Maintaining Safety While Discussing Suicide: Trauma Informed Research in an Online Focus Groups

Donna Epp¹, Kyrra Rauch², Candice Waddell-Henowitch³, Kimberly D. Ryan³, Rachel V. Herron⁴, Andrea E. Thomson³, Sharran Mullins³, and Doug Ramsey⁴

Abstract
Although trauma informed (TI) care has been well researched and is used in many disciplines, TI practices for research are less developed. In this article, we explore the use of TI practices when discussing the sensitive topic of suicide within an online focus group. Qualitative studies on rural suicide are sparse, even though the incidence of suicide is higher rurally than in urban areas. Rural communities are often close knit and stigma can be greater toward non-normative experiences such as mental illness and suicide. Due to the nature of rural communities, the trauma of suicide can affect many people. We conducted focus groups with rural community participants who had an interest in suicide prevention to explore the gaps in rural suicide research and the best methods for knowledge dissemination of existing research. Steps were taken to mitigate re-traumatization and/or severe distress in the participants through a TI research approach. An online video conferencing platform became necessary due to the COVID-19 pandemic. The online features promoted safety and transparency by: enabling participants to turn off camera and microphone if they became distressed, allowing them time to self-regulate until feeling sufficiently safe to return to the focus group discussion; leaving the discussion at any time with little disruption; and being able to choose a comfortable place to join the discussion. Other TI activities included ensuring ongoing consent throughout the process, recruiting through a third party to enhance safety, having support resource lists tailored to the region, and encouraging participants to share and debrief final thoughts. A number of participants commented on feeling safe within the environment of the focus group. Limitations included challenges identifying distress online and technological difficulties associated with rural internet services. To our knowledge, this is the first article using a TI approach for discussing suicide through an online method.

Keywords
committee based research, focus groups, methods in qualitative inquiry, qualitative evaluation, virtual environments

Introduction
Rural communities suffer from a higher number of deaths per capita by suicide than do their urban counterparts (Hirsch, 2006; Hirsch & Cukrowicz, 2014; Singh et al., 2012). Men living rurally are at a particularly high risk (Creighton et al., 2017; Hirsch & Cukrowicz, 2014), and certain rural occupations such as farming have been linked to increased suicides (Roy & Tremblay, 2015; Roy et al., 2013, 2017; Sturgeon & Morrissette, 2010). Often there is stigma around discussing suicide within rural environments, which complicates help seeking behaviours as well as limits support for those affected.

Such stigma can be internalized (i.e., the desire to not be seen as weak), and/or external (i.e., reluctance to seek treatment as

¹Faculty of Health Studies, Brandon University, Brandon, MB, Canada
²Brandon University, Brandon, MB, Canada
³Department of Psychiatric Nursing, Brandon University, Brandon, MB, Canada
⁴Department of Geography and Environment, Brandon University, Brandon, MB, Canada

Corresponding Author:
Rachel V. Herron, Geography and Environment, Brandon University, 270 18th Street, Brandon, MB R7A 4X8, Canada.
Email: herronrv@brandonu.ca

Creative Commons Non Commercial CC BY-NC: This article is distributed under the terms of the Creative Commons Attribution-NonCommercial 4.0 License (https://creativecommons.org/licenses/by-nc/4.0/) which permits non-commercial use, reproduction and distribution of the work without further permission provided the original work is attributed as specified on the SAGE and Open Access pages (https://us.sagepub.com/en-us/nam/open-access-at-sage).
the treatment would not be perceived as anonymous in a rural community) (Barry et al., 2020; Creighton et al., 2017a; Roy et al., 2013; Zaheer et al., 2011). For example, hegemonic masculinity in rural communities can promote qualities of stoicism, toughness and independence (Creighton et al., 2017a, 2017b; Roy et al., 2017); resulting in men not wanting to show any divergence from the norm (e.g., mental illness, depression, sexual difference) (Creighton et al., 2017a, 2017b).

However, stigma does not just occur with rural men. Higher levels of community cohesion in rural places can also lead to stigma towards those who do not fit into the social norm (e.g., mental illness) (Barry et al., 2020; Creighton et al., 2017a; Zaheer et al., 2011). Youth are affected as well by this stigma, not wanting to seek treatment because they believe their anonymity would not be maintained (Armstrong, 2011). Higher incidences of suicide and greater stigmatization within rural communities create a compelling need for research into rural suicide with a focus on understanding community perspectives.

The impacts of suicide are profound for individuals and communities, and the stigma associated with talking about the phenomenon may increase the risk of re-traumatization. Cerel et al. (2019) found those individuals exposed to suicide were much more likely to experience depression and anxiety; he also noted that “exposure to suicide is pervasive and occurs beyond family” (p. 100). Due to the nature of small communities, (i.e., everyone knows everyone) the trauma of suicide can have a community impact (Maple & Sanford, 2020). Those who are “bereaved by suicide” can include “family, friends, neighbors, classmates, patients, and co-workers” (Cerel et al., 2013, p. 413). Cerel et al. (2013) describes these as suicide survivors – someone who is “personally affected by suicide” (p. 416). According to a statistical estimate in the United States, each suicide results in 135 people who are exposed to that suicide (Cerel et al., 2019), which emphasizes the large number of people who may need support after exposure. Recognizing the trauma that suicide or suicide attempts can cause makes it imperative to consider a trauma informed (TI) research approach to any qualitative study that includes suicide as a topic for discussion. A TI research approach includes recognized strategies that assist the researcher to systematically plan for sensitivity in all aspects of the research process. The specific aim is to prevent re-traumatization or undue distress for the participant (Isobel, 2021).

An abundance of research investigating rural suicide currently exists; however, the number of qualitative studies is limited (Gibson et al., 2013; Rauch et al., 2022). Such paucity might be due to the challenges associated with conducting qualitative inquiry when research participants are at increased vulnerability for experiencing distress (Biddle et al., 2013; Gibson et al., 2013). In the Canadian context, the Tri Council Policy Statement for Ethical Conduct for Research Involving Humans (Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council, 2018) suggests that vulnerable groups “may need to be afforded special attention in order to be treated justly in research” (p. 8).

Although trauma-related research can lead to low or moderate distress if done carefully, Jaffe et al. (2015) highlighted the importance of taking measures to mitigate distress. The safety of participants in a focus group tends the fine line between “overprotective gate keeping” (Biddle et al., 2013, p. 356) and TI research (Isobel, 2021). Biddle et al. (2013) suggests that individuals can actually derive benefit from participating in research about their trauma and thus should not be left out of research participation. On the other hand, TI research recognizes the need for sensitivity in all aspects of the research process, including recruitment, consent, data collection, analysis and dissemination (Isobel, 2021). Due to the pervasiveness of suicide exposure in rural communities and the potential for trauma when discussing this emotionally charged subject, it is important to consider ways to protect participants from further trauma.

The study we undertook examined existing research about suicide in rural communities, followed by qualitative focus groups held across Canada with rural community participants who had an interest in suicide prevention. The COVID-19 pandemic along with the public health orders in Canada limiting in-person gatherings and travel dictated that we shift from conducting focus groups in person to conducting focus groups online (Marhefka et al., 2020) causing challenges that were not originally considered. There is limited research available that discusses maintaining safety within an online focus group setting. However, using this method of data collection for a sensitive topic requires careful consideration of how TI methods can be applied. In this article, we present the strategies used to promote research participants’ safety during online video conference mediated focus groups held to discuss suicide and suicide related issues. Although participants were asked about research related to suicide and not their own experience of suicide, we were cognizant that personal stories might be shared within the group. In the upcoming sections, we describe: current literature about TI approaches to research, our method, the challenges and strengths of promoting the safety of the participants within this study, and finally, situate our findings within what is currently known about maintaining research participant safety using a TI research approach.

Literature Review

Trauma informed research. Trauma occurs when an experience overwhelms a person’s ability to cope and includes both the event and the response to the event (Nonomura et al., 2020). This can be a singular event or a series of events experienced physically and/or emotionally (SAMHSA, 2014). Trauma can result from a spectrum of experiences including war, natural disasters, abuse, neglect, to witnessing violence, betrayal, and
relational dynamics and can vary in intensity from one person to the next (Isobel, 2021; Nonomura et al., 2020; SAMHSA, 2014). Suicidal behaviors are traumatizing experiences because they threaten “physical integrity and life” (Quijada et al., 2021, p. 580) and death by suicide is traumatizing for the survivors (Hibberd et al., 2010).

For the past 30 years TI care has evolved and been used in a variety of settings including mental health, substance abuse, child welfare, education and justice (Campbell et al., 2019; Wilson et al., 2013). Substance Abuse and Mental Health Services Administration (SAMHSA(2)) (2014) outlines the key assumptions of TI practices: realize the effect of trauma and possible paths for recovery, recognize the signs and symptoms of trauma, respond by integrating knowledge about trauma into practice, and resist re-traumatization (p. 9).

Using a TI lens in conducting research has only recently become more common. Jefferson et al. (2021) completed a scoping review detailing recommendations for TI research and concluded that trauma research is not “inherently harmful” but there is no gold standard for conducting TI research (p. 2). However, several authors have taken up the notion of TI research as an approach to preventing distress and re-traumatization (Campbell et al., 2019; Isobel, 2021; Nonomura et al., 2020; Voith et al., 2020). Isobel (2021) and Voith et al. (2020) provide frameworks for TI qualitative research; Isobel (2021) focuses on using a TI approach for mental health nurse researchers and Voith et al. (2020) examines research from a social work perspective when working with marginalized populations. Although the frameworks differ somewhat, they both pose a practical set of questions a researcher can ask prior, during and post study to determine if the study is applying a TI approach. These do not replace ethical guidelines or rigour in research but provide a TI framework to apply to decision making during each step of the research process (Isobel, 2021).

Initially, to stay true to TI, consideration must be given in the planning stage to why the research is being undertaken and whom it may benefit. Isobel (2021) suggests that collecting stories for educational purposes or for the development of an internal report can potentially violate the trust of the participants. Research should be linked to potential outcomes or actions. The researcher needs to examine their own motivation – is it “legitimate enquiry or curiosity” (Isobel, 2021, p. 1461).

The next step of a research project includes vetting the project through a research ethics committee (REC) or board. RECs have been described as “paternalistic and overprotective” when it comes to vulnerable populations (Lakeman & Fitzgerald, 2009, p. 13), sometimes resulting in a disempowering of participants by assuming vulnerability (Isobel, 2021). Newman et al. (2006) state that “evidence to date suggests that although survivors of traumatic events may indeed require special consideration and care, as a class they do not appear to meet the definition for a vulnerable group” (p. 38). Nevertheless, RECs are “charged with weighing the benefits and burdens of a research proposal” (Gibson et al., 2013, p. 18) and with foreseeing the “subjective responses of the participants” to determine risk, which is not an exact science (Gibson et al., 2013, p. 25). Gibson et al. (2013) suggest that a method of ensuring better decision making within an ethics committee would be to include research participants in the decision. Newman et al. (2006) suggest that the researcher can use “common sense, clinical judgement, prior experience, imagined personal substitution with the participant, and multi-disciplinary consultation” when making research process decisions (p. 30). However, they also caution that biases and assumptions may color these decisions. Researcher experience is second best and including a lived experience participant in the REC discussions and planning is described as beneficial to foster input into decisions that concern participant safety/interests.

Considerations of safety in recruitment, along with transparency of the process and shared power with the participants, were listed as important in the methodological frameworks reviewed (Isobel, 2021; Voith et al., 2020). Having a third party involved in recruiting has a number of advantages including: preventing the appearance of coercion by the researcher, having access to potential participants, and identifying suitable participants for the study (Nonomura et al., 2020). However, the third party can sometimes be coercive, intentionally or unintentionally. The participant may feel obligated to participate to support the person who contacted them (Nonomura et al., 2020). This can be prevented by clear communication with the third party that includes a written agreement, regular meetings and ongoing communication beyond the meetings (Nonomura et al., 2020).

In terms of safety for the participants, much of the onus is on consent. Newman et al. (2006) point out that it is important in the consent to suggest that a minority of the participants may experience distress, but also that, in past studies, participants have found the research beneficial and did not express regret in participating, even when experiencing distress. A danger exits that RECs and researchers may disempower individuals by assuming vulnerability and not respecting their agency to choose (Isobel, 2021). Abu-Rus et al. (2019) and Burrows et al. (2013) found that an abundance of potential risks listed in a consent form led to increased distress by the participants, described as the nocebo effect - risks listed are experienced due to the suggestion of risk. Voith et al. (2020) and Isobel (2021) emphasize ensuring the participant’s control during the consent process, exploring what elements might threaten safety and balancing those with empowerment, and promoting the transparency of the process (Isobel, 2021; Voith et al., 2020). It was also noted that distress cannot necessarily be predicted by the participant and thus, consent must be ongoing (Nonomura et al., 2020).

During the data collection phase, the TI approach promotes safety for the participant by ensuring the participant retains power over their words and actions (Isobel, 2021). The comfort of the participant is paramount and anything the researcher can do to promote comfort should be taken into
In this article, we contribute to the growing body of research focusing on TI approaches. Our question is - What TI strategies can be used to mitigate distress when speaking about the sensitive topic of suicide through an online medium?

Method

The overarching goal of our research project was to engage individuals in rural communities with current research on rural suicide in Canada to: identify gaps in research, suggest areas for new research, and identify effective dissemination strategies to turn research into action. Conducting focus groups with stakeholders enabled us to present the findings of a Canadian scoping review to those most invested and hear their diverse perspective on what rural communities and people with lived experience of suicide need. The focus group was chosen because the method can generate rich discussion about meanings, values and priorities among a group. The group effect can promote a deeper understanding for both participants and researchers as each individual builds on the thoughts of others; however, groups also involve special considerations to promote safety.

Promoting participant safety was prominent in all aspects of the research project. The following describes the steps that were taken to promote safety during the study design and the planning/delivery of the focus groups. We also provide participant feedback on the safety and the process of the study. This feedback was unsolicited but emerged as an important theme across all groups.

Study Design

Recognizing that the pandemic precluded face to face focus groups, a literature search was completed on how to run synchronous online focus groups as well as how to accumulate asynchronous feedback through online methods. The pros and cons of each were weighed and a decision was made to use synchronous focus groups through ZOOM™, an online platform. One strength of this platform was the ability to break the larger group into smaller groups, allowing for more intimate conversation among participants (Grabham, 2020). The ability to record and transcribe the meetings directly through the platform was another essential element in the decision process. The online platform provided a venue for people to take time out of their day without having to travel to a central location, and an opportunity for participants to choose their setting – many joined from their home, some from their workplace, and one farmer joined from his tractor.

Study Recruitment

Focus groups were conducted with individuals from six Canadian provinces (British Columbia, Alberta, Saskatchewan, Manitoba, Ontario, and Newfoundland). Determining
the appropriate individuals to participate in the focus groups was a multi-step process. Research investigators identified potential provincial key contacts through personal connections, professional associates and web searches (i.e., suicide support groups, suicide prevention groups, mental health organizations such as the Canadian Mental Health Association). These key contacts were provided information about the research project via email from the lead researcher. Key contacts then invited potential stakeholders/research participants from their local communities. Potential stakeholders were known to the key contact as engaged community members involved with suicide prevention or those who had lived experience with suicide. Interested stakeholders contacted the research team directly and were provided with the consent form, question guide, a local resource list, and a recommendations report created based on the scoping review.

Planning and Delivering Focus Groups

The intent of focus group questions was to generate participant reflection about current research investigating suicidality in rural communities. Since all participants were rural and invested in the subject, they were in a unique position to answer these questions. In an effort to mitigate the risk of re-traumatization experiences by participants, all questions were purposefully constructed to be future or action orientated (see Table 1), focusing on the presentation that was shared and what could be learned and acted upon in future research.

We were aware that a number, perhaps all, of the potential participants would have a lived experience related to suicide. We also recognized that no matter how the questions were worded, some participants might wish to share personal experiences, which, in turn, might lead to distress. We worked closely with each organizing agency to develop local support resource lists, which were supplied to the participants before, during and after the interviews. Although resource sheets are a common practice within research protocols, often they are not tailored to the area of the study, or they are not adequately detailed (Nonomura et al., 2020). Thus, each group had a list of resources that were accessible and relevant to their geographical area. Unanticipated events can and do occur though and have to be managed ‘in the moment’. To mitigate the possibility of the ‘in the moment’ scenarios, we ran a practice session and discussed possible situations prior to the actual focus groups.

A number of Registered Psychiatric Nurses were involved in the project as co-investigators. Researchers as a group discussed the role of these professionals in supporting the participants should they experience distress. Dickson-Swift et al. (2006) identified the issue of blurring boundaries between researcher and counselor and concludes that those boundary issues should be addressed in the planning stage of the project. Thus, it was decided that the researchers would not operate in dual roles (i.e. researcher and counsellor). Alternatively, the participants were asked to identify a support person they could talk to and were given time within the session to write down the name and contact information of that person. The participants were then reminded of that support several times during the session, along with the resource list. Lastly, one member of the research team always remained outside of the breakout room; participants were reminded that if they felt distress they could leave the breakout room and join that individual in the main room. This person was equipped with the resource sheet for the geographical area. The aim of this approach was to provide participants with support as well as the control to manage their own experiences (Newman et al., 2006).

Data Collection

The structure of the focus group discussion was consistent in all groups, although the time that it took for each group varied. All groups were scheduled for 2.5 h but the actual time ranged from 1 h 20 min to 2.5 h. Each consultation included informed consent, welcome and introductions, a brief background on the project, an overview of the research collected in the scoping review on rural suicide in Canada, discussion sessions, and concluded with a full group debrief. Attendance at consultations ranged from four to 10 people. Small group sizes were important to ensure that every participant had an opportunity to speak and develop some comfort with the other participants in the group.

Participants were provided with the consent form prior to attending and the consent form was read at the beginning of the consultation. Participants were provided opportunity to leave the online forum if they were not in agreement with the consent process and were told that by remaining on the consultation, they were providing consent. The breakout sessions focused on four questions (see Table 1) that expanded on the research presentation and explored ideas for future action. Breakout sessions were allotted 1 h, although some did not require the full hour. The number of breakout rooms depended on the number of stakeholders in attendance; each small group discussion had four to eight participants, so larger

| Table 1. Breakout Session Discussion Questions. |
|------------------------------------------------|
| 1. Of the information presented, tell us what is new to you? |
| 2. What research (information or questions) is needed to address suicide in rural and remote communities? |
| 3. What would be the best way to get this information out to you and others in your area? |
| 4. How could you take this information and turn it into action? Or, alternatively, who could turn this information into action? |
focus groups needed more breakout rooms. Throughout the focus groups different modes of communication were employed (i.e., large group discussions, small group discussions, development of written lists, annotations to determine priorities). Afterwards, all stakeholders came together for a final round table where stakeholders expressed the most significant thing they heard or discussed and any final comments they wanted to make. Shortly after each consultation, stakeholders were sent a $20.00 Amazon e-gift card as a thank-you for participating.

**Transcription and Analysis**

The consultations were audio-visually recorded. Upon completion of a consultation, the recordings were transcribed. Initially, recordings were sent to a transcription service, who abide by a strict confidentiality policy. The remainder of the transcripts were run through NVivo (QSR International, 2021) software and verified by the research assistant. The research assistant also changed all stakeholders’ names to provide anonymity.

Coding was conducted using Nvivo software. The first transcript was coded by the whole research team and a baseline codebook was developed. From then on, each transcript was coded by two members of the research team - the research assistant, who acted as the consistent coder, and one other researcher. An updated codebook was provided to each researcher prior to their coding session.

**Ethical Considerations**

This project was approved by a University Research Ethics Committee. Stakeholders were provided with the consent form prior to the focus group and it was read at the start of each consultation. As expressed in the consent form, by attending the consultations stakeholders gave informed and ongoing consent. A resource list of community supports was provided prior to and during each consultation that was specific to resources in that province.

**Results**

**Stakeholder Demographics**

Forty-seven stakeholders participated in the consultations from the six provinces. Seventy-six percent of participants identified as women and 88% identified as Caucasian. The majority of participants were ‘middle aged’ falling between 45 and 64 years of age. The participants were highly educated with 72% having a university certificate or degree at the bachelor level or above and 83% having at least some university or college education. The majority of stakeholders (59%) resided in a community of less than 10,000, the authors’ working definition of ‘rural’ based on existing literature (Burrows et al., 2013; Carlisle et al., 2012; Grigoriadis et al., 2017; Poon & Saewyc, 2009) and those who resided in a community of greater than 10,000 either

| Participant demographics | Total participants* n(%) |
|--------------------------|--------------------------|
| **Age (years)**          |                          |
| 25–34                    | 4 (8.7)                  |
| 35–44                    | 10 (21.7)                |
| 45–54                    | 15 (32.6)                |
| 55–64                    | 14 (30.4)                |
| 65–74                    | 3 (6.5)                  |
| **Gender**               |                          |
| Woman                    | 35 (76.1)                |
| Man                      | 10 (21.7)                |
| Prefer not to say        | 1 (2.2)                  |
| **Level of education**   |                          |
| College or other non-university certificate or diploma | 4 (8.7) |
| Some college or university | 5 (10.9)                |
| University certificate or diploma below bachelor level | 4 (8.7) |
| University certificate, diploma, or degree at bachelor level or above | 33 (71.7) |
| **Community size**       |                          |
| Less than 10,000         | 27 (58.7)                |
| Greater than 10,000      | 19 (41.3)                |
| **Lived experience of suicide** |          |
| Yes                      | 33 (71.7)                |
| No                       | 13 (28.3)                |

Note. *n = 46, 1 participant did not complete the demographic questionnaire.

The empirical findings of the study are elsewhere (Rauch et al., 2022).
provided service to rural communities or were involved in organizations interested in mental health and wellbeing in rural communities. See Table 2 for a breakdown of demographics.

Stakeholders had a variety of occupations/affiliations including: being an engaged community member, or community leader; being a service provider/working in the public health sphere; being engaged in education, research, or other related fields; and most predominately, having a lived experience of suicide. Lived experience was defined as either having attempted suicide or been close to someone who had attempted or completed suicide; 72% of stakeholders responded they had lived experience.

Feedback From Participants

Although participants were not specifically asked about feelings of safety, experiences emerged in the process of inductive thematic coding. During the first focus group, one participant left early in the discussion. She emailed us later to explain:

My entire life has been lived in the shadow of suicide. I’ve lost too many family members to mental illness, addiction and suicide so that now I find it extremely difficult to speak about this topic as casually and analytically as was being done on yesterday’s call. (Clara, MB)

As a research team, we reflected on how to share research about suicide, often written for an academic audience, with participants who have lived experience of suicide. Following this feedback and through further email discussion with this participant we added the following slide to the opening presentation:

We recognize that the research does not reflect your personal, professional, or lived experiences with suicide and while it may come across as academic at times, we do acknowledge the sensitivity and impacts of the topic. Everyone will be touched by suicide at some point in their lives, including members of our research team. This conversation may bring up emotions and memories that could be upsetting so please engage in the self-care you need and reach out for supports as necessary.

We then provided a link in the chat to a resource list that had been customized to the area where the participant lived.

In the following focus groups, the only participants who left did so because of another commitment or an unstable internet connection. However, we did no measure of distress, so are unable to determine the distress of those remaining on the call. In subsequent focus groups, a number of participants indicated that they felt safe to share. Ava, from British Columbia stated:

I wanted to thank the facilitators for providing a safe space and allowing folks the vulnerability to speak what they’re feeling. I feel that it was safe. I wasn’t afraid to, you know, comment and I really respect the folks out there who have lived experience and shared that with us. It’s not easy to be vulnerable. But this is this is definitely a first step in the recognition of the importance of mental health. And so I just wanted to sort of put my hands up to, to the folks on the call today for allowing the safe space. Thank you. (Ava, BC)

Nicole, from Newfoundland felt the space was nonjudgmental, which allowed the participants to not feel distressed when talking about suicide:

And we in our group, we were talking about how to make the space nonjudgmental. So, we – I truly believe we kind of participated in a way to nonjudgmental conversation today. (Nicole, Newfoundland)

Participants felt appreciated; that an opportunity to talk about suicide research and next steps provided them with hope for the future. For example, Bridget from Newfoundland stated they were not sure this forum would be for them, but they were really happy they had come. Additionally, Norm from Ontario stated:

I’m just thrilled that we’re having a conversation and that we’re continuing the conversation and that people of like minds have gotten together to try and further what all of us are kind of doing in our own little bubbles. And to know that there’s other people working on it is really heart-warming.

Discussion

Talking about suicide is challenging. Societal views of suicide are often enmeshed in a culture where the subject is avoided. This can be amplified in rural communities, as there is an acknowledged stigma toward mental illness and/or help seeking. However, learning about the experience of those with present or past suicidal ideation and/or those who have lost a person or people to suicide enhances understanding, informs future practice, guides prevention efforts, generates effective interventions, and, most importantly, gives voice to those with lived experience (Biddle et al., 2013; Gibson et al., 2013; Lakeman & Fitzgerald, 2009; Legerski & Bunnell, 2010; Quijada et al., 2021).

A TI approach to research requires the researcher be sensitive in the consent, recruitment, data collection, analysis and dissemination phases. As very little is known about maintaining safety within online focus groups the importance of implementing trauma-informed methods was especially important. Table 3 reiterates the recognized the TI strategies employed during this project.

Although many of the strategies employed above are hallmarks of any good qualitative research, a TI approach provides a trauma informed lens for doing research. The possibility of lifetime trauma is high in the general population,
Table 3. TI Strategies.

| Recognized TI strategies                                      | Strategies employed                                                                                                                                                                                                                                                                                                                                 |
|---------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Planning                                                      | Have a person with lived experience participate in planning -One researcher within the team that was able to provide a survivor’s perspective during all of the planning, as they had lost someone close to them through suicide.                                                                                             |
| Recruitment                                                   | Maintain transparency through the recruitment process -A third party, not in a position of power, did the initial contact. For the most part, we were able to involve organizations that did not offer clinical interventions such as self-help groups and suicide prevention organizations, preventing overlap between therapy and research and preventing a power dynamic. |
| Promoting safety within the focus group                       | Maintain participant safety by promoting autonomy through ongoing consent and realistic descriptions of confidentiality and anonymity -Recognizing that distress cannot necessarily be anticipated by the participant, we provided the consent form before the project, read it aloud prior to beginning the focus groups and reminded participants several times that they could turn their screen and microphone off and step away from the conversation for moments or drop from the conversation altogether. - Procedures were put in place to maintain anonymity and confidentiality within the group, but it was acknowledged that by being within a small group, anonymity and confidentiality can be encouraged but not guaranteed. |
| Develop other protocols that promote safety                   | A number of protocols for safety during data collection were instituted (e.g., a local support resource list; having the participants write down the name and contact information of a support person they could contact; reminding the participants that they could leave at any time, or turn off their microphone and camera and take a break to self-regulate). -All of the researchers were skilled facilitators and took care to be sensitive to participants’ need to share or step back from the conversation. -All breakout rooms had a facilitator and a recorder, both researchers, which allowed for two sets of eyes and ears to be sensitive to potential distress. -Many of the researchers are psychiatric nurses, well versed in TI care. A psychiatric nurse was present in each breakout room. -A practice session prior to the start of the focus groups was held to discuss potential safety issues and ways to mitigate them. -There was constant contact amongst the researchers to debrief and discuss any changes to protocols to enhance safety. |
| Provide a safe physical environment                            | The participants chose their own environment. There were a number of positives to this – participants did not have to travel, could leave anytime without any disturbance and could choose the environment in which they were comfortable.                                                                                           |
| Allow participants to share final thoughts, not specific to a question | We concluded with an opportunity for the participants to share the most important thing they heard during the focus group as a conclusion to the session.                                                                                                                                                                                                 |
| Analysis                                                      | Reflexivity -Staying true to TI in analysis included reflexivity throughout the entire research process that was grounded and guided by participant voices. -We adapted our approach based on participant feedback and our analytic codes centred on the words of participants.                                                                                                                                                  |
and higher still when participants have a vested interest in a traumatizing subject (Isobel, 2021). Thus, there is a need to be sensitive to the possibility of trauma in all aspects of the research, and the TI approach provides the framework for that sensitivity. The increasing use of the term TI research in academic research acknowledges that this is an important quality of responsible trauma research, and provides further information for researchers to be consider when utilizing these methods purposefully. We found no qualitative study that specifically spoke to a TI research approach.

As noted, the TI research approach is in its infancy, but is becoming more recognized as tools are being developed to assist researchers in employing the approach. Resources for future researchers include the Isobel (2021) and Voith et al. (2020) frameworks and the Nonomura et al. (2020) recommendations module on trauma informed research. Future researchers have the ability to train researchers on the TI method from the inception of the project using these resources.

However, we were able to support and implement a TI approach through the psychiatric nurses involved in the project with expertise in TI care. Although the TI approach was intrinsically used in this project, this paper has provided an opportunity for the researchers to review the project based on newer frameworks and TI research recommendations. A number of the recommendations were adhered to, making this an example of a TI research approach.

Our purpose for this paper was to explore the use of TI approach in research using online focus groups. The online medium provided some challenges, but overall was well received by participants and researchers. Several attributes of the online medium enhanced the ability to be TI sensitive (e.g., enabling participants to turn off camera and microphone if they became distressed, allowing them time to self-regulate until feeling sufficiently safe to return to the focus group discussion; leaving the discussion at any time with little disruption; and being able to choose a comfortable place to join the discussion). However, as Isobel (2021) states “a TI lens is relative to all forms of research” and much of the TI approach used during this project could be transferred to in person focus groups. In fact, all of the TI frameworks reviewed were designed for in person interviews, but transferred well to the focus group method.

Researcher Safety

Protocols are needed to promote researcher safety as the subject of suicide has the potential to cause distress for the researcher. Thus, having an opportunity to debrief with a mentor should be a component of the research protocol. In our case, the research assistants involved with the project were debriefed by an experienced psychiatric nurse while doing the literature review. This debrief occurred multiple times during the research project and allowed for conversation around difficult feelings and thoughts arising from the literature and the focus group comments. Normalizing difficult emotions and providing mentorship to discuss these emotions is often used in trauma-informed research to provide support and minimize distress of research assistants. As well, one researcher had a close family member who had died by suicide. This individual chose to be involved with the literature search and not the focus groups to protect their own lived experience; this choice was supported by the remaining research partners.

Limitations

We found it challenging with an online platform to see body language in the same way as in person focus groups. It was difficult to have all participants on screen at the same time and only faces filled the screen, making it problematic to identify some signs of distress. In addition, if participants were experiencing an unstable internet connection, they sometimes had to turn off their camera. Unless the participant told us, we were not always sure whether they were experiencing distress or had an unstable internet. Secondly, the sample is relatively homogenous, with the majority having attended university and a limited number of participants identifying as a member of a marginalized group. This makes the findings less transferrable. Thirdly, we did not set out with an established TI framework. Rather, we depended on the researchers who were psychiatric nurses to assist us with developing TI approaches. Future research has the benefit of frameworks for determining TI approaches. Finally, we did not include any questions to the participants about their impression of safety and levels of distress related to participating and we had to depend on unsolicited comments, when examining participants’ feelings of safety/distress.
Conclusion
The prevalence of suicide within rural communities increased the possibility that research participants may be re-traumatized while discussing suicide and suicide related issues. Through use of the online platform we were able to realize our goal of creating and sustaining a safe environment for focus group participants. Several participants disclosed that they felt sufficiently safe to participate in focus group discussions while others acknowledged that the non-judgmental space we had created, helped to reduce feelings of distress, while speaking of suicide.

The online features promoted safety and transparency by: enabling participants to turn off camera and microphone if they became distressed, allowing them time to self-regulate until feeling sufficiently safe to return to the focus group discussion; leaving the discussion at any time with little disruption; and being able to choose a comfortable place to join the discussion. Other TI activities included ensuring ongoing consent throughout the process, recruiting through a third party to enhance safety, having support resource lists tailored to the region, and encouraging participants to share and debrief final thoughts.

To our knowledge, this study is the first to use an online platform to conduct focus groups for the purpose of discussing a highly sensitive topic such as suicide. Further research is needed to determine how an online platform can be used to complement and augment use of TI methods when exploring topics that have the potential for generating painful and emotionally charged discussions.

Acknowledgments
Thank you to Shelby Doell, our Research Assistant, for her support in editing the final paper.

Declaration of Conflicting Interests
The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Funding
The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Public Health Agency of Canada (Contract).

ORCID iDs
Donna Epp https://orcid.org/0000-0002-2277-6032
Candice Waddell-Henowitch https://orcid.org/0000-0002-3013-4638
Rachel V. Herron https://orcid.org/0000-0003-4836-878X

References
Abu-Rus, A., Bussell, N., Olsen, D. C., Ardill, M., Davis-Ku, A. L., & Arzoumanian, M. A. (2019). Informed consent content in research with survivors of psychological trauma. *Ethics & Behavior, 29*(8), 595–606. https://doi.org/10.1080/10508422.2018.1551802
Armstrong, L. L. (2011). The anatomy of rural-urban youth suicidal ideation- who is at greatest risk. What factors to target. How to intervene. [Doctoral dissertation, University of Ottawa]. https://ruor.uottawa.ca/bitstream/10393/20217/1/Armstrong_Laura_Lynne_2011_Thesis.pdf
Barry, R., Rehm, J., de Oliveira, C., Gozdyra, P., & Kurdyak, P. (2020). Rurality and risk of suicide attempts and death by suicide among people living in four English-speaking high-income countries: A systematic review and meta-analysis. *Canadian Journal of Psychiatry, 65*(7), 441–447. https://doi.org/10.1177/0706743720902655
Biddle, L., Cooper, J., Owen-Smith, A., Klineberg, E., Bennewith, O., Hawton, K., Kapur, N., Donovan, J., & Gunnell, D. (2013). Qualitative interviewing with vulnerable populations: Individuals’ experiences of participating in suicide and self-harm based research. *Journal of Affective Disorders, 145*(3), 356–362. http://doi.org/10.1016/j.jad.2012.08.024
Burrows, S., Auger, N., Gamache, P., & Hamel, D. (2013). Leading causes of unintentional injury and suicide mortality in Canadian adults across the urban-rural continuum. *Public Health Reports, 128*(6), 443–453. https://doi.org/10.1177/003335491312800604
Campbell, R., Goodman-Williams, R., & Javorka, M. (2019). A trauma-informed approach to sexual violence research ethics and open science. *Journal of Interpersonal Violence, 34*(23–24), 4765–4793. https://doi.org/10.1177/0886260519871530
Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council. (2018). *Tri-council policy statement: Ethical conduct for research involving humans*. https://ethics.gc.ca/eng/documents/tcp2-2018-en-interactive-final.pdf
Carlisle, C. E., Mamdani, M., Schachar, R., & To, T. (2012). Predictors of psychiatric aftercare among formerly hospitalized adolescents. *The Canadian Journal of Psychiatry, 57*(11), 666–676. https://doi.org/10.1177/070674371205701104
Cerel, J., Brown, M. M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, C. (2019). How many people are exposed to suicide? Not six. *Suicide and Life-Threatening Behavior, 49*(2), 529–534. https://doi.org/10.1111/sltb.12450
Cerel, J., Maple, M., Aldrich, R., & van de Venne, J. (2013). Exposure to suicide and identification as survivor: Results from a random-digit dial survey. *Crisis: The Journal of Crisis Intervention and Suicide Prevention, 34*(6), 413–419. http://doi.org/10.1027/0227-5910/a000220
Creighton, G., Oliffe, J., Ogrodniczuk, J., & Frank, B. (2017a). “You’ve gotta be that tough crust exterior man”: Depression and suicide in rural-based men. *Qualitative Health Research, 27*(12), 1882–1891. https://doi.org/10.1177/1049732317718148
Creighton, G. M., Oliffe, J. L., Lohan, M., Ogrodniczuk, J. S., & Palm, E. (2017b). “Things I did not know”: Retrospectives on a Canadian rural male youth suicide using an instrumental photovoice case study. *Health: An Interdisciplinary Journal for the
Social Study of Health, Illness and Medicine, 21(6), 616–632. https://doi.org/10.1177/136345931638542

Dickson-Swift, V., James, E. L., Kippen, S., & Liamputtong, P. (2006). Blurring boundaries in qualitative health research on sensitive topics. Qualitative Health Research, 16(6), 853–871. https://doi.org/10.1177/104973306287526

Gibson, S., Benson, O., & Brand, S. L. (2013). Talking about suicide: Confidentiality and anonymity in qualitative research. Nursing Ethics, 20(1), 18–29. https://doi.org/10.1177/0969733012452684

Grigoriadis, S., Wilton, A. S., Kurdyak, P. A., Rhodes, A. E., VonderPorten, E. H., Levitt, A., Cheung, A., & Vigod, S. N. (2017). Perinatal suicide in Ontario, Canada: Preliminary results. Archives of Women’s Mental Health, 18(2), E1085–E1092.

Hibberd, R., Elwood, L. S., & Galovski, T. E. (2010). Risk and protective factors for posttraumatic stress disorder, prolonged grief, and depression in survivors of the violent death of a loved one. Journal of Loss and Trauma, 15(5), 426–447. https://doi.org/10.1080/15325024.2010.507660

Hirsch, J. K. (2006). A review of the literature on rural suicide: Risk and protective factors, incidence, and prevention. Crisis: The Journal of Crisis Intervention and Suicide Prevention, 27(4), 189–199. https://doi.org/10.1027/0227-5910.27.4.189

Hirsch, J. K., & Cukrowicz, K. C. (2014). Suicide in rural areas: An updated review of the literature. Journal of Rural Mental Health, 38(2), 65–78. https://doi.org/10.1007/rmh000018

Isobel, S. (2021). Trauma-informed qualitative research: Some methodological and practical considerations. International Journal of Mental Health Nursing, 30, 1456–1469. https://doi.org/10.1111/inm.12914

Jaffe, A. E., DiLillo, D., Hoffman, L., Haikalais, M., & Dykstra, R. E. (2015). Does it hurt to ask? A meta-analysis of participant reactions to trauma research. Clinical Psychology Review, 40, 40–56. https://doi.org/10.1016/j.cpr.2015.05.004

Jefferson, K., Stanhope, K. K., Jones-Harrell, C., Vester, A., Tyano, E., & Hall, C. D. X. (2021). A scoping review of recommendations in the English language on conducting research with trauma-exposed populations since publication of the Belmont report; thematic review of existing recommendations on research with trauma-exposed populations. Plos One, 16(7), Article e0254003.

Lakeman, R., & Fitzgerald, M. (2009). Ethical suicide research: A survey of researchers. International Journal of Mental Health Nursing, 18(1), 10–17. https://doi.org/10.1111/j.1447-0349.2008.00569.x

Legerski, J.-P., & Bunnell, S. L. (2010). The risks, benefits, and ethics of trauma-focused research participation. Ethics & Behavior, 20(6), 429–442. https://doi.org/10.1080/10508422.2010.521443

Maple, M., & Sanford, R. (2020). Suicide exposure and impact within a non-representative Australian community sample. Death Studies, 44(6), 329–337. https://doi.org/10.1080/07481187.2018.1554609

Marhefka, S., Lockhart, E., & Turner, D. (2020). Achieve research continuity during social distancing by rapidly implementing individual and group videoconferencing with participants: Key considerations, best practices, and protocols. AIDS and Behavior, 24(7), 1983–1989. https://doi.org/10.1007/s10461-020-02837-x

Newman, E., Risch, E., & Kassam-Adams, N. (2006). Ethical issues in trauma-related research: A review. Journal of Empirical Research on Human Research Ethics, 1(3), 29–46. https://doi.org/10.1525/erh.2006.1.3.29

Nonomura, R., Giesbrecht, C., Jivraj, T., Lapp, A., Bax, K., Jenney, A., Scott, K., Straatman, A.-L., & Baker, L. (2020). Toward a trauma-and violence-informed research ethics module: Considerations and recommendations. Centre for research & education on violence against women & children, Western University. http://kh-cdc.ca/en/resources/reports/Grey-Report—English.pdf

Poon, C. S., & Saewyc, E. M. (2009). Out yonder: Sexual-minority adolescents in rural communities in British Columbia. American Journal of Public Health, 99(1), 118–124. https://doi.org/10.2105/AJPH.2007.122945

QSR International. (2021). Nvivo (Version 12). https://www.qsrinternational.com/nvivo-qualitative-data-analysis-software/home

Quijada, Y., Inostroza, C., Vaccari, P., Riese, J., & Hausmann-Stable, C. (2021). Infusing the trauma-informed approach in youth suicide research: Lessons from the field. American Journal of Orthopsychiatry, 91(5), 579–588. https://doi.org/10.1037/ort0000558

Rauch, K., Ryan, K., Ramsey, D., Epp, D., Lee, S., Herron, R., Mullins, S., Thomson, A., & Waddell-Henowitch, C. (2022). Suicidality in rural communities: A scoping review of research in Canada [Manuscript submitted for publication]. Canadian Journal of Community Mental Health.

Roy, P., & Tremblay, G. (2015). L’expérience du stress chez les agriculteurs: Une analyse du genre masculin. Nouvelles Pratiques Sociales, 27(2), 236–252.

Roy, P., Tremblay, G., Oliffe, J. L., Jbilou, J., & Robertson, S. (2013). Male farmers with mental health disorders: A scoping review. Australian Journal of Rural Health, 21(1), 3–7. https://doi.org/10.1111/ajr.12008

Roy, P., Tremblay, G., Robertson, S., & Houle, J. (2017). Do it all by myself: A salutogenic approach of masculine health practice among farming men coping with stress. American Journal of Men’s Health, 11(5), 1536–1546. https://doi.org/10.1177/155798831669677

Singh, G. K., Azuine, R. E., Siahpush, M., & Kogan, M. D. (2012). All-cause and cause-specific mortality among US youth: Socioeconomic and rural-urban disparities and international patterns. Journal of Urban Health, 90(3), 388. https://doi.org/10.1007/s11524-012-9744-0
Sturgeon, R., & Morrissette, P. J. (2010). A qualitative analysis of suicide ideation among Manitoban farmers/Une analyse qualitative de l’idéation suicidaire chez les agriculteurs manitobains. Canadian Journal of Counselling, 44(2), 191–207.

Substance Abuse and Mental Health Services Administration (SAMHSA) (2014). Trauma-informed care in behavioral health services. https://ncjtc-static.fvtc.edu/resources/RS00006428.pdf

Voith, L. A., Hamler, T., Francis, M. W., Lee, H., & Korsch-Williams, A. (2020). Using a trauma-informed, socially just research framework with marginalized populations: Practices and barriers to implementation. Social Work Research, 44(3), 169–181. https://doi.org/10.1093/swr/svaa013

Wilson, C., Pence, D. M., & Conradi, L. (2013). Trauma-informed care. In Encyclopedia of social work. https://doi.org/10.1093/acrefore/9780199975839.013.1063

Zaheer, J., Links, P. S., Law, S., Shera, W., Hodges, B., Tsang, A. K. T., Huang, X., & Liu, P. (2011). Developing a matrix model of rural suicide prevention: A Canada-China collaboration. International Journal of Mental Health, 40(4), 28–49. https://doi.org/10.2753/IMH0020-7411400403