughts of homicide. Additionally, a person who calls with thoughts of homicide usually is

homicidal toward a specific person, thus this type of client is usually not a high-risk client to her.

Taylor shared with me several experiences in which she outreached clients in crisis who ended

up turning on her. Although she did not directly verbalize her conceptualization of homicide, her

stories are a good example of how the emotional pain experienced during a crisis can be both

internalized (e.g., self-harm and suicide) and externalized (e.g., aggression and homicide).

> And I went in there and this guy—he was telling me that he wanted to kill himself, he wasn't necessarily homicidal, and then he became homicidal toward me, and he ended up having a bunch of knives. . . . And so then he just changes, and he's like, "Yeah you know I think your time's up. I think you need to die." And he totally became homicidal toward me.

**Relational Crises.** Taylor shared that another common type of crisis occurs when a

relationship has been severed or when a person experiences loss or grief in a social context. She

noted that she often sees clients in crisis who are going through a breakup, just lost a loved one

or a pet, or are feeling socially isolated. Taylor noted that many of the clients she sees do not

have social supports in their lives, and this can amplify the feeling of isolation and loneliness that

a person is experiencing in a relational crisis.

> So it can be anything from, say, people are getting into arguments . . . or somebody could feel bullied . . . or like I said before, you could even use things like if somebody has an animal that passes away, or a loved one.

**Addiction Crises.** Taylor also described providing outreach to clients who are

experiencing a crisis in the midst of their addiction. A person who is experiencing addiction

often feels powerless to their disease; the reduction in self-efficacy combined with the

amplification of emotions due to intoxication can escalate the state of crisis. Taylor noted that for

individuals with drug or alcohol addictions, it is often the crisis that will motivate them to seek

treatment.

> The substance abuse stuff really heightens the way people feel and unfortunately when they come to us they're feeling worse, and that's when [they have] more of the thoughts of wanting to hurt themselves or other people, like family members or people they feel have done them wrong.

*Precipitating Factors*

Taylor shared that in her experience, clients reach out for help when the pain they are

experiencing becomes too overwhelming to cope with on their own. She explained that a crisis

can develop as a result of a stressful incident, or because of an emotional state that is

overwhelming. Essentially, a crisis develops when the experience of stress outweighs the

individual's ability to cope.

> Okay, so a crisis to me, you know when I first started this job I always thought a crisis meant it was like suicidal or homicidal, but I think a crisis can start from anything that can lead up to that, or even just people feeling overwhelmed, stressed out, depressed, having anxiety, whatever it is. . . . Anyone who's asking for help or needing help on something, I consider that now a crisis, because they're now needing that extra support in their life.

*Helping Clients in Crisis*

**Therapeutic Presence.** When I asked Taylor what appears to be most helpful to clients in crisis, she noted how the simple act of being present with and listening to a client is very meaningful. Being fully present and giving your focused attention conveys commitment, compassion, empathy, and support; it gives hope, as the person no longer feels alone in their suffering.

Taylor shared with me a story of an outreach she provided to a woman with a terminal illness. It was challenging to instill hope and strengthen the woman's desire to keep living in this situation. Taylor offered the client therapeutic support, and it was her genuine interest and care for the client that led the client to gain trust in her and to accept resources for future help. Taylor indicated that she unconditionally supports people in their crises and does not place judgment on their experiences, no matter how big or small the crisis may seem.

> I think just knowing that there's someone there that they can talk with. I think that's what the majority of people need . . . just having someone to spend time with and be there and listen, I really feel like this helps a lot of people. I feel like that's all they need. I mean every case is different—people need more than that sometimes. But I would say probably 60% of the time people just want someone to listen to them.

**Safety.** Ensuring safety is the priority for a crisis mobile outreach worker. Taylor shared that she does so by doing a safety assessment, taking a client to the emergency room or calling emergency services if the person is at high risk, and safety planning so that the person feels more confident in their ability to use internal resources (e.g., coping strategies) and reach out for help should they feel unsafe in the future.

Taylor stated that talking about suicide directly is not uncomfortable for her, and it makes it easier for clients to open up.

And I think . . . the biggest thing when we're going into schools, I think a lot of times the counselors or the teachers, or whoever it is, are very uncomfortable talking about [suicide]. And so when I come in, and you can see, say it's the kid, and they're kind of looking at you like can I talk to this girl about that and I flat out tell them, we can talk about anything. It's not hard for me because this is what I do. I think that kind of can get them to open up a little bit more too.

Taylor explained that her job is to stabilize a client, ensure the safety of the client and the community, give hope for the future, and provide resources. She noted that the crisis will not necessarily be over by the time she closes the case, however usually the client will have more future-oriented thinking and self-efficacy by the time she leaves. Having a sense of hope and confidence in one's ability to cope with a crisis are important mitigating factors for suicide.

**Crisis Intervention.** Taylor described her process of crisis intervention, which involves hearing the client's story, listening for what the client really needs, understanding and clarifying the problem, reframing the problem, assessing for current resources available, and providing resources. Throughout this process, Taylor is continuously assessing for safety and lethality.

***Sequencing the Narrative.*** Taylor shared that crisis intervention begins with hearing the client's story. As she listens to the client's story, she sequences events and puts the story together in order to gain a better understanding of the client and how they view their crisis.

When I get there what I normally do is let the client vent or just kind of talk or ramble or however you want to say it when I first get there, because then at least I'm kind of identifying some of the issues they're dealing with right now, and so I'll get there and I'll introduce myself and tell them what I'm there to do and our services and then I just kind of let them go.

***Listening for Poignancy.*** As the client shares their story, Taylor listens for poignancy, or the heart of the matter, in order to figure out what is driving the crisis. She observes the emotional state that the client is in and listens for what is most distressing. As the client

expresses difficult emotions and feels heard and understood by Taylor, the client begins to

deescalate as well.

> [I tell them] why don't you tell me more about yourself and what's happening. . . . They
> can kind of go on and on and on, and I'm collecting so much information at that point,
> and then I'm kind of trying to identify from what they're telling me, what's going on with
> them.

*Clarifying and Reframing the Problem.* After the client shares their story, Taylor helps

the client to identify the most significant or poignant aspect of the problem and reframes the

problem in a way that is solvable. Usually at this point, the client is calmer and able to see and

explain their situation more clearly. Taylor described the process of helping clients identify three

salient problems areas that she is able to assist with. Problem clarification and reframing helps

the client to feel less overwhelmed and stuck in their crisis. At this point, thoughts of suicide are

often softened, as suicide becomes less necessary when the problem seems solvable and less

debilitating.

*Assessing for Resources Available.* After the problems are illuminated and reframed,

Taylor engages the client in a discussion about current resources available. This usually involves

safety planning and talking about potential triggers or stressors, coping strategies, sources of

support, and emergency contacts. This process helps clients reconnect with their own internal

resources. Taylor shared that in her experiences working with clients in crisis over the years, she

had noticed that crises often lead people to find new strategies for coping with stressors, as well

as prompt individuals to reach out for help and resources. Discussing current resources is an

important part of crisis intervention, as it empowers clients to make positive choices for

themselves.

> It could be anything, like I said, like the coping skills, the safety planning, coming up
> with—not me telling them what they need to do but working on it together. It's very easy

to lead someone into conversation like that . . . but then have them come up with the actual plan of what they can do and putting it back on them.

***Providing Resources and Referrals.*** Finally, Taylor provides the client with resources and referrals in order to give the client more options for assistance and follow-up. At this point, she often will refer a client to a temporary crisis case manager who can then follow up with the client for 30 days. Taylor shared that her role as a crisis mobile outreach worker is to essentially help people reconnect with their internal resources, connect with community resources, and find effective ways of coping with their crisis.

> I mean who's never had thoughts of dying? Nobody can say they haven't. I mean that's impossible. Everybody's had that thought at some point. But they've also learned how to deal with it, cause they're still here. So they figured out something that works and that's what I'm here to hopefully do to other people, to help them figure out what it is that works for them.

### Mediating Factors

Taylor described several mediating variables that often affect the experience and outcome of a crisis. She observed that impulsivity and psychosis can increase risk of harm. Additionally, substance abuse is a risk factor for crises, suicidality, and homicidality, as it can amplify the emotional experience of a crisis and increase impulsivity. Taylor noted that a lack of social support or difficulty utilizing existing supports is one of the biggest risk factors for suicide.

> A lot of times people don't have someone. Especially with us, working with a lot of mental health [clients], they've already burned bridges with family and friends and they just don't have those people there because those people that were or are supposed to be important in their life, they've had it. They've given up on them or they just need a break from the people that we call our clients. . . . even if they have their friends, or if they're homeless, they might be in a homeless camp with other people, but they don't want to hear other peoples' problems—they've got their own stuff going on.

**Longevity and Job Resilience**

*Emotional Contagion and Letting Go*

When I asked Taylor about how she remains calm and grounded when working with clients experiencing crises, she stated that it is part of professionalism to her. Taylor explained that she is aware of how her own internal processes have the potential to affect clients, thus she focuses on the task at hand and mindfully leaves her own stresses "at the car."

> You know I think when I go out to my outreaches, no matter what it is that I'm going through, whether it's feeling happy or oh gosh I've had a hard day or being tired, any of the things that I'm feeling . . . I really have to reign that in . . . otherwise I'm just going to end up projecting what I'm feeling onto the client.

**Stay Present.** Taylor stated that she strives to be present and to be what each client needs. In this process, it appears that her focus on the client helps her to maintain her own emotional stability.

> And when I come in I just gotta give them the time that they need, I have to put my own stuff away. Cause this is not only my job, but I also need to be what that person needs. And that is someone to communicate with. . . . I'm focused 100% just on what's going on right now.

**Stay Task-Oriented.** Taylor is task-oriented during outreaches; she creates structure for both herself and clients and focuses on meeting goals. This strategy appears to ground her, even in a potentially intense situation. Focusing on something concrete helps not only to create emotional distance for Taylor, but also gives the client a sense of self-efficacy.

> I go in and I have my little spiel and I let them have their thing and then we kind of start into the assessment. And so yes, I totally feel like I have a structure when I'm going out to do my assessment.

**Do Your Best.** Taylor explained that when she is with a client, she does her absolute best to help the individual in that moment, and this makes it easier for her to let go of a case when it is done. She expressed understanding that there is only so much she can do, and as long as she

does whatever is in her power to do, there is no unfinished business. Taylor expressed that there are times when cases are more difficult for her to let go, for example when working with youth in crisis who are experiencing trauma or tragic events, however it is her approach to crisis work that prevents her from carrying the weight of challenging outreaches.

> I come in and do the best I can and then it's over. It's over for me. Just go on. Keep going on. I think that's where a lot of people have that hard time letting it go. And like I said, with the adults I've learned to just come in and do it and I have to be done, and I've learned, I've done my absolute best and now this case is over for me, I can't keep holding onto it.

**Characteristics of a Crisis Worker**

As I interviewed Taylor, it became clear to me that her job was an excellent fit for her personality, values, and mindset.

*Passion for Helping Others*

Taylor shared with me that she loves her job because of the fulfillment and meaning she finds in helping others and instilling hope in the midst of a crisis. Providing therapeutic support and building trust with clients are strengths of hers, and with a job dependent so heavily on the ability to quickly establish rapport and trust, Taylor excels in this position.

> I've always loved what I do. People would ask me and they're just like, "That's crazy that's what you do," and I'm just like, "But you don't get it, I love my job." I get to go in there and help someone who's not feeling at their best, and I get to make sure that they're safe, and sometimes all people need is someone to talk to and that makes them feel better and then that makes me feel awesome—that I've come in there and I'm helping someone.

*Thriving in the Crisis*

In addition to her genuine passion for helping others, Taylor also enjoys the unpredictability and variability that comes with crisis work. Every day is something new, and every case is different and unique. Taylor said she still feels excitement when she takes a call. As

someone who enjoys getting outside, being on the go, and meeting new people, being a crisis

mobile outreach worker was fitting, and Taylor thrived in her work.

> Every time that I go out it's never going to be the same thing. Ever—every case is different and unique. And that's what I love. I love—I don't want to say not knowing what I'm getting myself into—but kind of. I get this little blurb from Crisis Line that's a two-minute description of what I'm going out for and where I'm going. And then I get there and I get to figure out the rest myself, which—I absolutely love that.

### *Self-Care*

Taylor expressed that self-care is a critical part of her professional and personal life. She

has an active, well-established self-care routine, and this helps her to be more present when she

is with clients. Taylor stated that she enjoys recreational activities, traveling, and spending time

with her family. As much as she loves her job, she takes vacations when she can and enjoys her

time away from work. Taylor noted that she has tremendous support from her tight-knit family

and also doesn't hesitate to seek support from her supervisors at work when needed.

### Reflection

### *Changes in Perception and Growth*

Taylor shared with me that her perception of a crisis has developed and changed over

time. Her reference point for a crisis used to be thoughts of suicide and homicide, however after

encountering thousands of people in crisis, Taylor noted that she now has a broader definition for

crisis and understands that it is determined by an individual's perception and experience of pain.

Taylor indicated that she goes into the outreach with an open mind and does not place judgment

on a person's experiences.

> Where now, crises I'm realizing can be anything. Anything that can make the person feel upset, stressed out, overwhelmed, depressed, emotional. A crisis can literally be anything, and we're not the one that gets to say this is a crisis or this is not a crisis, that is up to the person and what they're feeling and what they're reaching out and needing help for.

*Challenges as a Crisis Worker*

Being a crisis mobile outreach worker involves challenges that many first responders face. Taylor shared that it is a high burnout job due to the intensity of the work, long hours, and safety concerns. She noted that the long, irregular hours can make it difficult for her to maintain self-care. Taylor indicated that safety is one of the biggest challenges, and can get in the way of being able to do her job. She shared about experiences in which clients became aggressive toward her; as a result of these experiences, Taylor prioritizes her safety, always knows her exit, and asserts firmer boundaries with clients when necessary. She noted that most of the time clients are safe, as they have been screened by The Crisis Line and are requesting help. However, Taylor explained that when someone calls The Crisis Line for the client, it is difficult to know what to expect or how receptive the individual will be to receiving services; these calls are more likely to be unsafe.

> I don't think it matters if you're male or female, to me anyways, we are going into some dangerous situations. . . . And I've had to leave sometimes, just because it's going to become an unsafe situation. See for me . . . my number one thing is keeping myself safe. And then whatever I can do to help the person I'm with.

**Exacerbating Events.** Before my second interview with Taylor, a significant event occurred that shifted her experiences as a crisis mobile outreach worker. This event was the COVID-19 pandemic. In my second interview with her, Taylor expressed to me that she was beginning to experience burnout for the first time in all her years of crisis work. She attributed this to concern about her own health and safety, limited efforts by her employer to ensure safety, staffing shortages, and the inability to engage in her usual self-care activities.

> I would say probably, in how many years—14, 15 years of doing this, this is probably been the most stressed out I've been with my job. And so I don't think—I can't remember ever a time where I was like, "Okay, you know what, I really don't want to go out there to help people." I think this is kind of the first time that this . . . affected me.

Interestingly, Taylor was now operating as a crisis worker in the middle of a global crisis. With an added layer of crisis, her work became more challenging. Taylor's response to experiencing a crisis herself while helping others in crisis speaks volumes of her resilience. Shortly after expressing her concerns about working during a pandemic, she reiterated her passion for helping people to choose life. Taylor's drive to serve others and to share with clients her own love for life has allowed her to excel as a crisis worker despite its challenges.

> I like to show [clients] that there's more, that there's more to accomplish in their life, that their life's not supposed to end. And I think for me, because of that, that's the reason that I've been able to do this for so long.

### Aka: Embracing the Present

I met with Aka over the course of two interviews in order to better understand her experiences as both a crisis mobile outreach worker and a crisis case manager. Although I had never had an extended conversation with her before, I had referred many clients to her for crisis case management over the past few years and heard positive feedback about her work.

**Unfolding the Next Adventure**

As I listened to Aka's stories, I was in awe of her wisdom and insight. Here was a 78-year-old woman who had spent the last decade of her life in crisis intervention. Aka worked in crisis mobile outreach for 10 years and eventually switched over to crisis case management. After several more years in crisis case management, she decided that it was time to move on. When I interviewed Aka, she had recently left her job as a crisis case manager and was working as a long-term case manager. She had the unique perspective of someone who was no longer actively working in crisis intervention, and was able to reflect on her experiences with a new eye.

Prior to working in suicide crisis intervention, Aka shared that she had years of counseling and mental health experience. Aka worked in an inpatient hospital setting with involuntary patients and saw individuals with chronic conditions and extended crises. She also worked as an abortion therapist, which gave her the opportunity to work with patients facing relational crises. As a result, Aka started working in crisis mobile outreach with a solid understanding of suicide and crises, and she noted that her perception of a crisis has remained constant throughout her years of working in crisis intervention. Aka shared that she had never intended to work in crisis intervention; she took the job after having to move departments due to a conflict of interest. Aka excelled in suicide crisis work and found it to be a natural fit.

> And she said, "Well we have an opening on the crisis team—" She said, "You can give it a try, and if you don't like it that's fine, and maybe you'll like it." And 10 years later, I was still doing it. So I guess that's that.

## Experiences as a Crisis Worker

### *The Phenomenology of Crises*

Aka described a *crisis* as an emotional state in which a person is unable to cope with a given situation with their resources available. Aka explained that a crisis is a subjective experience, as it depends on an individual's perception of stress and their ability to manage it. Due to her counseling experiences prior to working in suicide crisis intervention, Aka had seen great diversity in crises. Despite the differences in manifestation, however, she conceptualized a crisis as generally the experience of being unable to cope with overwhelming stress.

> [A crisis is] the inability to use any normal coping skills you would use in a given situation. It's the inability to cope. . . . that is what presented itself to me, was a person who could not cope with whatever event had precipitated the crisis.

**Acute Crises.** Aka differentiated between acute, time-limited crises, and chronic, enduring crises. She indicated that acute crises are often sudden, caused by significant changes or

events, and are shorter in duration. The most common acute crises that Aka encountered during

her crisis intervention work included suicidal and homicidal crises.

*Suicidal Crises.* Aka shared that suicidality can occur when the overwhelming pain

experienced during a crisis is internalized. She stated that suicide is often an impulsive reaction

to lessen the severity of emotional pain; it is an effort to end the pain rather than to end one's

life. Aka explained that a person who is suicidal does not feel that they can survive the pain; they

do not trust that the pain will subside. This kind of hopelessness mixed with impulsivity can have

lethal consequences.

> People go inward and take themselves out, and I frequently have thought if you could
> come back, I mean if you had an opportunity to come back would you say you regretted
> taking that action? And I think a lot of people would regret it, because they didn't give
> themselves the time factor, they didn't give themselves the time to think further on the
> outcome and its consequences. Further on the reality of their pain. They didn't get that
> this could pass. They never waited that long.

Aka shared with me that she believes death is another part of the journey in which one

transitions into another space. Aka does not see death as the end and does not fear death.

Therefore, suicidal crises do not intimidate her, and Aka is able to fully immerse herself in the

client's experience even when they are ambivalent about life.

> I guess the meaning of death for me would be transitioning from this space to another.
> But a space with no time, a space with no time or perimeters on it. And then I guess I
> think of the word eternity—timeless, spaceless—and that's just kind of a belief I have. I
> like to believe that I came from the other side. . . . [death is] just part of a journey.

*Homicidal Crises.* Aka observed that homicide is often the opposite reaction to suicide; it

is the externalization of overwhelming pain experienced during a crisis. She understood

homicidal behaviors as impulsive aggressions against others in order to lessen the severity of

pain that an individual is experiencing. However, Aka noted that homicide can also be related to

antisocial behaviors and personalities. She stated that homicide was not an area that she felt as

knowledgeable about or had as much experience with, and this is common for crisis workers

given that crisis intervention services are often not provided to homicidal individuals; homicide

is usually handled by law enforcement due to safety concerns.

> I guess we either get to turn it against ourselves, or against someone else. . . . Homicide, now, you know, that's got a pretty wide girth, cause that can run anywhere from a Ted Bundy, just an all out sociopathic pathological killer, that's just the mentality, no conscious at all, to somebody with no impulse control, no filter on at the time. The person committing the crime has obviously, to me, got no filter that controls their impulsiveness.

*Chronic Crises*. Aka understood chronic crises as crises that are often an accumulation of

deeper, unresolved issues. Relational and addiction crises are the most common chronic crises

that Aka encountered. For people in chronic crises, the pain can feel unrelenting; this can lead a

person to a state of hopelessness, haplessness, and deep despair.

**Relational Crises.** Aka shared about her experiences working with clients who were in

the midst of relational crises. These are common crises that occur when relationships with others

or oneself change significantly or are fractured. A relational crisis can also include the

experience of distress related to one's own identity or social role. Aka explained that relational

crises are not always acute like suicidal or homicidal crises, however the individual is still

experiencing overwhelming grief, loss, or distress, and often for a longer period of time.

> I was a medical social worker in a rehab ward. . . . almost all the patients were paraplegic or quadriplegic primarily as a result of accidents—motorcycle accidents, car accidents— kind of a younger population—and they were in crisis. Not like an acute crisis, like [crisis mobile outreach], but nonetheless . . . an overwhelming life crisis in that everything changed for them, and many times their spouses would leave them after a period of time.

**Addiction Crises.** Aka also spoke about addiction crises, which she encountered

regularly when working in both crisis mobile outreach and crisis case management. She noted

that substances like drugs and alcohol are often used to numb the pain that a person is

experiencing, which can create a buildup of unresolved issues and lead to a crisis. Aka observed

that addiction crises are unique in that often the crisis is beneath the individual's awareness. The

disease of addiction may lead a person through multiple chronic and enduring crises.

> I guess well let's say for instance a crisis that was coming before the person became aware of it, might be an alcoholic or a substance abuser who has relapsed. And the crisis that's being reported is the relapse and what's going on for the person during that relapse. But . . . the relapse began before they ever experienced it. . . . Maybe they stopped practicing the steps, maybe they stopped going to meetings, maybe they didn't contact a sponsor or maybe they drifted off from their sponsor. And then, the results of that accumulate until one day they find themselves picking up a drink.

### *Precipitating Factors*

Aka shared that a crisis can be precipitated by a significant event or change, or it can be

caused by compounding emotions and unresolved issues. The precipitating factors lead to a crisis

when an individual is no longer able to cope with their situation or emotional state.

> Because the crisis can originate before the person is aware there is a crisis. Or, it can happen immediately as in for instance, an auto accident, with no warning that a crisis is coming.

### *Mediating Factors*

In Aka's experience, a person's perception of their crisis appears to affect the outcome.

For example, perceiving oneself as a victim is disempowering and can prolong healing. She

observed that clients who understand their pain as temporary usually fare better than clients who

are fixated on their pain and cannot see past it. Aka shared that as a crisis worker, having the

perception of the crisis as temporary and solvable allows her to see a way out of the crisis for

clients. Aka noted that often people are not aware that they have the ability to change their

perception or to choose to see something in a different way.

> For instance, the perception in the crisis that *this too will pass*, that's a lot better perception than, "God I don't know what you're gonna do, god I don't know what I would do if I were you, oh this is really terrible."

Aka also observed that motivation and willingness to change impact the outcome of a crisis. She stated that simply being at rock bottom does not necessarily lead to significant change; a person has to be willing and open to change in order for healing to occur and their condition to improve. Change is a risk that a person has to be willing to take.

> I call it motivation, it all comes down to willingness, how willing are you, how open are you . . . . without the willingness, it's not gonna change, except it'll probably get worse. Cause there's no such things as just a bottom. People go through numerous bottoms when they're using and they're not using.

Aka indicated that mental illness is another significant mediating variable in a crisis, especially when the illness affects a person's clarity of mind or ability to cope. The majority of clients outreached by crisis workers have mental health concerns.

> If you don't want to [get help] and you're being forced to go, likely . . . your condition will not improve. But that's the horrible part about the mental illness, right? It will try to convince you that you don't need to do that.

**Cultural Differences.** Aka expressed understanding of how the perception of crises and suicide varies across the world. She shared her experiences of living in another country and seeing how suicide was perceived and reacted to very differently from her home country. Aka observed that there were differences in the types of precipitating events that might drive a person to take their life; there was a different cultural code that determined what was an acceptable reason to attempt suicide.

> He had lost face and he had humiliated his family by not securing the grade point average he was expected to maintain. And so life was over. . . it was a strange experience for me to witness. Because, I mean, you know if that had happened here, in college, gosh there would've been flowers and services, and candles being held—you know that's how we are here. And there it's just like—it was just like, life as usual.

Aka shared that having grown up in America, this experience was shocking and unsettling for her. She personally views suicide to be a very tragic and unfortunate cause of death, and connected this perception to the cultural and social context in which she lives.

> Because of the country I live in, because of the perception held here, that [suicide] is not acceptable—and actually too many people, what they consider a real sin—I feel it's a tragic event. And I feel that it's tragic for the families who are left with a giant hole in their heart that will never be filled.

### *Helping Clients in Crisis*

Aka shared that intervention techniques are slightly different for crisis mobile outreach and crisis case management. Crisis mobile outreach focuses more on deescalating and stabilizing a client, while crisis case management emphasizes maintaining stability and reaching short-term goals. Aka noted that in her experience as a crisis case manager, 30 days was usually enough time to help a client get linked to appropriate resources for follow-up.

**Therapeutic Presence.** Regardless of whether she was doing crisis mobile outreach or crisis case management, Aka noted that feeling heard and understood was most important and meaningful to clients. Aka indicated that she prioritized listening and truly trying to understand clients' experiences from their perspectives, conveying empathy, acceptance, and compassion. Aka sometimes used self-disclosure to emphasize understanding and empathy, however she used this cautiously and only when trying to help a client get unstuck. She noted that she helped and related to clients as another human being, not as someone who was any better because she was in a helping position. Approaching her work with humility and genuineness was very important to her.

> I think one of the most valuable things to the client is to be heard. I'll frequently ask the client, I'll say to them, "It's really important to me that I hear you exactly as you want to be heard." My desire is to hear them the way they want to be heard, not the way I want to interpret what they're saying.

Aka shared that validating clients' pain and providing a container or holding space for clients to express emotions is another significant part of crisis intervention, as it allows clients to release and sort through emotions. She added that she often encouraged this process of catharsis and views the willingness to express emotions as a sign of strength.

**Safety.** Aka shared some of her experiences with clients who were unsafe, and the challenge of trying to protect and maintain safety, while also empowering and giving clients a sense of self-efficacy. When working in a psychiatric unit, Aka saw the devastating effects of a client with mental illness receiving electroconvulsive therapy against her will. She also shared about a woman who managed to hang herself in her room, even though it was in a fully staffed and supervised psychiatric unit. It was a reminder of how vulnerable humans are, and that just because a person is hospitalized, it does not guarantee safety; if a person is intent on suicide, they will find a way. When working with clients in crisis, the most difficult task is to keep them safe from hurting themselves or others, while also trying to honor their self-efficacy.

**Crisis Intervention.** Aka described her process of crisis intervention when working as a crisis case manager. She noted that after a client is referred to a crisis case manager, the client is usually in a calmer state, as the crisis mobile outreach worker has provided the initial intervention and stabilized the client. The crisis case manager's job is to then follow up with the client and set goals based on the problems that the crisis mobile outreach worker has helped the client to identify.

*Goal Setting.* Goal setting is a significant part of intervention for crisis case management. At this point, the crisis mobile outreach worker has already identified and reframed the problem for the client, which allows the case manager to then assist the client in developing attainable

goals in order to resolve the problems. Aka shared that she tries to understand the problem as the

client sees it, and helps them to develop goals that are achievable within her 30 days of service.

This process gives clients more self-efficacy, hope for the future, and connects them with

resources for further follow-up. Aka indicated that the goals are usually met within 30 days and

then it is time to close the case.

*Encouragement and Empowerment.* Aka shared that empowering and giving clients a

sense of motivation and drive was one of her main goals in case management. She encouraged

clients to function independently and saw herself as an advocate. Throughout the 30 days, a

client in crisis will often experience some discouragement and ambivalence, and this is where the

crisis case manager steps in to help the client continue striving toward the goals. Aka said she

encouraged clients by trying to help them understand that the crisis does not last forever; it will

eventually pass, and the emotional pain is temporary. She expressed her trust and confidence in

the fact that while she does not know what might be around the corner, the crisis is never

permanent, as change is constant.

> And it's also great I think to let them know, this will pass. This crisis? This crisis will
> pass, I assure you of it. And it will. Right? It's not going to be like that—you're not
> gonna live in it forever. I don't know, you might live in it an hour or two, or a day or two,
> or weeks, but it's going to leave. . . . And I don't usually say it may be replaced with
> something worse, or it may be replaced with something really really wonderful, but for
> sure it will pass, and you know life is kind of—somewhat like a roller coaster ride.

*Providing Resources and Referrals.* Connecting clients to resources and referrals is

necessary for continuity of care. Aka shared that she often helped clients find healthcare

providers, apply for financial assistance, and connect with community resources. Aka noted that

crisis workers have the unique position of knowing the different parts of the mental health

system and the limitations that exist. She often told clients and their families to keep their

expectations down, and to understand that healthcare workers can only do their best within

limitations in the system.

> I mean I could sum it up for them in one sentence. We have a mental health system with
> limitations. Keep your expectations down. Yes, you may be taking your wife back again
> and again and again and again. And the hospital will continue saying, "Here comes that
> revolving door client," and they will do what they do again and again and again and
> again. And so I think when we talk about simplicity, it's just, we're gonna do the best we
> know how to do, given the limitations of our system. We can't do any more than that.

### *The End of the Crisis*

Aka shared that a crisis ends when a person feels that they are better able to cope with

their current situation and emotional state. The turning point in a crisis is when clients are no

longer fixated on the pain or the problem and can look forward. It does not necessarily mean that

the crisis is resolved or that the pain is gone, however the client is feeling more confident in their

ability to move forward. In the same way that a crisis is a subjective experience, the end of a

crisis is a subjective judgment.

> I think that the client knows when the crisis is over. I could say as . . . a former crisis
> worker, I could say I'm aware that the primary crisis has been resolved—I should say the
> person's reaction to the crisis has been resolved—you know, they deescalated, their
> condition has stabilized. However, that doesn't mean that the person isn't still in grief and
> still experiencing the ongoing effects of that crisis. It's just not acute. But it doesn't mean
> it's gone.

*Post-traumatic Growth.* One of the themes that stood out to me most during my

conversations with Aka was the idea that pain is one of our greatest teachers. Aka accepts the

crisis; she understands that the crisis is not something to be eliminated, but rather it is a part of

life and can be an impetus for growth. As painful as a crisis may be, Aka explained that it can

result in resilience and strength. There is opportunity in crisis, as suffering can lead a person to

reexamine their lives and come out of the crisis with greater clarity, confidence in their ability to

cope with future crises, and a deeper understanding of themselves. Without the crisis, a person

may not have the opportunity to develop in this way.

> I think that pain, emotional pain, can be one of our best teachers. It's almost as though if one didn't experience emotional pain, how would one grow? . . . How would you expand your reality? It's . . . almost like a necessity that we experience that in order to then find out how to cope, to learn coping skills, and as the result of that we can grow . . . emotionally and probably spiritually. . . . In fact, [emotional pain] might be a necessity. That sounds strange to say, but as I say, if you or I or anyone never went through any kind of a crisis or a severe emotional pain . . . people who have that experience and grow from it—they have become stronger because of it. It gives them more strength to cope with life on life's terms.

## Longevity and Job Resilience

### Challenges as a Crisis Worker

**Safety.** Safety is one of the challenges that crisis workers face, as they are often working

with clients who are experiencing psychiatric emergencies and are doing community outreach

without the safety precautions that are available in institutions. Aka indicated that she had some

experiences in which she feared for the safety of her clients and herself. She noted that she rarely

felt unsafe herself; however, she acknowledged that in crisis work you never know what you are

walking into. Aka shared about an outreach in which a client she was transporting to the hospital

jumped out of her truck while driving on the freeway.

> Without any notice, she opens the car door, and she—I grabbed her parka and she slips out of it. And now she's on [the freeway] and I'm in the pickup holding her jacket. And then to make matters worse, my cell phone is dead. What to do, what to do. And I see her heading down the freeway, she's walking down the freeway, not in it but on the side, and I'm like, what am I going to do? . . . But it was kind of that thing of—what could have happened? You just—you never know, especially in the [crisis mobile outreach] job.

Aka also shared about an outreach in which she arrived at the client's house and the client

had died moments before her arrival. It was particularly memorable to. A crisis worker's job is to

keep a person safe; in this case she unfortunately didn't have the opportunity to do her job.

And so I went to the house and walked up and I saw the EMS there, oh I looked over and there was my client, he was on the lawn, and he was dead. And he was like 32 years old. And his father came out of the house and said, "Oh are you the crisis worker?" And I said, "Yes." And he was like apologetic, "Oh I'm so sorry my son's dead."

Aka's stories illustrate the challenges that crisis workers face when trying to help clients choose life. Crisis workers are sometimes with clients in life or death situations; their role can shift unexpectedly, and they have to be able to adapt and respond quickly.

**Challenging Clients.** Aka shared that having strong boundaries with clients is one of the ways in which she manages difficult behavior. She indicated that she did not tolerate aggression from clients, and learned to create structure for herself and for clients in order to prevent escalation. Aka would set limits on the expression of anger, as it was not helpful to her or to the client at that point. She noted that she learned to prioritize her safety.

I have really strong boundaries. And it hasn't happened often to me, but a couple of times I've been with a male who is becoming assertive and aggressive, and I've given them a warning. I said if you continue this behavior—I will walk away from you. And if it continues I literally walk away, get my car and leave. I don't try to change the behavior in that situation.

Aka also shared that it can be challenging when clients do not participate actively in the recovery from their crisis. She noted that she does not take this personally and remains committed to these clients, although it is easier to be committed to clients who participate. Aka expressed that the most challenging clients are those who ask for help but are ambivalent about change and have a fixed, rigid way of thinking.

And [this client] convinced me, not by saying it at all, because you know she wants [my help], but my encounters with her, my many outreaches with her, my [case management] assignments with her, have led me to that thought—and that is that I have absolutely nothing to offer. I have absolutely nothing to offer. It's like, game over, you won. Because I think she's that ill . . . that educated, and articulate, and sick. That she is able to manipulate a mental health system.

*Emotional Contagion and Letting Go*

I asked Aka how she was able to maintain her own emotional stability and grounding when working with clients in crisis. Aka stated that it has always been fairly easy for her to detach herself from a case and to avoid taking on another person's baggage. She did not invest an emotional reaction; she focused on the client during the outreach and then let the case go when it was over.

> I think I totally let it go. Sometimes if you ask me about a client that I discharged a week ago I might say who? Let's see, can you give me a visual on that? What was the situation? Yeah, I mean I leave it there. Once I'm gone I am gone.

**Do Not Personalize it.** Aka indicated that she does not personalize what clients are going through or react strongly to their experiences. Her understanding of the greater picture, that pain is not the problem but rather the teacher, allowed her to see the client's situation in a different light. Aka was able to separate her own experiences; she helped clients explore their crisis and gain clarity without taking on their story. In order to help clients get unstuck, Aka recognized that she could not be standing in their shoes.

> Their pain doesn't become my pain. And if I did personalize it then I would not be so available to assist them in their pain. If I took it on as mine . . . as a crisis worker, for me to feel that way, have that response, would disable me from helping them. I would then be in their shoes right? I would've taken on their pain, and I would be like "Oh my god, well god what are you gonna do?"

**Stay Present.** Another theme that stood out to me when speaking with Aka was her focus on the present moment. She conveyed that living in the "now" instead of the past or the future keeps her grounded and gives her gratitude and appreciation for the present moment. It was clear to me that this approach to life allowed Aka to thrive in crisis work. Aka found that worrying about the past or the future was not productive or helpful to her, and the best thing she could do

for herself was to focus on accepting the present moment. Aka's mindfulness helped her to

manage emotional contagion and to stay out of her own head.

> And that's what helps a lot being with clients, is for that moment in time—like at this moment in time that you and I are together, that's all that's happening right now, is you and me. That is all that is happening. And when I'm with a client that is all that is happening. So it's actually, it's interesting because the clients, in working with the clients, provides an escape from the stresses, the other stresses of everyday life. It's like an escape.

**Stay Task-Oriented.** Aka shared that she values problem solving and figuring out how

to help someone. Her task-oriented approach to crisis intervention was grounding for both her

and her clients. Aka focused on helping clients to approach problem solving rather than solving

problems for them; this likely created a sense of healthy distance, as she was not invested in any

outcome.

**Do Your Best.** Aka learned over the years that things do not always turn out as

anticipated. She expressed understanding that she can only do her best, and that clients are

ultimately responsible for making their own changes. Aka recognized that the problem was often

more complex than her and the client, and knowing that she did everything she could to help

allowed her to accept the outcome and let go of the case after it was closed.

> And I think another aspect of it that wasn't encountered regularly is, things don't always turn out as anticipated. You thought you'd do this, this, and this, and then they have expectation of what the result will be, and suddenly that whole thing fell through. The client relapsed, the client went back to their alcoholic girlfriend. The client disengaged in the plan. And I think learning to accept that that is just life, on life's terms, sometimes it all turns out and sometimes it doesn't. But I think it's almost a matter of, I can't allow that to alter my participation down the road. I can't let it affect me. Or I wouldn't be willing to put in the effort with people, if I focused on the disappointing moments.

**Keep Expectations Realistic.** Aka shared that it was important for her to keep her

expectations realistic and to encourage clients to do so as well. Knowing the limitations of the

system, Aka understood that there was only so much she could do. Conditioning her expectations

for herself, for clients, and her own performance allowed her not to feel disappointed by the outcome. Aka recognized that some clients did not participate in fulfilling their part in the recovery from their crisis, and as a case manager she had no control over that. As a crisis worker you can only go as far as the client is willing and ready to go; you can't force change on anyone or save every person.

> If they are not interested or let's put it this way—if they're so deep into their disease that they show no motivation at all for change, then I just have to let it go. Because I think . . . recovery doesn't seem to work well until someone is ready to surrender.

**Small Victories.** Aka noted that she recognized the value of small changes. This kept her from feeling disappointed or discouraged, as crisis work can be unpredictable and often change occurs very slowly. Aka shared that even if a client did not take steps forward, if they showed any motivation to do so she considered it a win. She stated that she does not believe that any client or situation is hopeless, as you can never know what is around the corner.

> I find it rewarding if I can find any motivation. Any motivation at all. That that client doesn't want to live in that situation. That that client is willing to take some kind of step toward getting sober. Or getting clean. . . . So I gotta always remember I can never second guess it, ever. So I don't ever like to take any addict or alcoholic as hopeless. It's just a matter of, is this the time?

## Characteristics of a Crisis Worker

### *Passion for Helping Others*

As Aka spoke about her passion for helping others, it was clear that she has a heart for service. She expressed that she finds fulfillment in helping others and being part of the solution. Crisis work was fitting for Aka, as it gave her the unique opportunity to help people find a way out of their crisis and gain hope for their lives.

> [Healthcare] is a great field to be in. And how often have you heard people say, "Gosh I just wonder what's my purpose here, what's my purpose in the world?" And I'm thinking to myself, well it's pretty easy to me, we're supposed to help one another. We're

supposed to be helping one another in this life. . . . The good feeling is when you're with the client, you're being of service.

### *Perseverance*

Perseverance is another characteristic that allowed Aka to excel in crisis work. Her

commitment to her clients and to her work was evident. She persevered with clients through the

ups and downs of their crises and continuously strove toward the goals they set together. In

doing so, Aka instilled hope in clients and modeled a healthy way of approaching and coping

with crises.

> You know [a client] texted actually and said, "I hope you never leave." And I told them, "I actually have no control over that but I'll do my best to try to make it the longest experience as possible." . . . He said to me, "You're very committed to your job aren't you?"

### *Thriving in the Crisis*

Aka shared that she enjoyed the unpredictability and variability that comes with crisis

work. She noted that responding to a call and not knowing what could happen was exciting to

her, as it posed the challenge of a unique situation and problem to solve. In this way, Aka thrives

in the crisis, as the unknown and variability is not destabilizing to her.

> That's part of I think why I like that, I just like walking into a situation and seeing, well, what can happen here? . . . . never will there be an identical situation. You could see 10 alcoholics but they could each have a different situation. Even though they all share that diagnosis in common, the situation isn't the same for any of them.

### *Organization*

As a crisis case manager, being organized allowed Aka to keep track of her large

caseload. Especially in crisis case management, where clients are being serviced for only 30

days, it is necessary to be able to plan ahead and work efficiently.

> I have a tendency to be an organized person. I'm organized. So clients all have their folder in my binder with what's going on, with what's tabbed as a priority or I might have

a list for the day with names on it, and what the action needs to be taken, so that I can keep track on a daily basis.

### Self-Care

Aka expressed that self-care is a necessity in order for her to maintain a work-life balance. For Aka, self-care includes everything from taking care of her physical, mental, and social health to maintaining firm boundaries with others. She noted that she does not take her work into her personal life, and does not wait until burnout happens; Aka indicated that she removed herself from her last job as soon as she began to feel a lack of support from her employer. Aka stated that she also values therapy as an outlet and maintains healthy relationships.

> If you are going to be of service to others, you can't do it without being of service to yourself. . . . My self-care is called leave it at work, don't bring it home. I'm pretty much of a social person, so I like contacting other people. I like being with other people. . . . I have healthy relationships.

### Resilient Mindset

Aka's way of approaching life is indicative of a resilient person. Aka views life as a journey down a path and does not fear or focus on what might be around the corner. Rather, she is curious about it, and has confidence in her ability to cope with and use her resources to manage whatever might happen. Aka focuses on the process rather than the outcome; she remains present and lives in the solution rather than the problem. Like Aka, a resilient person is able to remain centered and balanced through the ups and down of life.

> Roller coaster, yeah it's like up down, up down, up down, and we certainly met clients that—that's what they're in. But I think the best scenario is, it's a roller coaster ride with a censor track on it that is feeling centered, balanced—you're not totally manic, and you're not severely depressed, you're at peace with yourself, you have serenity, you're on the middle of the road there—and it's not gonna stay either.

**Reflection**

As Aka reflected on her past experiences working in crisis intervention, she noted that she preferred crisis mobile outreach because of the heavy caseload that came with crisis case management. She explained that she enjoyed not having a caseload and being able to do a one-time intervention, then referring clients to another resource for follow-up. Aka noted that she is currently doing long-term case management, however her caseload is more manageable. She stated that she is looking forward to developing relationships with her clients, and there is not another job she would rather be doing right now.

*Lessons Learned*

**Reading Clients.** Aka shared with me some of the lessons that she learned throughout her time in crisis work. She noted that she learned to always observe a person's eyes, because the eyes are very telling of a person's mental state. She also learned to trust her intuition, and to allow her intuition, past experiences, and observations of nonverbal cues and paralinguistic information to guide her judgments.

> I mean I frankly do listen to my intuitive feelings, and I think there was a time in my life when I didn't trust intuitive feelings but time passed, and time passed, and time passed, and experiences happened, and now I very much trust my intuitive feelings. . . . I trust my intuitive feelings aligned with my experience and judgment around people.

**Employer Support.** Aka's experiences show the importance of having a supportive employer and work environment, especially in a high-stress, high-burnout job. She noted that she became overwhelmed by her caseload of clients and did not feel that her voice was heard. Aka indicated that having a supportive employer and feeling that her needs and limits are acknowledged is extremely important to her.

> I also like the support of my employer. One might put that in the classification of self-care. Part of self-care is, I want to be supported. So if there's conflict in the

administration or bureaucracy that I'm in, then I'm not gonna feel nurtured. And then it can affect my performance.

**Exacerbating Events.** Right before my interviews with Aka, the COVID-19 pandemic hit. Aka acknowledged that the pandemic has created global crises, however, she had not seen it affect her clients significantly. She explained that for her clients, their crises remained the same; they were perhaps exacerbated by the pandemic, but not caused by it. Again, Aka showed understanding of the fact that the problem in a crisis isn't necessarily the stressor.

> The crisis, regardless of the global crisis, the crisis in front of me remains the same. Anybody I've been talking to about crisis, their crisis is not about the virus. Their crisis is about what their mother just did, or their wife, or they've mismanaged their funds again. As though they are living separately encapsulated within this global thing. You know, in their own world. . . . my clients that I'm talking with, there's not a lot going on in terms of a crisis being instigated due to the state of affairs.

### *Looking Back*

In hearing Aka's stories, I was struck by her ability to persevere through her crisis work and maintain her own stability despite the challenges that come with the job. Aka shared that in reflection, her job was, in fact, stressful at times. She wondered if she had been in denial about the stressfulness of the job when she was immersed it.

> So now, I look back in retrospect and I'm like, huh, I either have a great sense of denial or I don't know what it is, but I never ever felt like I was stressed out at my job or that I couldn't handle my job, or that, you know, any of that until I got out of my job. And then I looked back and . . . that was a damn stressful job. It was.

However, Aka expressed that she genuinely enjoyed her work, as it was fulfilling to help people through crises. Interestingly, she noted that her focus on the present kept her from feeling stressed or overwhelmed by her job. Aka's way of coping with challenges as a crisis worker is a beautiful reflection of her own way of approaching crises.

> I really did enjoy my work. I did. So it fed me a lot. And I wouldn't think about, "Well let's see, when are you gonna stop being a [crisis mobile outreach worker], when are you

gonna stop"—I wouldn't be. I would be living in the moment and one day to the next and I would be like, "This is all fine." Yeah, it didn't appear to be stressful to me until I look at it relative to my current job.

Like each journey she took in life, at some point it was time for Aka to move on. Crisis work was an enriching experience, and when it seemed that it was time for a change, she embraced the next adventure. Aka trusts that life will take her to where she needs to be next, and she embraces whatever might come her way.

So maybe it was just, maybe it was just as simple as time to move on. And that it worked while I was there, it worked for me, and then it didn't, and then it's time to move on, and in terms of seeing things a certain way, I would say life becomes more of like a journey down a path and I have no idea what lays around the corner, I really don't. But instead of it being a fearful thing, oh my god what's gonna happen next, instead of it being that, now its more of, I wonder what it's gonna be?

### John: Embracing Life

I met with John for two interviews in order to capture his experiences as a crisis line screener. I had never met him in person before, however I had spoken with him many times on the phone for crisis mobile outreach dispatches. As a crisis mobile outreach worker, I appreciated his thorough screenings and thoughtful interventions. After finding out that John had worked with The Crisis Line for over 17 years, I knew that he would be an exemplary screener with much wisdom to offer.

### Curiosity and Wonder

John's stories were compelling to me as a researcher; we spoke the same language of curiosity and wonder about the human experience. John shared that he went to school for social work but had never planned to work at a crisis line, let alone in the mental health field. His passion for helping others and openness to experiences led him to The Crisis Line, where he thrived in providing telephone interventions to people in crisis.

> I was just thinking more of having a job, but then I was thinking at the same time for knowledge base it would give me a set of skills that I never had because I never worked in a crisis before, when I came here. And that's what led me to it. It's not like I was dreaming when I went to school that I'm gonna go work at a crisis line [laughs] so—but I can honestly tell you being here has been so rewarding. . . . When you know that you made a difference in someone's life, that you helped them, pulled them back from the brink of death, is a reward in itself.

**Experiences as a Crisis Worker**

*The Phenomenology of Crises*

John described a *crisis* as a state in which an individual is unable to cope with and adjust to adversity. He indicated that it is highly subjective, as it depends on an individual's stress appraisal and ability to cope. John noted that what might be a crisis to one person may not be a crisis for another.

> Well for me, a mental health crisis I have to look at it from the point of view of the individual, because a mental health crisis could be anything that's affecting an individual that they're not able to function or do things on their own. . . . When you're not able to, you know, adjust and handle adversity, then it becomes a crisis to them, they're feeling like they need some kind of support to be able to handle that.

John expressed respect and acceptance for each person's experience; he understands that although peoples' crises may have similarities, each person's pain is unique. He noted that he does not make assumptions about crises or judge what constitutes a crisis for another person; he strives to be open to what clients share. Although John did not define types of crises, he indicated that the common thread in crises is the deep despair and sense of alienation and disconnection that a person experiences.

> 'Cause they feel hopeless. They feel—when you start feeling hopeless you feel like nobody cares what you're going though. Nobody's really gonna try to help you, they could care less.

John noted that in this state of distress it is easy to get fixated on the problem instead of the solution. It is hard to see the way out when in crisis.

**Suicidality.** John shared that suicidality can occur when a crisis leads a person into a state of hopelessness and despair. He indicated that suicide is a symptom of a deeper problem, which can feel so overwhelming that a person begins to lose sight of their reasons for living. Thoughts of suicide can set in when a person feels that there is no solution or end to insufferable pain.

> So for me personally, anytime they have a breaking point of despair and they feel like there's no reason to live . . . you have reached a point—like I hear some people sometimes, "There's no sense in going on, life's not worth living, what's the point?" . . . They feel no hope, so it seems like kind of "All the joy has gone, all the life, there's no reason for me to be here, I would just be better off dead, I'm gonna go ahead and just take my life," and that for me is always a risk for a person to harm themselves.

John noted that a person experiencing thoughts of suicide is not focusing on the way in which their actions will affect others. They are so deep in their crisis that they are unable to see the potential consequences. John expressed that he has compassion for people in this position and does not condemn or judge anyone who chooses suicide. He acknowledged that having thoughts of suicide is a common experience.

> I think at some point everybody thinks about [suicide], at some point or another, especially in this day and time.

John shared with me that he does not see death as the end; rather, he believes that death leads to a change in the spirit's form. Death is not something to be feared, as he embraces it as an extension of life. John gives clients experiencing suicidality the space to explore the possibility of death, while guiding them back to the hope that remains in life. His spiritual beliefs and way of understanding the world allow him to focus on the client's story rather than the potential for death.

> Death to me is just another chapter in this phenomenon we call life. . . . Matter and energy are one. You cannot destroy matter, you can only change its form. . . . The core of my spiritual beliefs is that . . . we are all spiritual beings living in physical bodies. . . .

[The individual soul] is ultimately eternal consciousness. . . . It is eternal and survives the death of the body.

**Homicidality.** When asked about his understanding of homicidality, John responded that he perceives homicidality to be the opposite of suicidality, as it is the externalization of pain. He explained that hopelessness can lead to anger, which can then turn into aggression, and even homicidality. John shared that he has worked with clients who projected their frustrations onto him. Often, clients amplify their pain and cast it onto others; underneath, the person is in despair and feeling unheard and misunderstood. John indicated that clients sometimes project their frustrations with society, systems, and government onto crisis line screeners, as they are seen as part of the system.

> So it's like some kind of way. "I just want to vent. I want to let this steam out. This is how I feel. You're making me feel hopeless. You're making me feel like I can't do anything right. So I'm just angry at the world." So it can just turn into that hatred and anger for everybody, instead of being suicidal they wanna harm everybody else, because it's like, "I want you to feel what I feel." And it's almost like they want to project their feelings, their pain onto you 'cause "you don't understand. So I want you to feel what I'm feeling. So if I hurt you or if I hurt your family or if I hurt society then you'll understand."

**Loss.** John described working with clients who were experiencing the loss of a relationship, their family, or a job. Their crises can also include loss of identity, self-worth, or social role. John explained that these crises can be especially challenging due to the emotional investment that people have in their relationships and roles. It can be difficult for a person to move forward after losing their sense of self in relation to others or society.

> I have had some people that call that was terminally ill and saying, "My life is worthless now. What can I do for my family? I can't work anymore, I can't do anything anymore, I'm a burden to them," and this type of thing.

**Addictions.** John also shared about his experiences in providing crisis intervention for people with crises involving addictions. He indicated that people often feel powerless in relation

to their addictions. Addictions can create an emotional numbing that prolongs the crisis, and a person enduring this type of chronic crisis can begin to feel hopeless and tired of fighting the addiction.

> And he's telling—I can hear the slurring in his voice, he's totally intoxicated . . . and he didn't have many reasons to [kill himself] besides he couldn't beat his alcoholism. And he said, "I'm just an alcoholic. I'm tired of it. I'm just gonna kill myself."

### *Precipitating Factors*

John highlighted that the precipitating factors for a crisis are dependent on an individual, their ability to cope, and the things in which they find meaning. For example, John stated that he frequently works with people whose crises were precipitated by breakups, relationship problems, depression, job loss, health issues, and homelessness. He also works with people who have a history of trauma and are experiencing triggering, re-traumatizing events. When a person loses something that is meaningful to them, especially something that provides a sense of purpose, they can experience grief, despair, and hopelessness. It is difficult for a person who has lost their sense of purpose and reason for being to have hope for the future.

### *Mediating Factors*

John identified some variables he thought seemed to affect the duration and outcome of a crisis. He mentioned that social support gives a person hope and confidence that they can cope with their crisis; having a solid support network can increase resilience in a crisis. John indicated that hopelessness is often a sign of suicide risk, because it tells him that a person is in a state of deep despair and does not see a reason for going on.

> So evidently if they have no hope . . . if they feel no hope so it seems like—kind of all the joy has gone, all the life—"There's no reason for me to be here. I would just be better off dead. I'm gonna go ahead and just take my life," and that for me is always a risk for a person to harm themselves. So just kind of looking for those clues in the conversation that you feel that they're in danger.

He noted that intoxication and substance use could increase suicide risk, as it decreases inhibitions and heightens impulsivity. John stated that lack of mental clarity can exacerbate a crisis and increase the potential for harm, as a person is more unpredictable. For example, people who are experiencing hallucinations or are not oriented to reality are more at risk for harming themselves or others.

### *Helping Clients in Crisis*

**Therapeutic Presence.** When asked what seems to be most helpful when providing crisis intervention over the phone, John responded that showing empathy, compassion, and genuine love toward clients appears to be the most helpful. John expressed understanding and unconditional positive regard for clients; he conveyed care, concern, and commitment to helping. He believes that expressing genuine care about the client is the first step to instilling hope. He has found that showing empathy and giving his full attention to clients encourages and empowers them. It communicates that their story matters to someone.

> So I think when you show that genuine love and compassion towards them. It's like, "I hear you, I feel what you're going through." So kind of put yourself in their shoes. I think that's the biggest thing. They just want to know that somebody cares. "You hear me. You feel me—what I'm going through—I'm not just in this alone." So I think when they hear that, that's the beginning of hope. They have some hope. 'Cause they feel like well somebody cares. You're not just brushing me off. . . . So I make them feel important. "You are the most important thing to me right now—this call. I'm not worried about the next call, it's about you." So I'm listening to them, hearing their story—so you can truly engage with them.

John noted that sometimes all you can do as a screener is give empathy and hope; sometimes they run into gridlock problems that aren't necessarily solvable.

> 'Cause a lot of times you may not have the resources that they need. You know sometimes you do run into roadblocks. You can only do so much. But the thing is, I think when you give them hope, people don't realize that makes the greatest difference.

John mentioned that one of his strategies for conveying empathy is expressing understanding and normalizing client's experiences. He stated that he tries to emphasize the bigger picture, that every human being experiences hardship at some point. John shared his perspective on pain—that pain is part of the human experience. He encourages clients to hold onto life even though it is painful.

> So you kind of let them know that life brings difficulty to everyone regardless of status, regardless of race, gender—it doesn't matter. . . . Nobody is exempt from difficulties.

John noted that his approach to crisis intervention does not change when a client is aggressive or projecting their pain onto him. He recognizes that either way a client is in despair, and by showing empathy and acknowledging their feelings, a client can begin to feel understood and hopeful.

*Safety.* Ensuring safety is John's primary goal as a screener. One of the main ways in which he establishes safety is by providing therapeutic presence. John's compassionate way of offering a holding space for clients' raw emotions creates a natural and effective sense of safety. He also utilizes safety assessments and creates structure in order to ground clients.

*De-escalation and Grounding.* John indicated that he de-escalates and grounds clients by building rapport and showing empathy. One of the ways in which he conveys empathy is through his voice; John noted that having a calm, steady voice is critical when working over the phone. Often clients call in a state of heightened emotion. John noted that it could be difficult to understand and assess a client until they are calm and can tell a coherent story. John shared that clients in crisis are often so overwhelmed that they are disconnected from reality. In these situations, John tries to connect the client to his voice, the location, their story, or their situation in an effort to help ground them. Although a client may be in a state of panic, John remains calm

and connected, stays descriptive, and helps the client to slowly unpack their crisis. His natural

ability to connect with people allows him to build trust and plant seeds of hope along the way.

*Assessing and Securing.* John shared that he uses both logic and intuition when assessing

for suicide risk. He indicated that he has to be very direct when assessing for suicide. John noted

that sometimes a client will not give him all of the information he needs, though, and that is

when intuition and past experience helps guide his assessment.

Some of John's most memorable calls were those in which clients were actively suicidal

and had the means to kill themselves; these high-risk calls require resourcefulness and

strategizing. John shared experiences in which he had to come up with creative ways of getting

more information from clients and convince them to hold on a little longer. John's job requires

him to quickly activate the part of the person that wants to survive. This is not an easy task, and

it is clearly an area in which he naturally excels. John noted that he has had to distract clients

from wanting to kill themselves while he made plans to get them safe. One of his strategies is to

"talk story" with clients to buy more time.

> And I can actually hear the cars going by down the road, and only thing I could think
> of—he's intoxicated—one slip and he's gone. So I'm tryina get this rapport with him
> really fast. How am I gonna get him back over this [balcony railing]? [He said,] "No
> reason to talk. I'm just gonna jump. . . . I just wanted to tell somebody before I did it." I
> said, "No I hear you, but just talk to me for a minute. I just want to hear everything
> you're going through okay? Just talk to me." . . . So I had to use a little strategy to get
> information out of him. I said, "Man I think I been out there before." I was like, "What
> hotel are you in?" So he give me the hotel name, not knowing that I'm pulling it out of
> him. . . . So I'm just kind of giving a natural talk story with him, being friends with him,
> and was like, "Wow that's really cool, that's a nice place." I said, "You on the 16th floor?
> Wow, what room?" He had no clue. I was asking for information so he told me what
> room. So now I got what hotel he is in, what room he's in. . . . So I gave a coworker the
> hotel room, and here's where he's at. And so [emergency services] was in route already
> but I'm keeping him on the phone, but I got all the information I need.

John shared that part of securing a client's safety involves reframing emergency services so that a client is more receptive to help when the police, ambulance, or crisis mobile outreach arrive. Because John has built rapport and trust with clients, they are more open to receiving the assistance that he dispatches. When he transfers care to emergency services, he reassures clients that he is still there to help and support them.

> And [the police] said, "Can you open the door?" She said, "No," [and] let the window back up. So I kept talking with her and talking with her and I said, "Come on, I promise you I'll stay on the phone with you until they help you. They're not gonna hurt you. They just want to help you, okay?" Finally, she opened it.

*Building Rapport.* Establishing rapport quickly with clients is one of John's strengths. There is no time to spare when keeping clients safe, and screeners have to be strategic about their conversations. John indicated that he builds rapport by showing empathy, offering comfort, giving unconditional acceptance, and allowing clients to be vulnerable. He noted that he sometimes will offer a suggestion of how the client might be feeling based on what he is sensing, and this technique is effective because it makes the client feel understood on a deeper level. John shared that he sometimes uses self-disclosure to further encourage clients and instill hope, however he uses self-disclosure sparingly.

> You can kind of build rapport with them and say, "Well you're not the only one, and I feel it too. I've been through difficulties but I made it through it." So I kind of let them know—it's like, "Well then, it's a possibility if he made it—telling me he's been through stuff and he's there and he's working, okay." It helps.

John noted that part of building trust and rapport is walking with and beside clients; he does not try to argue with clients. This is especially effective when working with clients who are not thinking linearly or are expressing hostility toward him.

> 'Cause when they start talking about the "government," "got probes in my head," "I'm hearing things," it's like, "Hmm maybe, but you know what, I know this guy that can come out and talk to you. Let's figure this out. You could be right but let's see what's

going on . . . [crisis mobile outreach] can come out, talk to you, see how they can help you. . . . We want to figure this out." And they're like, "Yeah." So you just putting it like—don't put it like they're crazy. Put it like, "I hear you. It could be a possibility. I don't know." . . .  So they're more inclined to getting the help if you put it to them that way.

**Crisis Intervention.** After client is calm, safe, and rapport has been built, the screener can begin to unpack the client's story.

*Listening for Poignancy.* Being a screener requires the ability to listen well and to hear the subtle and underlining meanings. John explained that he listens for the emotional state that a person is in, beneath the context of their story. John listens for emotional pain, as this will help him locate the heart of the matter and better understand the problem.

*Clarifying and Reframing the Problem.* After listening for poignancy, John helps the client identify the problem and reframe it from something that appears to be hopeless to something that is solvable. This process re-categorizes and restructures the problem so that it does not feel so overwhelming. This helps clients see hope outside of their pain and moves them along in the process of change.

*Assessing Need and Providing Resources.* After John completes his triage, has de-escalated the client, and ensured safety, he assesses what resources the client currently has available and provides referrals appropriately. When additional crisis intervention is necessary, John dispatches the crisis mobile outreach to further assist the client in crisis. If the client does not currently have case management and would benefit from temporary crisis case management, he has the crisis mobile outreach complete a referral for case management. John facilitates communication and connect clients to other services.

*Empowering and Instilling Hope.* John shared that the most important part of crisis intervention for him is to empower clients and instill hope. His goal is to build resilience and

self-efficacy in clients. John explained that throughout his conversation with clients, he helps

them to see their situation in a different light and to make positive choices for themselves.

> I think once you empower the person even though you might not have any follow-up of what happens to that individual's life, I think you can be satisfied in the fact that you gave them a start on the road, on the path, the process of change in their life, and tried to empower them. I say, "Look, this is how you can make a difference in your life, this is how you can change it, but it's within you. Not in me. It's not in all these organizations, but what you can do for yourself."

John respects clients' self-agency and does not tell them what to do; rather than just

giving clients a solution, he shows clients how to approach a problem and provides them with

tools and resources to make changes for themselves. He noted that the greatest thing you can do

for a person is to change their mindset, empower them, and give them hope, regardless of what

resources you have to offer.

> And that whole saying—"Don't give a man a fish, teach him how to fish, and he will eat for the rest of his life"—You know, I can hand it to you but if you don't know how to do it for yourself then you still gonna be in that same position all the time for the rest of your life. So you trying to change that mindset, from failure and gloom to a positive outlook, and to me that's the biggest key.

John's job is to help a person choose life by showing love, instilling hope, and helping

them to see options beyond suicide. He points out the strengths within a person and what they

have to offer in order to impart a sense of self-efficacy and self-worth. John acknowledged that

sometimes it can be challenging to see the light in a person's situation, however he always

believes that there is a glimmer of hope. John noted that he does not give false hope, as he tells

clients that there are no guarantees, but that he will do his absolute best to help them in their

situation.

> You get some calls like that and you hear some of the people's stories and what they've been through in the past, and what they're currently in, and it looks hopeless. I mean literally, some of them you hear their stories and you're like "Wow." But I still think that

there's always a glimmer of hope. Even when we can't see it. . . . We're looking at it from the perspective that they're giving us, instead of outside of it.

**Post-traumatic Growth.** As John shared his process of crisis intervention with me, I was struck by the wisdom in his understanding of crises. John perceives a crisis as more than a painful experience; he saw it as an opportunity for growth. When working with clients in crisis, his goal is to help them move through their crisis and experience post-traumatic growth. John asserted that it is the experience of adversity that creates resilience, but adversity can be transformed into something meaningful. To John, a crisis is not something to be feared, as the crises we experience and overcome shape our lives and ultimately make us stronger.

> I always tell people to—I always use my little analogy—to turn that stumbling block into a stepping-stone—because you're always gonna have challenges in life. No human being is exempt from that. So you're gonna have difficulties. You're gonna have things you go through in life. And everything is not gonna go your way all the time. Does that mean that you're a failure? No, that means that there's another opportunity for you to be successful, for you to grow. So I never look at—I never have failure in my vocabulary. I always tell people the only way you can fail is just doing nothing at all. Period. Just totally give up, nothing. Because as long as you're striving to do the right things, to do better, even though you hit these stumbling blocks, you can just turn it over and keep right on going. . . . When you go through that adversity and come out of it, like they say, "forced into fire" right, you're stronger. 'Cause you say I've been there, done that, I've been through it and this is how you can come through it—stronger because of it. And you are.

**Unique Aspects of Telephone Interventions.** When providing crisis intervention over the phone, there are unique challenges and advantages. John noted that as a screener, he does not have access to nonverbal cues and relies on paralinguistics and the context of what clients say or do not say. When there is only a phone line between the screener and the client, the screener is unable to physically ensure safety. John acknowledged that it can be challenging to assess someone for safety and prevent harm when he is not there in person with clients. However, John shared that there are also advantages to working over the phone. Sometimes the separation is

beneficial in that it gives screeners a higher tolerance for challenging clients. For example, when managing hostile clients, screeners only have to maintain composure in their voice. John noted that clients are not able to see the screener's reactions, and this is helpful when stabilizing clients.

**Longevity and Job Resilience**

John shared that in his 17 years of working as a crisis line screener, he had never experienced burnout or perceived his job to be particularly difficult. He never lost his passion and joy for this work. In a field with high burnout and turnover rates, John is an exemplary case.

*Emotional Contagion and Letting Go*

**Do Not Personalize it.** I asked John how he is able to avoid emotional contagion when working with clients who are in a state of crisis. John stated that being with a person in crisis does not affect him personally; he is able to have compassion while separating his own experience from those of his clients. John noted that in order to be able to help another person, he cannot get too emotionally involved. He acknowledged that sometimes a story hits close to home and resonates with him, however he is able to set aside his own story and be fully present for another person's suffering.

Even when clients project their frustrations onto him, John is able to remain compassionate and curious about their stories. He shared a story about a client who would call every day and try to upset the screeners. John noted that he was not bothered by the client's hostility, and patiently continued to try to connect with the client until he finally opened up. This is where John was able to intervene and eventually get the client help.

> But yeah he did call me every name in the book too. And it actually got to the point—he called me the n-word. And I said, "Yeah that's fine, but it's okay—so how was your day?" And then he finally stopped. He said, "You know what, I've never heard you get

angry." . . . But then when you got down to it, no matter how you looked at it for him, he had legitimate reasons to feel that way. He had been in the military, he had lost his wife, he had lost everything, he had cancer, he was an alcoholic, and everything was compounding and just—forget life. And [he] blamed everybody else. And so he wanted to make everybody else miserable too. And then it came to a point when we had that conversation, were talking, [and] he let me help him. [I] got him some help, psychological help, and he got better.

**Do Your Best.** John shared that doing his very best to help a client allows him to let go of a call after it is done. He acknowledged that there is only so much he can do to help, and ultimately it is the client's story. This understanding helps him to focus on the individual and be present with them; he does his very best, hopes for the best, and lets the client continue on their journey.

It's only so much you can do. But you do whatever you can to try to save that life or help that person. When you give it your all, 100 percent—and that's all you can do. So that's what I go in—with that. I'm gonna do the best I can do to help this person. And hopefully [they will] meet me halfway. . . . So as long as I know that, I can always remain calm regardless of the situation.

## Characteristics of a Crisis Worker

### Passion for Helping Others

Throughout my interviews with John, I was struck by his genuine love and passion for helping others in this capacity. He emphasized how rewarding and fulfilling his job is, as it gives him the opportunity to make a significant difference in a person's life, to provide encouragement in the midst of a crisis, and to help a person choose life. John also stated that he enjoys building relationships with like-minded colleagues in the field who want to make a difference in people's lives. John's compassion and love for helping others keeps him excited about his job.

### Perseverance and Patience

John understands that crisis intervention involves a process and is not always linear. He has the ability to persevere and remain patient with clients as they explore their crises. John

allows clients to experience the crisis and the pain until they feel heard, begin to wonder about possible solutions, and discover a sense of hope for the future. This is not an easy task, and John's ability to persevere with the client until they are no longer stuck in their pain is reflective of his own resilience.

### Quick Thinking

John's ability to think quickly and improvise under pressure allows him to thrive as a screener. As previously mentioned, John often has to come up with creative ways of getting more information about a client when they are ambivalent about life. Being a successful screener requires the ability to problem solve while stabilizing the client.

### Self-Care

John shared that he keeps himself balanced by practicing meditation and self-care. He recognizes that self-care is necessary, as you cannot help someone else until you help yourself. John indicated that he makes sure that he is spiritually and mentally prepared before he does this work. He works through his own challenges in life in order to be completely invested in clients.

> I always tell people you can't help no one else until you help yourself. So that's kind of being a hypocrite too, right, you tell them how to get past it but you haven't even got past your own stuff. So, I think for me, anything I have in life, I work through it first. I'm gonna make sure that I work through it, I'm mentally grounded and set, so I have no personal issues myself, so that way I can be 100% invested in that person to hear their problems.

### Resilience

**Pain Is the Teacher.** John's ability to flourish in crisis work is reflective of his own resilience. He accepts pain and suffering as an inevitable part of life, and allows pain to be the teacher rather than the problem. John views every crisis as an opportunity for positive change.

This understanding allows John to guide clients in crises and have hope when they are not yet able to.

**Shared Experiences.** John expressed that his own experiences of hardship have deepened his understanding and compassion for others who are experiencing loss, tragedy, and heartbreak. His parallel life experiences help him guide and connect with others in a genuine and meaningful way. John acknowledged that some stories are closer to his own and touch him in a different way; however, he is able to separate his story from the client's and uses his experiences as an instrument and motivator to help the individual.

> But I think when you truly understand it, human nature . . . you can kind of understand what they going through, so I think you can have more compassion for people, to be able to direct them though that, to give them hope, and light at the end of the tunnel.

**Transcendence.** Transcendence is what comes to my mind when I think of John's way of being in the world, although I am not sure that transcendence fully encompasses it. John shared with me how spirituality keeps him whole, grounded, and connected. His meditation practice allows him to remain calm and to thrive in the midst of crises.

> I'm deeply spiritual, so I think it's just my—I got a sense of grounding within my spirituality and my meditation. It's just to learn to always be calm. And plus through studying martial arts . . . in any situation regardless of the situation, you have to remain calm in order to be effective. . . . Like I said, crisis things, it doesn't really affect me as far as making me lose balance. I'm always balanced. And I tell people that all the time— you gotta find your core, your inner self. So for me [I am] functioning from that inner place of tranquility.

It is through meditation practice that John began to understand himself and the world around him in a deeper sense. He learned a way of seeing and experiencing life to the fullest; he observes, experiences, embraces, and understands life. He sees the possibilities of every moment. John noted that meditation taught him how to accept and embrace the experience of life, including that which is uncomfortable and painful.

To me, life—and it's just for me—is really simple. Even though it can bring you a lot of different scenarios, whether they're good or bad, that's one of the things you learn in meditation. There's gonna be good and bad. So you don't assign anything to your experiences. That's what they are—experiences. So you're gonna have them. You're gonna be on this rollercoaster ride. Good things are gonna happen, bad things are gonna happen. . . . It's not the situation itself, it's how you're reacting to the situation that makes the difference.

John takes time to be with silence and recognizes that stillness is his way of being fully connected with the universe. Connecting with his inner core reenergizes him and allows him to remain centered and balanced. John's philosophy of life runs seamlessly through his actions and his being. It is clear that he brings his whole self into his work, and facilitates healing by sharing the peace and connectedness that he experiences in his own life. John's work flows from his internal state.

It's a place of bliss within yourself that's naturally there. You don't have to make it happen. You don't have to make it come about. It is what it is. It's already there. It's your very nature. But we don't know it because we've been busy with the outside world. So when you learn to turn within, you learn to go to your core if you wanna call it the center. They call it *atma*, self, or you can call it self-realization, spiritual realization, whatever you wanna call it. . . . You wanna discover yourself, who you really are. And once you go inside, you come to this place of stillness, of peace, and you just this perfect bliss and calm. So no matter what's going on in the outside world you function from that core. . . . So when people learn to meditate . . . they go inside and they start to have that peace and feel that joy and that bliss, and then what that does is it spills over into your life. It becomes a way of life.

**Curiosity.** John has a curiosity and wonder for life that keeps him engaged in crisis work. He has genuine curiosity for each client's story, and listens in a way that makes clients feel important, held, and cared for. John shared that he is intrigued by science and nature, and always loved learning, studying, and figuring things out. Crisis work is an excellent fit, as each call provides him with a new challenge and learning experience. John embraces life and is fascinated by it; this is evident in his interest in clients' lives and desire to understand and connect.

**Hope.** John shared with me that he firmly believes there is always hope; for every problem there is a possible solution. He remains hopeful even when clients cannot see a way out of their pain. John's ability to find hope in any situation speaks volumes of his resilience, faith, and understanding of life.

> So it does look like, say well, in their corner of the path it seems like it's hopeless. But you still have to tell people that there's no such thing as "there's no hope." Because you never know what's right around the corner.

## Reflection

John shared that working as a crisis line screener has been a truly rewarding and invaluable experience. John noted that he enjoys working with clients over the phone, and prefers this method of intervention now. As I spoke with John, it was clear to me that he is still passionate and excited about his work even after 17 years.

### *Changes in Perception and Growth*

John indicated that his understanding of a crisis has changed over time as he worked in crisis intervention. When he first started, John noted that he perceived a crisis to be a huge, life-changing experience, as that is what he would have personally considered a crisis. However, as he spoke with people who were having vastly different experiences, he learned that a crisis is really anything that is destabilizing to an individual. John's understanding of the subjectivity of crises allows him to be compassionate and nonjudgmental of clients' experiences.

> Like even working here, our definition of crisis is broad. So we can't dictate to the individual—I can't sit there and say, "That's not a crisis, get it together." For them it is a crisis. Because I look at—everybody's mentality and way of thinking, outlook about life is different, and just because I see it that way doesn't necessarily mean that they gonna see it that way.

*Exacerbating Events*

Before interviewing John, our world was hit with the COVID-19 pandemic. As a crisis line screener, John noted that he saw the ripple effects of the pandemic and was beginning to receive calls from clients in distress about the changes occurring. He observed that some people were having a hard time adjusting to lifestyle changes, as well as difficulty coping with the larger sense of unrest and uncertainty in society. John indicated that although he was observing significant suffering, he was also seeing people help each other and work collectively to cope with hardship. Rather than focusing on the suffering that was occurring, John was immediately able to identify hope in the midst of this global crisis.

> And I think that's the glimmer that we have in this, even though it's a very terrible thing that happened, people are dying and losing their lives, the good thing I hope to come out of this, is that we're changed—in our mentality, in our approach in life. That we see everybody, this world—cause we only have this earth. It belongs to all of us. And so we've got to learn to approach it from that—we need to love and help each other. . . . And I think, like I said, that's the glimmer in it; it changes people's hearts I hope.

John's perception of the current crisis is a true representation of his life philosophy. His appreciation for life in all of its forms allows him to see possibilities where others might not and to embrace crises with a growth mindset.

> And so I'm always, no matter what the situation is, I'm looking to grow from it. And they say that's the key to life. Whatever you go through, good or bad, if you put it in a positive light and you grow from that situation, you only gonna be stronger.

## Similarities and Differences Between Participants

Each participant had unique experiences and stories. This was anticipated, as they held different positions within the field of crisis intervention and played distinct roles in clients' treatment. Although their experiences varied, there were many similar themes woven throughout each story.

**Discovering Crisis Work**

One of the first commonalities I noticed was the fact that none of the participants had intended to go into crisis work. All of them stumbled upon their jobs and had not sought careers in crisis intervention. They were open to the new experience and discovered that their jobs were an excellent fit; they naturally flourished in their positions and thoroughly enjoyed their work. It was as though crisis work found them.

**Experiences as a Crisis Worker**

*The Phenomenology of Crises*

All participants broadly defined *crisis* as an emotional state in which a person is feeling overwhelmed and unable to cope with their resources available. They each asserted that a crisis is a very subjective experience, as it depends on a person's stress appraisal and ability to cope. All participants indicated that a crisis is a universal experience that each human will encounter at some point. John and Taylor both believed that thinking about suicide or wanting to die is also part of the human experience.

All participants shared their experiences working with clients in crisis who were experiencing suicidality, homicidality, loss, relational issues, and addictions. Aka differentiated between acute crisis and chronic crises, and observed that a crisis can either be short-term or persistent and longer lasting. Taylor pointed out differences in the experience of crises between adults and children, and explained that youth often have difficulty grasping the finality of suicide and the consequences of self-harm. Although John described similar characteristics of crises, he did not differentiate between types of crises. John seemed to conceptualize them as experiences that are so unique to each individual, that they cannot be categorized or defined without taking away from the phenomenology of the experience.

**Suicide and Homicide.** All participants indicated that suicide and homicide stem from similar experiences of emotional pain; however, suicide occurs when a person turns inward, and homicide occurs when a person turns outward. In this way, they conceptualized suicide and homicide to be on opposite ends of a spectrum. They all identified impulsivity as a risk factor for violent behaviors, whether directed toward the self or toward others. Aka also noted that homicidal behaviors can stem from antisocial personalities or the lack of empathy.

**Precipitating Factors.** The participants all observed that a crisis can be precipitated by significant events or changes, as well as an emotional state that becomes too much for an individual to endure. They indicated that a crisis can be caused by compounding emotions and unresolved issues. John added that crises can also be precipitated by the loss of something meaningful to a person, especially something that provides a sense of purpose. All participants agreed that a state of distress becomes a crisis when the suffering outstrips an individual's ability to cope.

**Mediating Factors.** All participants identified mental illness as a factor that can affect the outcome of a crisis. Mental illness alters an individual's perception and ability to cope, and can exacerbate a crisis. Aka shared that a person's mindset and perception of their crisis can either prolong healing or increase resilience. Taylor observed that lack of social support and substance abuse can amplify a crisis and increase risk for suicide. John also listed social support and substance abuse as a mediating variables. He noted that hopelessness is often a sign of suicide risk.

*Helping Clients in Crisis*

**Therapeutic Presence.** All participants identified therapeutic presence as most important and helpful for clients in crisis intervention. Therapeutic presence includes listening, being

nonjudgmental and accepting, validating clients' pain, and providing a container for clients to express emotions. Therapeutic presence conveys empathy, concern, and commitment to helping. All participants indicated that it can be healing for a client to feel heard and to feel that they are not alone in their suffering.

**Crisis Intervention.** Each participant's method of crisis intervention varied slightly, as they play different roles in the client's crisis. John's crisis intervention focused more on triage, securing clients' safety, and de-escalation, as he is the first one to talk to clients. Taylor's crisis mobile outreach concentrated on stabilizing clients and clarifying and reframing the problem. Aka's case management interventions were more goal-oriented and emphasized connecting clients to resources for further support. Although their roles in crisis intervention were different, all participants emphasized the importance of empowering clients, instilling hope, and helping clients to feel less stuck in their crisis. All participants also mentioned the idea that a crisis can lead to a person improving their situation and experiencing growth after the crisis. Aka and John perceived a crisis as an opportunity for growth; they both expressed that pain and hardship are necessary in order to create resilience and strength.

**Longevity and Job Resilience**

***Emotional Contagion and Letting Go***

All participants demonstrated the ability to be present with clients experiencing heightened distress without feeling personally affected, experiencing occupational stress, or feeling emotionally drained. Taylor and Aka described how focusing on the present moment with clients and being what the client needed helped them to maintain their own emotional stability. John and Aka both emphasized the importance of not personalizing what clients are going through or reacting strongly to their experiences; they were able to separate their own stories

from those of their clients. Taylor and Aka described how remaining task-oriented and creating structure was grounding for them and their clients. All participants shared that doing their absolute best to help clients allowed them to let go of cases. They understood their part in the client's crisis and recognized that they could only do so much; as long as they did whatever was in their power to help, there was no unfinished business.

*Challenges as a Crisis Worker*

Taylor shared that safety was one of the more challenging parts of her job. Taylor is an outreach worker who meets with clients in the community when they are in crisis; consequently, she is more likely to encounter safety concerns than Aka, who meets clients after the crisis mobile outreach has stabilized the client. Both Aka and Taylor shared concerns about the safety of their clients as well. John, on the other hand, did not have to worry about his own safety due to being a crisis line screener. However, the safety of clients was more concerning to him due to his inability to physically be there with clients or to assess them face-to-face.

*Characteristics of a Crisis Worker*

**Passion for Helping.** All participants expressed a genuine passion for helping others. Taylor stated that she loved her job because she enjoyed being able to help others choose life. Aka noted that her job was fulfilling and fed her, as it allowed her to be part of the solution and gave her a sense of purpose. John said that his job was rewarding and fulfilling because he had the opportunity to make a significant difference in a person's life.

**Thriving in Crises.** I was struck by the ways in which each participant seemed to flourish in the midst of crises. John remained centered and open to life experiences; he embraced suffering and saw the possibilities in every moment. Taylor and Aka enjoyed the unpredictability and variability that comes with crisis work, as it kept them interested and excited about their

work. Taylor loved being on the go and doing community outreach, while Aka loved the challenge of a novel situation and problem to solve. None of the participants seemed particularly affected or drained by crisis work, rather they found it energizing and compelling.

**Self-care.** All participants shared with me that they took self-care seriously and understood that they could not help others unless they took care of themselves first. John shared that his meditation practice kept him balanced and spiritually and mentally prepared for crisis work. Taylor noted that she enjoys recreational activities and spending time with her tight-knit family. Aka said that she was intentional about taking care of her physical, mental, and social health, as well as maintaining firm boundaries with others.

**Perseverance.** Another characteristic that I observed in each participant was the ability to persevere in crisis work. Aka persevered with clients through the ups and downs of their crises and continuously strove toward the goals they had set. John patiently stayed with clients as they explored their crises over the phone. Taylor persisted through the challenges that came with crisis work and her commitment to helping clients never waivered.

**Resilience and Hope.** Resilience and hopefulness were characteristics that all participants demonstrated. John and Aka both shared that they have learned to accept suffering as an inevitable part of life; they allow pain to be the teacher rather than the problem. All participants showed the ability to have hope when clients could not. They understood that pain was temporary, that crises eventually end, and that there was always some form of help or resources available to clients. The participants were able to see the light even in seemingly hopeless situations, and were able to instill this hope in their clients.

**Exacerbating Events**

The participants all had different experiences in working with clients through the COVID-19 pandemic. This is possibly due to the timing in which I interviewed the participants, as well as the varying degrees in which the pandemic directly affected their work. When I interviewed Taylor, the pandemic had just hit, and she was experiencing a lack of safety measures and personal protective equipment. Taylor expressed that she did not feel safe doing her job, and noticed that this was beginning to take a toll on her. John indicated that he was receiving calls from people who were having difficulty adjusting to the lockdown changes and coping with the sense of fear and unrest in society. Aka stated that she did not notice very many changes, and indicated that the crises her clients were facing were not caused by the pandemic, but possibly exacerbated by it. As I spoke with participants about the unfolding pandemic, it was clear that each participant was approaching this global crisis with the same patience and resilience that they have when working with clients in crisis. They expressed hope, understanding, and acceptance of the present experience, and reiterated their passion for helping others during this time.

CHAPTER V. DISCUSSION

**Discussion of Findings in Relation to Research Questions and Extant Literature**

The purpose of this study was to explore the phenomenology of a crisis from the perspective of a crisis intervention team, including a crisis line screener, a crisis mobile outreach therapist, and a crisis case manager. The goal was to understand the experience of a crisis, factors that optimize helping capacity, and how to support both crisis workers and individuals in crisis. This discussion will include an overview of findings in relation to the following research questions:

1.  How do crisis workers describe a mental health crisis?

2.  What is the crisis worker's experience of a crisis?

3.  How do crisis workers' perceptions of crises develop and evolve over time?

4.  How do crisis workers remain resilient while being present with a client, in the face of emotional contagion?

5.  What makes this work meaningful to the crisis therapist?

**The Phenomenology of Crises**

*Defining Crisis*

The experience of a crisis, while widely referred to in literature and practice, is not well developed in theory. There is no universal criteria for *crisis*, and researchers have varying definitions and understandings of a crisis. Efimova and colleagues (2015) meta-analyzed theoretical and empirical studies worldwide and concluded that the concept of a crisis is insufficiently developed in the theoretical literature and has no accurate dictionary definition.

Despite varying approaches to psychological crisis, Efimova et al. (2015) proposed that the universal criterion for a psychological crisis appears to be mental tension and situation

complexity. They argue that unsuccessful attempts to overcome an obstacle result in the growth of mental tension. A difficult situation includes a combination of objective (e.g., situational characteristics) and subjective characteristics (e.g., perceptions and attributive processes) that create an extremely negative emotional experience for an individual. A person's behavior in a crisis (e.g., constructive overcoming, change of attitude and values, suicide, self-injurious behavior, and deviant behavior) depends on the objective situational characteristics and subjective perceptions of the crisis. When an individual experiences the crisis state of mental tension and situation complexity, a full or partial transformation of one's identity may take place. In the case of teenagers, personality formation and world perception may also change. Efimova et al. assert that crisis is a crisis of life, a critical moment, and a landmark in one's life journey. Thus, the individual's life journey and personality is at the core of understanding crises.

In my discussions with the participants in this study, their definitions and understandings of crises supported the results of Efimova et al.'s meta-analysis. All participants broadly defined crisis as an emotional state in which an individual is feeling overwhelmed and in despair; this is similar to the concept of mental tension. The participants also noted that a defining characteristic of crisis was a feeling of being unable to overcome the hardship, whether it was a situation or a painful emotional experience. Participants shared that this was a subjective experience and dependent on an individual's stress appraisal and ability to cope, as two individuals can be in the same situation and yet only one might be in a state of crisis.

Efimova et al. proposed that in addition to mental tension, there must be situational complexity, which includes a combination of objective situational characteristics and subjective perception. All of the participants in this study emphasized the importance of the individual's unique experience, which includes an understanding of where the individual is in their life

journey. Taylor and John noted that their perception of a crisis shifted over the years as they saw the significance of subjectivity and perception in an individual's crisis. The participants' emphasis on phenomenology also mirrored Efimova et al.'s results.

**Mediating Factors.** Participants in this study also identified various behaviors that can occur in a crisis and noted that these behaviors are dependent on an individual's situation and perception. For example, they believed suicide and self-harm to be the internalization of pain, with homicide and aggression being the externalization of pain. Aka shared that the outcome of a crisis is significantly affected by an individual's perception, for example victim mentality can delay healing in a crisis. All participants acknowledged the potential for crises to result in constructive overcoming and positive changes in attitude, values, and resilience. These results are also consistent with Efimova et al.'s (2015) research, indicating that a person's behavior in a crisis depends on the objective situation and subjective perception of the crisis.

The participants in this study emphasized the role that perception plays in an individual's crisis. As Dulmus and Hilarski (2003) observed that in a crisis, an event or circumstance was not a stress, trauma, or crisis in and of itself; it was the individual's unique perception of the event that caused the individual to experience stress, trauma, or crisis. Dulmus and Hilarski asserted that stress, trauma, and crisis exist on a continuum. Individuals experience stress when the environment is appraised as taxing or exceeding their coping resources and endangering wellbeing. A stressful experience then becomes a trauma when there is a perceived physical or psychological injury that shatters one's worldview. Dalmus and Hilarski noted that at this point in the continuum, an individual may find healing or may progress to perceiving a trauma as a crisis. In the crisis state, there is instability and disorganization due to an unresolved acute or chronic perceived stress. All participants in this qualitative inquiry similarly noted that a crisis

state included instability, disorganization, or a disruption in previous functioning. Although participants did not explicitly describe stress, trauma, and crisis in the context of a continuum, they explained that a crisis is more than a state of stress—it was a state in which stress pushed the individual into a state of instability.

Taylor, John, and Aka all observed that personal characteristics influenced the interpretation of stress as a crisis. This notion was also supported by Dulmus and Hilarski (2003). Dulmus and Hilarski proposed that individuals who perceive that they are capable view the stress event as a challenge. On the other hand, those who view themselves as incapable focus on perceived incompetence, view the world as dangerous, and can overreact to the life event; this can lead the individual to perceiving the stress as trauma and subsequently crisis. Aka similarly observed that perceiving oneself as a victim is disempowering and can prolong healing in a crisis. She noted that clients who understand their pain as temporary usually fare better than clients who are fixated on their pain and cannot see past it. Aka also found that motivation and willingness to change impact the outcome of a crisis. For an individual to view a stress event as a challenge, it requires confidence in one's ability to adapt to the challenge.

Other mediating variables identified by the participants in this study include social support, resilience, mental illness, substance abuse, and hopelessness. John, Aka, and Taylor all highlighted the significance of social support during crises. John stated that social support gives a person hope and confidence that they can cope with their crisis and increases resilience. Dulmus and Hilarski (2003) also identify social support as a safeguard against stress and a predictor of increased life satisfaction and decreased depressive symptoms. John shared that hopelessness is often a sign of suicide risk, as it indicates that a person is in a state of deep despair and does not see a reason for going on. Hopelessness has been consistently identified as a

predictor of suicide in cognitive psychology research (Beck et al., 1989). Lastly, mental illness and substance abuse have also been consistently found to be risk factors for suicide due to the effects on impulse control and agitation levels (Nock et al., 2010).

**Acute and Chronic Crises.** An unexpected concept that emerged during this study was the differentiation between acute and chronic crises. Aka observed that crises can be sudden, caused by significant changes or events, and shorter in duration. She noted that crises can also be chronic and caused by an accumulation of deeper, unresolved issues. The difference between acute and chronic stress in the context of crises is an area in which extant literature is limited. Dulmus and Hilarski (2003) differentiated between acute and chronic stress, defining *acute stress* as involving an isolated event in one's life experience (e.g., car accident), and *chronic stress* as involving an ongoing cumulative effect situation (e.g., substance abuse).

Bryan et al. (2015) examined the effects of acute (recent onset) and chronic (persistent) life stressors on acutely suicidal US Army Soldiers. Their results showed that soldiers with a history of multiple suicide attempts reported the most severe suicide ideation and the greatest number of chronic stressors. Chronic stressors were correlated with severity of suicidal ideation, however acute stressors were not. This study suggested that chronic stressors are associated with more severe and persistent suicidal crises. Bryan et al.'s research highlights the difference between chronic and acute stressors in the context of crises. As Aka noted, chronic crises such as relational and addiction crises can lead a person to a state in which the pain feels unrelenting; this can progress into hopelessness, haplessness, and deep despair. Thus, it appears that chronic crises are experienced differently from acute crises. This is an area that warrants further research, as it has significant implications for crisis assessment and intervention.

*Post-traumatic Growth*

One of the prominent themes throughout my discussions with participants was their experience of crises as opportunities for growth and change. Taylor stated that crises can motivate individuals to seek help and improve their current situation. Aka and John shared the perspective that pain can be one of our greatest teachers, and it is the experience of adversity that creates resilience. The participants believed that crisis was not something to be eliminated or pathologized, but rather seen as a part of the human experience and an impetus for growth. There are opportunity in crisis, as suffering can lead people to reexamine their lives and come out of the crisis with greater clarity, confidence in their ability to cope with future crises, and a deeper understanding of themselves. This perspective is supported by research on post-traumatic growth in the context of crises.

Parikh and Morris (2011) suggested that a crisis has the potential to lead to adaptive or maladaptive end results. Individuals in a state of crisis can learn new coping strategies, increase interpersonal connectedness, increase personal agency, and become more flexible. When these new developments are applied to future situations, it can increase an individual's adaptability. Similarly, Albert's (2017) research study on positive self-transformation resulting from mental health crises demonstrated that when participants accepted their crises and integrated them into a positive self-concept, this led to improved relational, vocational, and self-care strategies.

*Suicide and Homicide*

Another concept that emerged during this study was the idea that suicide and homicide appear to be related in some ways. Taylor shared stories of providing outreach to suicidal clients who became homicidal toward her. Aka and John noted that suicide and self-harm appeared to involve the internalization of pain, whereas homicide and aggression often involved the

externalization of pain. All participants had stories of working with clients who projected their distress in the form of hostility or aggression.

Aka shared that she did not feel as knowledgeable about homicide. In fact, none of the participants received training on homicide other than screening for homicide as part of their safety assessments. What seemed apparent in their stories was that suicide and homicide are handled separately. Suicide crises were usually addressed by mental health professionals, whereas homicidal crises were mostly addressed by law enforcement. Interestingly, this appears to reflect contemporary theory that regards homicide and suicide as separate and independent phenomena stemming from distinct root causes.

Historically, however, both have been conceptualized as alternate expressions of the same underlying processes. This is consistent with the observations of the participants in this study. Within the integrated homicide-suicide theory, suicide and homicide are understood as two distinct channels in a single stream of lethal violence. Therefore, the direction in which internal pain is expressed is dependent on cultural and structural factors that affect how people attribute blame and responsibility (Batton, 2004). Contemporary literature on suicide and homicide focuses more on the relationship between the two in the context of murder-suicides. Additional research and training on the relationship between suicide and homicide in the context of mental health crises would be beneficial to the field of crisis intervention

***Longevity and Job Resilience***

One of the biggest questions I had going into this study was how the participants, who had all done crisis work for over 10 years were able to remain present with clients in crises and not experience emotional contagion, burnout, or compassion fatigue. Crisis work has a high turnover rate. It can involve high levels of occupational stress, as the crisis worker is servicing

vulnerable populations in a context which inevitably involves listening and repeatedly being exposed to an individual's pain and suffering. The crisis worker's experience is unique in that the client is most often in a state of heightened distress, disequilibrium, traumatization, and affective lability. The day-to-day exposure to clients in crisis and the distress they experience can become emotionally taxing. This may result in secondary traumatic stress, vicarious traumatization, compassion fatigue, and professional burnout (Newell & MacNeil, 2010).

All participants demonstrated the ability to be present with clients in crisis without feeling personally overwhelmed, experiencing occupational stress, or feeling emotionally drained. When asked how they were able to accomplish this so effortlessly, Aka and Taylor initially had some difficulty identifying any particular factor or skill to account for this resilience. John responded that he remained balanced through his spirituality and meditation practice. Some of the themes that emerged in conversations about occupational resilience include "focusing on the present," "not personalizing the client's experiences," "remaining task-oriented or creating structure," and "doing your best." In addition, there were similarities in characteristics of participants that I believe allowed them to flourish in their work. These characteristics included "a passion for service," "the ability to thrive in crises," "the prioritization of self-care," "perseverance," "resilience," and "hopefulness."

The participants' ability to work with clients in crisis and yet remain balanced and resilient echoed the results of Pietrantoni and Prati's study (2008) on first responder resilience. The researchers found that first responders experience a good level of job satisfaction and low levels of burnout and compassion fatigue; most first responders surveyed were not affected by traumatic stress or burnout syndrome despite exposure to critical incidents. The researchers concluded that first responders likely rely on personal and social resources (e.g., a sense of

belonging to the community in which they live and work, self-efficacy, and confidence in job-performance) in order to cope with occupational stress. In a similar study done with disaster behavioral health and emergency preparedness response professionals, Burnett and Wahl (2015) found that the majority of participants possessed adequate skills for adapting to change and managing adversity. Their findings suggested that resilience plays an important role in mediating the effects of compassion fatigue and burnout. It is possible that those drawn to first-responder positions have a natural resilience or ability to cope with this type of occupational stress. It is also possible that they have developed unique ways of flourishing in their jobs.

As a crisis worker myself, I was intrigued by the participants' initial difficulty identifying the factor or skill that contributed to their job resilience and longevity. During their member checks, I asked participants if they could name this factor. John stated that it was his preparation, mentally and spiritually, that allowed him to take on difficult tasks with calmness. His spiritual practice has prepared him to go into the crisis fully present, open, and mindful. Interestingly, Aka had a slightly different position from Taylor and John in that she was no longer actively doing crisis work at the time of her participation in this study. With a slightly removed position, Aka was able to reflect on her experiences with a new eye. In the first interview, Aka wondered if she had been "in denial" about the stressfulness of the job. When asked to elaborate on what she had referred to in the second interview as her experience of denial, Aka said that denial was maybe not the appropriate word, and she clarified that while she was involved in crisis work, she had been living in the moment, one day to the next, and did not perceive it to be stressful at the time. Aka reflected further on this during the member check and stated that it was a combination of detachment and denial that allowed her to remain resilient in her work.

> The two words that would occur to me are detachment and denial. I think I have a tendency, and I mentioned this to you earlier, that while being a crisis worker I would be asked many times by people, "Oh don't you find that so stressful?" I would say, "No, not really." And then after I no longer was in that position, I looked back and went, "Whoa, that was a stressful job" [laughs] and I had to think, why do you see it that way now but you didn't see it that way when you were in it? And I think that I am able to—to an element detach from crisis. And it's almost a rational thought of, if I buy into the crisis, like if I buy into having a lot of feelings about it, then how helpful am I gonna be to the person experiencing the crisis? Not very.

In qualitative research, we sometimes ask a question that may seem meaningless to participants. It is possible that asking a crisis worker what allows them to manage occupational stress is such a question. It appeared that this line of questioning flummoxed these three exemplary crisis workers. For John and Taylor, who were still active crisis workers, perceiving their job as stressful was not experienced as a possibility.

An interesting shift occurred during the study when Taylor shared her experiences of working conditions during the pandemic. She noted that the work was beginning to take a toll on her, and she admitted that she was starting to experience symptoms of burnout. However, during this conversation, Taylor immediately redirected her attention to her passion for helping others, and reiterated her love for her job. Perhaps, as Aka described, living in the moment and not overthinking or reacting to the challenging parts of crisis work are adaptive practices that shield the worker from burnout.

**Suffering and Flourishing.** Another striking characteristic that all participants exhibited was the ability to be present with another person who is experiencing great suffering. Suffering was accepted by participants as a part of the human experience. Aka and John noted that the goal should not be to eliminate suffering, but rather to allow it to occur and be a catalyst for change and growth. The state of crisis can be challenging due to the high levels of emotional distress and problems that are not immediately solvable. As John explained, sometimes all a crisis worker can

do is provide empathy and hope, especially with clients who are trying to cope with gridlock problems or roadblocks. The participants in this study demonstrated that in order to excel as a crisis worker, one must be able to persevere with a client who is experiencing deep suffering and create a holding space for clients to express and work through their pain.

The concept of accepting suffering is very powerful. It is also somewhat problematic from a clinical psychology perspective. In a profession that aims to alleviate suffering, is it always beneficial to alleviate suffering and should that be the treatment goal? As the participants in this study observed, the goal for many clients in crisis was to end the overwhelming pain; this goal often leads clients to consider suicide or harmful ways of coping in order to alleviate the emotional experience of suffering. However, in the context of a crisis, it appears that providing a container for clients to express emotions while showing empathy and therapeutic presence is most helpful. Although discussing coping strategies to alleviate distress is part of crisis intervention, it is not necessarily the most important piece, nor is it most helpful. The participants in this study understood that allowing clients to experience and sort out their feelings lead to the discovery of new insights, catharsis, and increased confidence in their ability to tolerate and cope with distress. Hall et al. (2010) proposed that suffering is not something to get rid of or to be pursued for its own sake, rather it can be understood as a marker for disordered living, a means of cultivating character, and an opportunity to reorient the client's worldview. Suffering can cultivate a flourishing life.

In clinical psychology, suffering is often discussed in a context of alleviating or reducing the severity of pain. For example, some interventions aim to change feelings, thoughts, and behaviors so that the severity of the painful emotional state is reduced and the person returns to baseline functioning. However, if the goal is to lessen the suffering, we could potentially limit

clients' healing and growth processes, and even hinder their ability to flourish. In contrast, the facilitation of clients' acceptance of suffering as part of their narrative and transformation of negative life events into meaningful opportunities for growth may promote healing (Hall et al., 2010).

### *Exacerbating Events*

The participants in this study were in a unique position at the time of the interviews, as they were working in the context of a global crisis. The COVID-19 pandemic was beginning to affect daily life, and clients were reporting an increase in symptoms due to difficulty adjusting to changes and uncertainty about the future. Although the participants did not see clients in crisis solely because of the pandemic, it appeared that the pandemic was exacerbating preexisting issues.

The pandemic is a good example of the ways in which crises are not simply intrapsychic, for there are environmental influences and overlapping variables that affect the experience of crises. Emile Durkheim (1897) was the first to conceptualize suicide as a phenomenon that arises from social and environmental factors. He proposed that when individuals experience changes in their roles in society, it can lead to uncertainty, confusion, and feelings of alienation. During past epidemiological tragedies, such as the Ebola outbreak, studies have shown that the number of people whose mental health was affected tended to be greater than the number of people affected by the infection. In fact, mental health implications can last longer and have greater prevalence than an epidemic itself (Reardon, 2015), and it is very possible that we will see similar repercussions of the COVID-19 pandemic.

*Meaning and Fulfillment*

All participants in this study expressed a genuine passion for helping others. They found meaning and fulfillment in their work, as it gave them the opportunity to make a significant impact on a person's life, to help others choose life, and to be part of the solution. The way in which these participants flourish and find meaning in the midst of crises reflects their resilience and fit for crisis work. The findings of this study suggested that exemplary crisis workers are models of resilience, as they were able to create meaning and opportunity out of crises both with clients and in their own lives.

## Clinical Implications of the Study

The findings of this study have clinical implications for mental health providers, crisis workers, and those who train, hire, and support crisis workers. First, the results of this study emphasize the importance of phenomenology, or the individual experience, of crises. Although there may be a desire to rush or simplify exploration of client narratives in the case of crises, the individual's experience and life journey must be considered when assessing and intervening. Emphasizing phenomenology respects the diversity of client experiences. In crisis intervention, the focus should be on understanding the individual's inner world and unique affective experience. This can help providers prioritize therapeutic presence, which the participants in this study identified as most helpful to clients in crisis. Therapeutic presence encourages the acceptance of human suffering rather than attempting to alleviate it. By allowing clients in crisis to explore their experiences before trying to problem solve, providers can facilitate clients' development of insight, meaning, and confidence in their ability to cope with suffering. Genuine interpersonal connection is protective against suicide. It builds trust (allowing the provider to get an accurate safety assessment) and instills hope. Suicidal crises should also be viewed as a

common phenomenon experienced by individuals rather than pathologizing it. In the same way, providers can help an individual understand suicidal thoughts as a sign for wanting change, assist clients in problem clarification and reframing, and help clients to feel less stuck in their crises. The goal for crisis intervention should be to help clients create meaning out of their crisis and allow it to be an opportunity for positive change and growth.

I argue that crisis intervention should not occur only in the context of crisis work. Mental health providers such as psychologists and therapists work with clients who will inevitably experience crises at some point. Although crisis intervention is often executed by paraprofessionals, it is an area in which mental health providers also should be competent, especially due to the potential for danger in crises. Crisis intervention is a unique and difficult art. Crisis intervention training is unfortunately limited in many professional training programs, however it is an area that necessitates thorough training and understanding. Not understanding the phenomenology of crises when intervening can have serious consequences even with good intentions. As previously discussed, allowing clients to express and sort through their suffering and pain is an important part of helping clients to move through the process of healing. If we cut this process short and rush to discuss safety planning and coping strategies, we convey discomfort with crises and miss out on an opportunity to utilize the crisis as a catalyst for growth. Part of training for mental health providers may include increasing their own tolerance for sitting with suffering and addressing countertransference issues that arise when working with people in crisis. For example, it is necessary that clinicians do their own self-examination of how they think about death. If we fear living in that we cannot accept that death is a part of it, we cannot provide clients the space to fully explore suicidal crises. Fear of death, existential issues, or

judgments about suicide can lead a clinician to ask the wrong questions or focus on symptoms rather than the deeper problem that is driving the crisis.

The findings in this study also illuminated the differences between chronic and acute crises. As previously discussed, chronic and acute crises appear to be experienced differently and have varying outcomes. Acute crises may have a more accessible window for intervention, whereas it can be challenging to instill hope in individuals who have been experiencing persistent suffering, are fatigued, alienated, and struggle to understand or create meaning out of their crises. It is therefore possible that certain intervention strategies would be more helpful depending on the type of crisis.

The results of this study highlighted the importance of comprehensive training and hiring processes in preventing high turnover and burnout rates in crisis work. As discussed by two of the participants, lack of employer support was a significant issue affecting job satisfaction and got in the way of them being able to do their job. In a high burnout field, employer support is critical. The participants described employer support as including a feeling that one's needs are being recognized and actively addressed. Additionally, the results of this study indicated that there might be characteristics and skill sets that allow people to excel as crisis workers. Some of the characteristics that emerged in this study included a passion for service, the ability to thrive in crises, the prioritization of self-care, perseverance, resilience, and hopefulness. Focusing on the present, not personalizing client's experiences, remaining task-oriented or creating structure, and doing your best were some of the strategies that contributed to participants' longevity in crisis work. These are strategies that might be included in training, and characteristics that can aid in the hiring process.

Finally, the results indicated the presence of a factor or characteristic that allowed crisis workers to remain resilient in the face of emotional contagion. My hypothesis is that processing or reacting to crises sometimes may not be beneficial or productive for crisis workers. It appears to have been adaptive for the participants to focus on the present or the task at hand, taking one day at a time, and not overthinking or reacting to the challenging aspects of crisis work. It was also helpful for participants to prepare mentally, spiritually, and physically (using meditation, spiritual practices, and self-care strategies), so that they were able to remain present at work and not invest an emotional reaction to clients' crises. In contemporary psychology, the processing of trauma is often recommended as best practices; however, it is possible that in the case of first responders and crisis workers, the lack of processing protects them from burnout or emotional contagion. This has important implications for supporting crisis workers, first responders, or those who encounter stressful experiences or events on the job, and are required to persevere through these challenges. The practice of extensive psychological debriefing could potentially be counterproductive for some individuals working through crises.

### Limitations of the Study

There are inherent limitations in this study due to the small sample size. Although participants held various roles within the field of crisis intervention, this qualitative inquiry explored a phenomenon experienced within a small population with one methodology, using selected methods. Consequently, this may affect the analytical generalizability and transferability of the study's thematic findings. At the same time, studying the phenomenology of crises in depth within a small sample size promoted theoretical saturation of data, and served the purpose of informing future studies and the development of theory.

Due to the interruption caused by the pandemic, I was unable to conduct in-person interviews for all of the participants and my method of interviewing was inconsistent both between and within participant meetings. As a result, I may have missed out on non-verbal information that could have further informed my understanding of their stories by eliciting more or different questions than the ones I asked. The depth of information gathered also may not have been consistent from interview to interview, and this may have affected the reliability of the study.

Additionally, despite efforts to enhance trustworthiness and transferability (e.g., peer debriefing, peer examination, and addressing biases), the final narrative is heavily dependent on my own interpretations and analyses of the data collected. As stated before, my position as a crisis therapist inevitably affected my interpretation and analysis of the data collected and may have unintentionally affected results. Therefore, the transferability of thematic findings may be limited by the methodology of this study. On the other hand, my role as a crisis therapist also may have been advantageous, as it allowed me to better understand the participants' experiences and provide a basis for my research questions.

**Recommendations for Future Studies**

The findings in this study raised the question of whether there was an "it factor" that might characterize the essence of an exemplary crisis worker, or if there are skills and characteristics that could be developed through training and experience. Future studies could expand sampling to include more individuals working in crisis intervention and in each position within crisis work (e.g., crisis mobile outreach, crisis case management, and crisis line screener). With replication, one might provide a more comprehensive understanding of factors that optimize helping capacity and occupational resilience in the field. Crisis workers have much to

teach us about resilience and crises, and a qualitative inquiry would be a fitting method of research due to the depth and breadth of information that could be obtained by exploring a participant's experiences. Further replication and expansion in future qualitative inquiries would contribute to a more robust understanding of the phenomenology of crises and the ways in which crises are experienced by crisis workers.

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# Chaminade University

March 8, 2020

Protocol Number:     CUH 122 2020

Protocol Title:       The Phenomenology of Crises: A Qualitative Inquiry
Type of Review:      Form III – Full committee review

Dear Dr. Tanji and Courtney Sen,

The CUH IRB IRB00007927 reviewed the above research.

The CUH IRB IRB00007927 **APPROVED** the above research.

The Board was able to determine under 45 CFR 46.110(b)(1) that the research does constitute human subjects research.

The Board was able to determine under 45 CFR 46.110(b)(1) that the research meets the criteria for full review, which was completed and ratified at a meeting of the IRB on February 6th 2020.

The Board deferred action at the February 6th 2020 meeting pending responses to stipulations. Adequate responses were received on March 3rd 2020, and the Board subsequently ratified the decision to approve.

| | |
|---|---|
| Date of IRB Approval: | March 8th 2020 |
| Date of IRB Approval Expiration: | March 8th 2023 |
| DUE DATE OF ANNUAL/FINAL REPORT | March 8th 2021, 2022, 2023 |
| Determination Category: | Human Subjects Research |

If applicable, informed consent (and HIPAA research authorization) must be obtained from subjects or their legally authorized representatives and documented prior to research involvement. The IRB-approved consent form and process must be used. Changes in the research (e.g., recruitment procedures, advertisements, enrollment numbers, etc.) or informed consent process must be approved by the IRB before they are implemented (except where necessary to eliminate apparent immediate hazards to subjects).

Approval will be valid for **three years** from the date of IRB review when approval is granted or modifications are required. The approval will no longer be in effect on the date listed above as the IRB expiration date. A Form IV Annual/Final Report is due annually on the dates specified. A

final report must be provided to the IRB and all records relating to the research (including signed consent forms) must be retained and available for audit for at least 3 years after the research has ended.

**The faculty PI (Dr.Tanji) is responsible for all reporting (annual, final, adverse event) and for data/records storage and security for the required 3-year period).**

It is the responsibility of all investigators and research staff to promptly report to the IRB any serious, unexpected and related adverse events and potential unanticipated problems involving risks to subjects or others.

Annual report and final report forms are available form the IRB Chair or via the CUH Portal and IRB Website.

Please feel free to contact the IRB above with any questions or concerns.

Kind Regards,

Claire Wright, PhD
Chair, Chaminade IRB Committee

**Appendix B**

**THE PHENOMENOLOGY OF CRISES**

Hawaiʻi School of Professional Psychology at Chaminade University of Honolulu

**INITIAL CONSENT FOR PARTICIPATION IN RESEARCH**

1. *Who are the researchers?* My name is Courtney Sen and I am a student at the Hawaiʻi School of Professional Psychology at Chaminade University of Honolulu. I am conducting this study in partial fulfillment of my requirements for the degree of Doctor of Psychology, in Clinical Psychology.

2. *What is the aim of the study?* The aim of this qualitative research study is to explore the experience of crises from the perspective of crisis workers, the experiences they have had at different times in their work with crises cases, and their thoughts about these experiences. The ultimate aim of this study is to help me understand more about your experiences and what they have meant to you.

3. *How was I chosen?* You have been chosen because of your longevity in the field of crisis intervention and suicide prevention. I believe you have valuable insights to offer that will provide a deeper understanding of crises.

4. *What will be involved in participating?* Your participation in this study is completely voluntary. If you participate in this research, I would like to schedule three interviews with you and one meeting toward the end of the study to see whether I have captured your experiences accurately. The interviews will last between an hour to an hour-and-a-half. During our meetings, I would like to explore the experiences that you have had in the field of crisis intervention and suicide prevention. With your permission, I would like to audiotape our conversations and make transcriptions of the tapes, so that I may attempt to represent your perspectives with greater accuracy. I would also like to take notes to help me better organize my thoughts and understand what was shared. Our interviews will take place in a location that is quiet and private, as well as centrally located to you for your convenience. Before our last meeting, I would like to review your transcripts with you and my understanding of what you have shared with me. During our last meeting, you will have the opportunity to add, remove, or adjust the write-up to make it more accurate. To ensure that I understand what you have shared, I will take notes and then allow you to review the edited draft. A final informed consent and release of information procedure will be provided at the end of the study.

5. *Who will know what I say?* In addition to me, members of my support team will have limited access to your password-protected transcripts/audio recordings in order to assist me. My support team includes my clinical research committee chair and primary peer

debriefer and peer examiner, Joy M. Tanji, Ph.D.; and my clinical research committee member, Robert Anderson, Ph.D. The role of the committee is to oversee this process, ensuring that I am doing things ethically and with methodological rigor. The role of my debriefer is to help me tell your story with as much accuracy as possible. The role of my peer examiner is to check my analysis of our conversations. The role of my committee chair and member is to oversee this process and provide me with further instructional support. I will undertake the role of the transcriptionist and will be auditing or checking the accuracy of the transcriptions against the audiotapes.

6. *What are the potential risks associated with participation?* Although I do not foresee any major risks to you, talking about your experiences may bring up some unexpected memories and insights that can be upsetting. The remembrance and experience of intense feelings associated with critical experiences may be painful and unresolved. Should this happen, I would like to stop the interview, turn off the tape recorder, and take time off the record to better understand what is coming up for you. Then, I would like to support you in deciding what may be the most helpful way to address these concerns. This might include taking a break and then completing our conversation, ending the interview for the day and returning to complete it later, or withdrawing from the study; your welfare, above all else, is important to me. Whatever we discuss off the record will not be included in the study. In the event that you may need more emotional support, I will encourage you to speak with your mental health provider or to utilize the community resource list I will provide along with this initial informed consent form.

During the study, I will attempt to protect not only your confidentiality (what you said) but also your anonymity (who you are). Since this is a small community, though, there is always the possible risk that despite my best efforts, someone who reads the study may be able to figure out who you are and be able to link what you have shared during the study with you. To minimize this risk, your name will not appear on any transcripts or in my write-up; rather, I will allow you to select your own pseudonym. You will also be interviewed in a private location of your choice, unaffiliated with your or my employers. In addition, when not in use, I will store the password-protected recordings and transcripts of our conversations in a locked filing cabinet or locked file box to which only I have the key. My research committee members will only have access to these materials when performing their duties described above. In my journal entries and discussions with them, I will not refer to you by name. Finally, you will be given the chance to review and edit all materials before and after the final write-up; during this time you may remove, reword, or add to any data that is sensitive in nature.

Your confidentiality will be protected at all times, as the law requires, with the following exception: I am required by law to inform an appropriate other person if there is reasonable suspicion that a child, elder, or dependent adult has been abused by you, or if there is reason to believe that you are at risk of imminent harm to yourself and/or others.

My intent would be to ensure your safety and the safety of others by networking you to resources that could support you through current challenges.

7. *What are the potential benefits of participation?* Sometimes people find participating in a focused conversation to be beneficial insofar as it gives them a chance to talk about things that matter to them. I hope the same will be true for you as well, and I hope that due to our common backgrounds in crisis work, it will be a fulfilling conversation for both of us.

8. *What are my rights as a respondent?* You may ask any questions regarding the study, and I will attempt to answer them fully. You may withdraw from the study at any time without fear of negative consequences with me, the members of my team, or Chaminade University. Again, your participation is voluntary. If at any time you would like to speak off the record, you may turn off the tape recorder, then turn the tape recorder back on only when you feel ready. Anything we discuss during this time will not be entered into the data unless you discuss them on the record at a later date. You may waive any question you do not wish to answer. You may also defer and answer the question at a later date. You have the right to review my work at any point in the process. After I have generated a narrative of what you have shared with me during the study, I will give you an opportunity to add, revise, and remove material you believe does not accurately represent your experiences.

   After I have completed the requirements for my clinical research project, I am required by the Institutional Review Board of Chaminade University to securely store the digital audio recordings, transcripts, and analysis of our conversations together for three years so that I may respond to queries about my research. On July 31, 2023 I will shred the paper documents that are associated with the study and permanently erase the digital audio recordings of our conversations.

9. *What will be published or presented anywhere?* This study will be published and may be presented in public. As mentioned above, I would like to review the narrative write-up of my findings with you during our last meeting. At that time, I will ask for your permission to use certain quotes from our conversations to illustrate your experiences more clearly to others. You have the right to review these materials and decide which quotes you will allow me to include in my final write-up. You may also reword, add to, or decline my use of these quotes.

10. *If I want more information, who can I contact about the study?* If at any point in the study, you have questions about my study, you may contact me at (808) 489-2345. This study has been approved by the Institutional Review Board of Chaminade University. If you have questions about your rights as a participant, you can contact the chair of the Institutional Review Board at Chaminade University, Claire Wright, Ph.D., at irb@chaminade.edu. Any concerns you may have about my work with you or your rights

as a participant may be directed to my clinical research project chair. Her contact information follows:

> Joy Tanji, Ph.D.
> Hawaiʻi School of Professional Psychology at Chaminade University of Honolulu
> 3140 Waialae Avenue, Honolulu, HI 96816
> Office: (808) 739-7428
> Email: joy.tanji@chaminade.edu

-----------------------------------------------------------------------------------------------------------

By written notification to Courtney Sen, below, I indicate that I am 18 years or older. I also indicate that the information presented in this document has been reviewed and explained to my satisfaction, but that this procedure does not preclude me from seeking further clarification of items in the future. I understand the nature and intent of this study. I also understand my rights and what is being asked of me as a participant. I understand all of the above and provisionally agree to the conditions specified. I understand that I will be given an opportunity to complete this informed consent procedure at the completion of my participation – after I have had a chance to review the materials I have provided for this study. This will allow me to make any corrections, changes, or additions to the study's portrayal of my experiences. I understand that I still maintain the right to revoke this consent at any time during the study without cause.


_____
*Participant, please print name*


_____          _____
*Participant, please sign name*                                    *Date*



_____
*Interviewer, please print name*


_____          _____
*Interviewer, please sign name*                                    *Date*

**Appendix C**

**THE PHENOMENOLOGY OF CRISIS**
Clinical Research Project
Hawaiʻi School of Professional Psychology at Chaminade University of Honolulu

**Final Informed Consent and Release of Information Form**

I, _____, hereby authorize Courtney Sen to submit the following
          (*participant*)
information, collected in the course of my participation in the study indicated above, in partial
fulfillment of her requirements for the Doctor of Psychology degree in Clinical Psychology,
through the Hawaiʻi School of Professional Psychology at Chaminade University. I hereby
indicate that I have made the necessary corrections, additions, and retractions to my interview
transcripts, and have reviewed the narrative and/or analysis of my story for accuracy.

I hereby authorize the use of these materials as part of Courtney Sen's Clinical Research Project.
I also authorize the use of the highlighted quotes in the final write-up to illustrate the
perspectives/themes they are being used to represent.

My signature, below, indicates that I am 18 years or older. It indicates that the nature and intent
of the study, as well as my rights as a participant, have been reviewed, again, so that I may
refresh my memory of the issues reviewed in the original informed consent procedure. I am
aware that I may still withdraw from the study and withdraw the information I have shared as a
participant at any time without cause or negative consequences from the researcher and/or
Chaminade University. I understand the material reviewed and agree to the conditions specified
now that I know what I am specifically contributing to the study. I understand that the final write
up of this study, including the materials I have reviewed and given my consent to use, will be
published and may be presented in public. I have been informed that the audiotapes, transcripts,
and analysis for this project will be maintained until June 30, 2023 or three years past the
completion of the requirements for Courtney Sen's Clinical Research Project. I have been
informed that with the exception of the final write-up of the findings of this study, on July 31,
2023, the paper documents associated with the study will be shredded and the digital audio
recordings will be permanently erased.

_____
*Participant, please print name*

_____          _____
*Participant, please sign name*                                              *Date*

_____
*Interviewer, please print name*

_____          _____
*Interviewer, please sign name*                                              *Date*

**Appendix D**

**THE PHENOMENOLOGY OF CRISES**
Clinical Research Project
Hawai'i School of Professional Psychology at Chaminade University of Honolulu

**Community Resource List for Oahu, Hawai'i**

As a researcher, one of my top priorities is your welfare and the welfare of others. I encourage you to maintain communication with your own mental health provider or treatment team, and contact them should the need arise.

     In the case I, _____, experience psychological distress during this
<div align="center">(Participant)</div>
study,

     \_\_\_\_\_ I currently have a mental health provider I maintain communication with,
       regularly see, and have immediate access to.
     \_\_\_\_\_ I currently do not have a mental health provider, but had one previously and can
       return to that provider as needed.
     \_\_\_\_\_ I currently do not have a mental health provider.

Below, I also have compiled a list of mental health centers with multiple providers and services, as well as a 24-hour crisis line should you experience any feelings of distress, whether due to your participation in this study or not.

## Mental Health Centers:

**Kalihi-Palama Community**
**Mental Health Center**
1700 Lanakila Ave
Honolulu, HI 96817
808-832-5770

**Mental Health Kokua**
1221 Kapiolani Blvd
Honolulu, HI 96814
(808) 737-2523

**North Shore Mental Health**
46-001 Kamehameha Hwy # 213
Kaneohe, HI 96744
(808) 235-1599

**Windward Community Mental Health**
45-691 Keaahala Rd
Kaneohe, HI 96744
(808) 233-3775

**Waianae Coast Comprehensive**
**Health Center**
86-260 Farrington Highway
Waianae, HI 96792
(808) 697-3300

**Waimanalo Health Center**
41-1347 Kalanianaole Hwy
Waimanalo, HI 96795
(808) 259-6449

**Crisis Line:**
You may call the 24-hour Access line at (808) 832-3100 on Oahu or toll free at 1-(800) 753-6879 for support. They are open 24 hours a day, seven days a week.

My signature, below, indicates that I understand in the event that I feel distressed, I will be encouraged to maintain communication with my current mental health provider. In the case where I do not have a mental health provider to reach, I acknowledge that I have received and may use the Community Resource List provided, above.

_____
*Participant, please print name*

_____          _____
*Participant, please sign name*                                    *Date*

_____
*Interviewer, please print name*

_____          _____
*Interviewer, please sign name*                                   *Date*

**Appendix E**

**THE PHENOMENOLOGY OF CRISES**
Clinical Research Project
Hawaiʻi School of Professional Psychology at Chaminade University of Honolulu

**Participant Information File Form**

| | |
|---|---|
| **PARTICIPANT'S NAME** | |
| **PHONE NUMBER** | |
| **EMAIL ADDRESS** | |
| **PSEUDONYM** (A PSEUDONYM WILL BE USED IN REPLACEMENT TO YOUR NAME TO PROTECT YOUR IDENTITY THROUGHOUT THIS PROCESS) | |
| **PLEASE INDICATE YOUR PREFERRED METHOD OF CONTACT WITH ME** | **PHONE** <br><br> **E-MAIL** |

**Appendix F**

**THE PHENOMENOLOGY OF CRISES**
Clinical Research Project
Hawai'i School of Professional Psychology at Chaminade University of Honolulu

**Emergency Contact Information**

As a researcher, one of my top priorities is your welfare. I would like to obtain the phone number of an emergency contact person who might be reached in case of an emergency. I will only contact this individual in the event that you are sick, or unable to contact them yourself. The nature of our relationship and your participation in this study will be kept confidential.

I, _____ will allow Courtney Sen to contact the named emergency contact
       (Participant)
person at the phone number provided, written below, in case of an emergency.

**Emergency Contact Name:** _____
                                   (First and Last)
**Relationship:** _____

**Phone Number: (_____) _____ - _____**


_____
*Participant, please print name*


_____      _____
*Participant, please sign name*                    *Date*


_____
*Interviewer, please print name*


_____      _____
*Interviewer, please sign name*                *Date*

**Appendix G**

**THE PHENOMENOLOGY OF CRISES**
Clinical Research Project
Hawai'i School of Professional Psychology at Chaminade University of Honolulu

## Scripts for Audio Recordings

I plan to use the following scripts for turning the recorder on (begin the session) and off (end the session) to give the participant clear notification each time. It is also a courtesy so that the participant can mentally prepare him or herself for the interview process to begin and end.

**Turning Recorder On**

RESEARCHER: "Hi _____. Thank you so much for taking the time to talk with me today. Our meeting today will be about one to one-and-a-half hours long with breaks as needed. Let's go ahead and get started. Are you ready for me to begin recording our conversation today?"

PARTICIPANT: *(Verbal approval of participant.)*

RESEARCHER: "Okay, great. Just as a reminder, I want you to know that if you feel the need to speak off the record that you may do so at any time and without negative consequences. Please stop the recorder or let me know whenever you'd like to speak off the record. At that time, I will stop the recorder and only begin recording again once you are ready to do so. I will now press record and we can begin."

*(Press record and begin.)*

**Taking Breaks**

PARTICIPANT: States he/she would like to take a break.

RESEARCHER: "Okay, that's not a problem. I'm going to turn off the recorder now. Let me know when you're ready to resume and we can continue at that time."

**Off-the-Record Discussions**

PARTICIPANT: States he/she would like to speak off the record.

RESEARCHER: "Okay, that's no problem at all. I'm going to turn off the recorder now, and I want to remind you that whatever you share with me off record will not be part of the study unless you share the same information with me later on the record."

*(Turn off the recorder. Attend to off record discussion, and ensure safety and wellbeing of participant. Utilize the Community Resource List should the participant be experiencing feelings of distress beyond the scope of processing*

*through conversation with the researcher, and consider taking a break or discontinuing for the day, depending on issues that have come up.)*

**If the Participant Shares He/She Is Ready to Begin Recording Again**

RESEARCHER: "Okay, so it sounds like you are ready to begin recording again?"

PARTICIPANT: *(Verbal approval of participant.)*

RESEARCHER: "I am going to press record on the recorder and we can begin again."

*(Press record and begin.)*

**Concluding an Interview for the Day/Turning Recorder Off**

RESEARCHER: "Okay _____.  Thank you so much for sharing your story with me today, and for being part of my study.  I think we did some wonderful work for today, and are now at the time to be finished.  Are you ready for me to stop recording?"

PARTICIPANT: *(Verbal approval of participant.)*

RESEARCHER: "Ok, I'm going to stop the recorder for the day. Thank you again."

*(Press stop.)*

**Appendix H**

**THE PHENOMENOLOGY OF CRISES**
Clinical Research Project
Hawai'i School of Professional Psychology at Chaminade University of Honolulu

**Confidentiality Agreement for Transcriptionist**

As a researcher, one of my priorities is to uphold and protect the confidentiality of the participant in my study. The nature of the information in the audiotapes/transcripts may be personal and sensitive and must be kept confidential in order to protect the privacy of the participant. By signing this agreement, the transcriptionist acknowledges the importance of protecting the participant's confidentiality and agrees to protect the information contained in the audiotapes/transcripts, including the identity of the participant. The limits of confidentiality extend throughout the duration of the study and even after the study has been completed.

I, _____, have accepted the responsibilities of transcribing
                  (*Transcriptionist*)
audiotapes for Courtney Sen's research project. I understand that these recordings/transcripts contain personal and confidential information. The researcher, Courtney Sen, has instructed me that she will transport and deliver all audio recordings, transcripts, and project drafts for my review in password-protected data storage unit (USB flash drive) kept in a locked box.

By signing below, I agree and understand that:

1. Data will include only digital audio and transcripts of recordings. No hard copies of any kind are authorized to be produced.

2. Data will be worked from an encrypted, password-protected flash drive which only I (and the researcher, Courtney Sen) will know the password.

3. Keys to the locked box will be kept by the person in possession of the data directly on their person or locked securely somewhere only he/she has access.

4. Transcripts of the audio recordings will be saved onto the password-protected USB (electronic storage unit) provided by the researcher. I will not store any data on my hard drive.

5. Data stored on a password protected USB will be transported securely in a locked box provided by the researcher to which only the researcher and I have the key.

6. When not in use, the data (e.g., password-protected USB, audio recordings) will be stored securely in the locked box provided by the researcher, and locked in a filing cabinet.

7. Passwords will be communicated by the researcher to me (the transcriptionist) in a separate e-mail or in person.

8. I am responsible for keeping the participant's identity and data confidential and secure during and after the conclusion of the study. I will not discuss the contents of the interview with anyone but the researcher, Courtney Sen.

My signature, below, indicates that the information presented in this document has been reviewed and explained to me to my satisfaction. I have read the terms and conditions of confidentiality listed in this document. By signing this agreement, I agree to protect the identity of the participant(s) in the study. I also agree to keep all documents, audiotapes, and transcripts secure, and agree to protect the personal and sensitive information contained in these materials.

_____
*Transcriptionist, please print name*

_____          _____
*Transcriptionist's Signature*                                          *Date*

_____
*Researcher, please print name*

_____          _____
*Researcher's Signature*                                               *Date*

**Appendix I**

**THE PHENOMENOLOGY OF CRISES**
Clinical Research Project
Hawai'i School of Professional Psychology at Chaminade University of Honolulu

**Confidentiality Agreement for Debriefer/Peer Examiner/Auditor**

As a researcher, one of my priorities is to uphold and protect the confidentiality of the participant in my study. The information contained in the audio recordings and transcripts of interviews conducted in this study may be sensitive in nature and personal, and must be kept confidential in order to protect the privacy of the participant. By signing this agreement, the Debriefer/Peer Examiner/Auditor acknowledges the importance of protecting the participant's confidentiality and agrees to protect the information contained in the conversations, audiotapes, and transcripts, including the identity of the participant. The limits of confidentiality extend throughout the duration of the study and even after the study has been completed.

I, _____, have accepted the responsibilities of reviewing and
       *(Debriefer/Peer Examiner/Auditor)*
discussing transcriptions and audiotapes as a part of the research support team for Courtney Sen's clinical research project. I understand that these tapes and transcripts, and the discussions I will have with the principal investigator will contain personal and confidential information. I understand that during the course of the study, I will be provided with limited access to research materials in order to help me provide appropriate feedback and support to the principal investigator. While in my possession, I accept responsibility for keeping the password-protected documents provided by the principal investigator, Courtney Sen, protected and secure. When in my possession, I agree that when not in use, I will keep the audiotapes and transcripts being reviewed stored in a locked box in a locked filing cabinet to which only I have the key. I will not release these research materials to, and will not discuss their contents with, anyone other than the researcher, Courtney Sen. No copies of the transcripts or discussions will be retained by me during or after the study. I understand the importance of keeping all discussions, audio recordings, and transcripts secure and confidential.

I have read the terms and conditions of confidentiality listed in this document. By signing this agreement, I agree to protect the identity of the participant(s) in the study. I also agree to keep all documents, audiotapes, and transcripts secure, and agree to protect the personal and sensitive information contained in these materials.

_____
*Debriefer/Peer Examiner/Auditor, please print name*

_____     _____
*Debriefer/Peer Examiner/Auditor's Signature*           *Date*

Page 1 of 2 _____ Initials _____ Date

_____
*Researcher, please print name*

_____          _____
*Researcher's Signature*                                                    *Date*

**Appendix J**

**Integrated Coding List**

**Core Code: Embracing the Journey of Life**

**Taylor: Passion for Service**

The Journey Begins
Experiences as a Crisis Worker
  The Phenomenology of Crises
    Suicidal Crises
    Homicidal Crises
    Relational Crises
    Addiction Crises
  Precipitating Factors
  Helping Clients in Crisis
    Therapeutic Presence
    Safety
    Crisis Intervention
      Sequencing the Narrative
      Listening for Poignancy
      Clarifying and Reframing the Problem
      Assessing for Resources Available
      Providing Resources and Referrals
  Mediating Factors
Longevity and Job Resilience
  Emotional Contagion and Letting Go
    Stay Present
    Stay Task-Oriented
    Do Your Best
Characteristics of a Crisis Worker
  Passion for Helping Others
  Thriving in the Crisis
  Self-Care
Reflection
  Changes in Perception and Growth
  Challenges as a Crisis Worker
    Exacerbating Events

**Aka: Embracing the Present**

Unfolding the Next Adventure
Experiences as a Crisis Worker
  The Phenomenology of Crises
    Acute Crises
      Suicidal Crises

**John: Embracing Life**

                Suicidality
                Homicidality
                Loss
                Addictions
        Precipitating Factors
        Mediating Factors
        Helping Clients in Crisis
                Therapeutic Presence
                        Safety
                        De-escalation and Grounding
                        Assessing and Securing
                        Building Rapport
                Crisis Intervention
                        Listening for Poignancy
                        Clarifying and Reframing the Problem
                        Assessing Need and Providing Resources
                        Empowering and Instilling Hope
                Post-traumatic Growth
                Unique Aspects of Telephone Interventions
Longevity and Job Resilience
        Emotional Contagion and Letting Go
                Do Not Personalize It
                Do Your Best
Characteristics of a Crisis Worker
        Passion for Helping Others
        Perseverance and Patience
        Quick Thinking
        Self-Care
        Resilience
                Pain Is the Teacher
                        Shared Experiences
                Transcendence
                Curiosity
                Hope
Reflection
        Changes in Perception and Growth
        Exacerbating Events