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Evaluating Applied Suicide Intervention Skills Training with Counselors-in-Training: Enhancing Sensitivity, Awareness, and Intervention Skills with Suicidal and Non-Suicidal Clients

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ACCEPTANCE

This dissertation, EVALUATING APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST) WITH COUNSELORS-IN-TRAINING: ENHANCING SENSITIVITY, AWARENESS, AND INTERVENTIN SKILLS WITH SUICIDAL AND NON-SUICIDAL CLIENTS, by NIKKI ELSTON, was prepared under the direction of the candidate's Dissertation Advisory Committee. It is accepted by the committee members in partial fulfillment of the requirements for the degree, Doctor of Philosophy, in Counselor Education and Practice in the College of Education and Human Development, Georgia State University.

The Dissertation Advisory Committee and the student's Department Chairperson, as representatives of the faculty, certify that this dissertation has met all standards of excellence and scholarship as determined by the faculty. The Dean of the College of Education and Human Development concurs.

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EVALUATING APPLIED SUICIDE INTERVENTION SKILLS TRAINING WITH COUNSELORS-IN-TRAINING: ENHANCING SENSITIVITY, AWARENESS, AND INTERVENTION SKILLS WITH SUICIDAL AND NON-SUICIDAL CLIENTS

By

NIKKI CAROL ELSTON

Under the Direction of Dr. Dennis Gilbride

ABSTRACT

Suicide is a serious mental health concern, it is the tenth leading cause of death in the United States, the second leading cause of death for young adults (10-34), and the fourth leading cause for persons aged 35 to 54 years (Centers for Disease Control [CDC], 2015). Counselors-in-training (CIT) often encounter clients with suicidal ideation, and they often report feeling, and are found to be, under-prepared to respond effectively (Barrio Minton et al., 2011; Erikson & Abel, 2013). One potential approach to helping augment the skills of counselors-in-training is extending suicide intervention training beyond their formal course work. Applied Suicide Intervention Skills training (ASIST) is a 14- hour, 2-day standardized and manualized training designed to train people in the helping professions to identify and effectively intervene with people considering suicide (LivingWorks, 2013). ASIST has been recognized by the Substance Abuse and Mental Health Services Administration (SAMHSA), branches of the US Military, the Center for Disease Control (Rodgers, 2010), and the National Registry of Evidence-based

Programs and Practices (NREPP), as an effective training for suicide prevention. However, ASIST has yet to be rigorously evaluated as a systematic means of enhancing CIT preparedness to deal effectively with suicidal clients in a fieldwork setting. It is clear that further research is warranted to evaluate the ability of ASIST to increase the skills of CIT.

This study evaluated the use of ASIST by CIT with both suicidal and non-suicidal clients and examined how ASIST may offer a standardized and measurable means of enhancing CITs sensitivity, awareness, and intervention skills in responding to persons-at-risk, for both suicide and other significant mental health issues. This is the first study to evaluate the utilization and generalizability of ASIST by CIT in practice and over time.

INDEX WORDS: Suicide, Non-Suicidal, Counselors in Training, Applied Suicide Intervention Skills

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DEDICATION

For my dad, Nick Elston. I miss you, every day. Without you I could not and would not have made this journey. Thank you for teaching me the value of hard work, for believing in me and my success, and for loving me no matter what I chose to do with my life. This dissertation, and the work I will do for the rest of my life, it is all possible because of you. I am so proud to be your daughter.

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1 SUICIDE TRAINING: IMPLICATIONS FOR COUNSELORS IN TRAINING

Client death by suicide is the number one fear of mental health practitioners (Jhan, Quinnett, & Ries, 2016; Pope & Tabachnick,1993), yet, attention to suicide in counselor education curriculum is limited (Barrio Minton & Pease Carter, 2011). Counselor education and training for individuals working with persons-at-risk of suicide has been shown to enhance suicide knowledge, attitudes about suicide (i.e. do I believe that suicide is preventable?), and suicide intervention skills (Shannonhouse, Lin, Shaw, Wanna, & Porter, 2017). The 2016 standards of the Council for Accreditation of Counseling & Related Educational Programs (CACREP) requires suicide awareness and risk assessment for trainees in clinical mental health programs, however, there are not specific guidelines for how long or where suicide curriculum should be inserted. School counselor competencies set forth by the American School Counselor Association (ASCA, 2005) requires knowledge, ability, and skills for crisis but does not specifically address suicide. In the recent absorption of the Council on Rehabilitation Education (CORE) by CACREP, rehabilitation counselors are called to be aware and understand the impact of crisis, without specifically mentioning suicide (2017). Therefore, considering that more than 80% of new professional counselors report working with suicidal clients (Wachter Morris & Barrio Minton, 2012), adopting a formalized suicide intervention program may help enhance counselors-in-training sensitivity, awareness and intervention skills for someone at risk of suicide and perhaps non-suicidal persons as well.

Counselors are often anxious, fearful, and uncomfortable when counseling clients that are suicidal or in crisis (Binkley & Leibert, 2015; Pope & Tabachinick, 1993; Schmitz et al., 2012). Barrio Minton and Pease Carter (2011) found that masters-level students graduate with 10 or less clock hours of crisis preparation, and only 16.7% of the programs in their study required a course

focused on crisis counseling. Similarly, Wachter Morris and Barrio Minton (2012) reported that 37.5% of their participants received zero hours of classroom crisis preparation, 67.36% attended programs that did not offer a crisis course, and 11.92% did not take a crisis course that was offered. These findings align with Jhan et al., (2016) who found that counselors have reported feeling hesitant to work with clients that present as suicidal due to a lack of training in suicide and crisis intervention. In their study, 30% of mental health practitioners reported that they did not find their suicide training sufficient, although they were working with suicidal clients. Therefore, this paucity of crisis training, particularly related to issues of suicide and lack of skills, may result in trainees' (as well as novice and seasoned professional counselors') avoidance of crisis and suicidal issues, or ineffective intervention due to insufficient knowledge and preparation (Watcher Morris & Barrio Minton, 2012).

Applied Suicide Intervention Skills Training (ASIST; Lang et al., 2013) is a skills-based standardized training in *suicide first-aid*, that teaches participants how to intervene with a person-at-risk at the moment needed the most. Part of the National Registry of Evidence-based programs (NREPP), ASIST provides the Pathway for Assisting Life (PAL), suicide intervention model (SIM), to help counselors connect, understand, and assist the suicidal client. Unlike other suicide training programs, ASIST "teaches a suicide intervention model that envisions a wide range of pathways of safety and stresses the importance of developing a SafePlan" (LivingWorks Education, 2013; p. 3). ASIST empowers the person-at-risk to develop an individualized plan to keep 'safe for now', equips the counselor to do an in the moment intervention, while moving the suicidal person from thoughts of the past to engagement in the future (Lang et al., 2013). Rather than encouraging helpers to immediately assess lethality and contract for safety, the ASIST SIM centers on the quality of the interaction between the counselor and the person at risk (Rodgers,

2010). The safeplan replaces a "no suicide" contract. "No suicide" contracts have not been proven clinically effective (Edward & Sachmann, 2010; McMyler & Pryjmachuk, 2008; Range et al., 2002; Rudd, Mandrusiak, Joiner, 2006), and clients see them as confining and of little help (Bartlett, Carney, & Talbott, 2009).

Individuals trained in ASIST have been found to effectively work with ambivalence about dying and assist the person-at-risk in identifying a reason to live (Gould, Cross, Pisani, Munfalsh, & Leinman, 2013), by using specific steps in effective safety planning. Researchers (Griesback, Dolev, Russell, & Lardner, 2008; McAuliffe & Perry, 2007; Turley, Pullen, Thomas, & Rolfe, 2000) have found those trained in ASIST report feeling increased levels of comfort, competence, and confidence when responding to and intervening with a person at risk of suicide. Additionally, ASIST trained persons have been found to have enhanced suicide intervention skills (Gould et al., 2013; Shannonhouse et al., 2017), increased knowledge and more helpful attitudes about suicide prevention and intervention (Illich, 2004; Rodgers, 2010; Shannonhouse, Lin, Shaw, & Porter, 2017; Tierney, 1994; Turley et al., 2000).

Those at Risk of Suicide

Counselors-in-training interact with a broad spectrum of clients, many who will be contemplating suicide, planning suicide, attempting suicide, or completing suicide. Therefore, it is critical for future clinicians to be aware of the prevalence and signs of suicide, and to be able to delineate when a person, or a member of an at-risk group, *is really at risk.* Suicide is individual and complex, with biological, psychological, spiritual, and sociological factors influencing risk (Rodgers, 2010). Lang and colleagues (2013) provide a set of tools to help us delineate who is at risk and when, through the use of the Pathway for Assisting Life Model.

Failure to acknowledge, understand, directly ask about suicide, and help clients identify a safe plan and support systems results in life-or-death consequences.

Suicide has been the tenth leading cause of death for all ages since 2000 (Centers for Disease Control [CDC], 2013). It is estimated that 121.1 people die by suicide every day in the United States, which equates to one suicide every 11.9 minutes (McIntosh & Drapeau, 2016). In 2015, *reported* suicides accounted for 44,193 deaths, and it is estimated that 9.4 million adults have contemplated suicide in the past year (CDC). For every completed suicide, twenty-five attempts have been made, with approximately 1.1 million suicide attempts in 2015, this equates to one attempt every 29 seconds (McIntosh & Drapeau, 2016). Suicide is the second leading cause of death for youth and young adults aged 10-34 years, and for age groups between 10 to 64, suicide is one of the top ten leading causes of death (Curtin, Warner, & Hedegaard, 2016; Heron, 2016). Suicide is devastating and the loss of life impacts individuals, families, and communities. Death by suicide touches everyone, with some groups more researched and identified at higher risk.

Lesbian, Gay, Bisexual, and Transgender (LGBT) communities, members of the military, and persons with disabilities are often identified as at higher risk of suicide. Most U.S. studies have found that approximately 40% of the LGB population reports a lifetime history of suicidal ideation (Balsam, Beauchaine, Mickey, & Rothblum, 2005; Cochran & Mays, 2000; Garcia, Adams, Friedman, & East, 2002; Grant et al., 2011; James et al., 2016; McBee-Strayer & Rogers, 2002). Hottes, Bogaert, Rhodes, Brenan, & Gesink (2016), asserted that at least 20%, or 1 in 5, LGB adults will consider suicide at some point in their life. In a survey conducted by the National Gay and Lesbian Task Force and National Center for Transgender Equality, 41% of adult transgender respondents reported attempting suicide (Haas, Rodgers, & Herman, 2014).

High school students questioning their sexual orientation have been found 3.4 times more likely, than their straight peers, to attempt suicide (Eisenberg & Resnick, 2006; Garofalo et al., 1998). Compare these numbers to the 4.6% of the overall U.S. population that reported a suicide attempt and the LGBT population is at least nine times more likely to contemplate or attempt suicide (Haas, et al., 2014; Kessler, Borges, &Walters, 1999; Nock & Kessler, 2006). However, according to the American Association of Suicidology [AAS], (2017) being LGBT is not the sole reason for wanting to die, encounters with discrimination and harassment, as well as rejection from family and friends is often the catalyst for suicidal behavior.

Active or retired members of the U.S. military are also highly susceptible to suicide. All branches of the U.S. military report that suicide has been on the rise since 2006 (Brashwell & Kusher, 2010), making it the second highest cause of death for active duty members (Corr, 2014; Cox, Edison, Steward, Dorson, & Ritchie, 2006; Ritchie, Keppler, & Rothberg, 2003). Using a multistage probability sampling design, Kaplan, Huguet, McFarland, and Newsom (2007) followed 104,026 veterans for 12 years and found that veterans were twice as likely to die by suicide than non-veterans. The U.S. Department of Veterans Affairs (2017), has reported that twenty military veterans died by suicide every day in 2014, which accounted for 18% of the U.S. adults that completed suicide. However, it was not being a member of the military that resulted in the suicide, rather issues such as mental health (Bush et al., 2013; Pruitt et al., 2016), job classification (Anglemyer, Miller, Buttrey, & Whitaker, 2016), difficulty in the transition to civilian culture (Bryan, Jennings, Jobes, & Bradley, 2012; Coll, Weiss, & Yarvic, 2011; Elliott, Gonzalez, & Larsen, 2011; Pease, Billera, & Gerard, 2015), and failed spousal or other intimate relationships (Bust, et al., 2013; Pruitt, et al., 2016) being cited as common triggers.

According to the U.S. Census Bureau, approximately 56.7 million Americans, 19% of the population, live with a disability (Brault, 2012). Persons with disabilities experience heightened suicidality when compared to people without disabilities (Dennis et al., 2009; Forman-Hoffman, 2015; and Giannini et al., 2010; Kaplan et al., 2007; Khazem, et al., 2015; Lund, Nadorff, & Seader, 2016). In a study conducted by McConnell, Hahn, Savage, Dube, and Park (2016), adults with self-reported disability were 3.5 times more likely have suicidal ideation than adults without disabilities. The type of disability has been shown to impact suicidality. Individuals experiencing physical disabilities (Giannini et al., 2010; Kaplan et al., 2007: Khazem et al., 2007; Pompili et al., 2012), sensory disabilities (Pompili et al., 2012), cognitive and/or mental disabilities (Lund, Nadorff, & Seader, 2016; McConnell, Hahn, Savage, Dube, & Park, 2016; Segers & Rawana, 2014), as well as chronic illness (Kaplan et al., 2007) have been found to have increased rates of suicidal ideation and suicide attempts compared to individual with other disabilities. Considering that persons with disabilities also feel more burdensome (Khazem et al., 2007), have higher rates of unemployment and low income (Brault, 2012), as well as higher rates of anxiety and depression (Dennis et al., 2009; Giannini et al., 2010; Lund, Nadorff, & Seader, 2016), there are numerous factors that create risk factors for suicide, not only the presence of a visible or invisible disability.

Of the groups listed above, it should be noted that affiliation with a particular group is not cited as the reason for suicide, rather there are other issues that engender the belief that death would be easier than life. In 2009, the Substance Abuse and Mental Health Services Administration Office of Applied Studies conducted a survey of U.S. household and found 8.3 million adults had serious thoughts of suicide, 2.3 million made a plan for suicide, and 1.1 million had attempted to die by suicide. The three high risk groups listed above do not account

for the millions of people with suicidal behaviors, therefore it becomes critical to underscore the importance of looking for signs of suicide in all populations, across all groups. Reserving inquiry about suicide to groups considered more at-risk leaves a large swath of the population without adequate suicide attention and intervention.

The World Health Organization [WHO] (2017), estimates that nearly 800,000 people die by suicide each year, or one death every 40 seconds. Globally, suicide is the second leading cause of death for 15 to 29 year olds, 78% of suicides happen in low and middle income countries, and ingestion of pesticides, hanging, and firearms are the most common methods of suicide (WHO, 2017). Suicide is a worldwide tragedy that does not discriminate, it impacts every country and community. As suicide rates increase across the globe, all mental health professionals will inevitably encounter suicidal clients throughout their career, necessitating heightened awareness of signs and triggers.

Encountering Suicide

A majority of mental health practitioners will work with a suicidal client during their practicum and internship, and prior to licensure (Feldman & Freedenthal, 2006; Kleespies, Penk, & Forsyth, 1993). Nearly 25% of counselors will lose a client to suicide (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1998; McAdams & Foster, 2000). While few studies have examined the frequency of client suicide and suicidal ideation with counselors and counselors-in-training, available data does illuminate the frequency of client suicidality. Hunt and Rosenthal (2000) surveyed 153 rehabilitation counselors and found that those counselors experienced 102 client deaths by suicide, within the previous 5 years of practice. Lund et al. (2017) surveyed 223 rehabilitation counselors and found that 121 (54%) of their participants worked with clients that expressed suicidal thoughts and behaviors. When Kendrick and Chandler (1994) surveyed 245

school counselors, 93% of the respondents reported working with at least one student that experienced suicidal ideation. The school counselors in their study reported that 38% worked with one to two suicidal students, 33% worked with 3 to 5 suicidal students, 12% worked with 6 to 10 suicidal students, and 9% work with 10 or more suicidal students. In a study consisting of 376 counselors from a variety of counseling settings, 23% (21 counselors-in-training, 68 professional counselors) reported working with a client that completed suicide (McAdams & Foster, 2000). Consequently, the prevalence of client suicidal behavior is not met with the prevalence of suicide intervention training.

Suicide Preparation in Counseling Curriculum

Beginning counselors report feeling fearful, anxious, and worried about being underprepared to deal with suicidal clients (Jahn, Quinnett, & Ries, 2016; Knox, Burkard, Jackson, Schaack, & Hess, 2006). When clinicians lose clients to suicide they often question their clinical competence, feel ashamed, become more selective about the clients they serve, and doubt their choice of profession (Ellis & Patel, 2012; McAdams & Foster, 2000; Sanders, Jacobson, & Ting, 2005). Binkley and Leibert (2015) surveyed 113 practicum students and found CITs who had some training in suicide intervention, prior to starting practicum, experienced lower anxiety and higher confidence when they encountered a suicidal client.

An increased level of confidence and decreased level of anxiety is beneficial to the counselor, but crucial to the client contemplating killing her/himself. Counselors that are untrained and unskilled with suicide intervention, and fail to recognize and talk about suicide, are perceived as non-accepting and reinforce the feeling of isolation (Paulson & Worth, 2002). CITs with little to no suicide intervention skills often want to refer clients to other counselors (Jahn, Quinnett, & Ries, 2016), due to lack of preparation prior to practicum and internship (Barrio Minton & Pease Carter,

2001). Wachter Morris and Barrio Minton (2012) asserted that crisis intervention skill training, in the classroom, is lagging behind the needs and expectations of fieldwork sites. Unfortunately, many counseling programs reported that they do not address crisis and suicide intervention skills until after master's students start their first clinical experience (Barrio Minton & Pease Carter, 2001). According to the American Counseling Association's (ACA) professional code of ethics (2014) counselor education programs are responsible for training and educating competent clinicians that have a reasonable level of awareness and skills, and should only refer clients when they are working outside their scope of practice. With the prevalence of suicide in our profession, ensuring that counselors-in-training are adequately prepared to identify, intervene, and assist suicidal clients is not just a professional responsibility, but an ethical imperative. Suicide is too common across multiple populations and work settings to not be part of almost every counselors' scope of practice.

Numerous studies have found that there is a dearth of suicide and crisis intervention preparation in mental health training programs (Barrio Minton & Pease Carter, 2011; Binkley & Leibert, 2015; Hipple & Beamish, 2007; Jahn, Quinnett, & Ries, 2016; Lund, Schultz, Nadorff, Galbraith, & Thomas, 2017; Van Asselt, Soli, & Berry, 2016; Simith, Silva, Covington, & Joiner, 2014; Watcher Morris & Barrio Minton, 2012). Wachter Morris and Barrio Minton (2012) found that approximately 80% of practicing counselors have worked with suicidal clients, and 24% have reported losing a client to suicide (McAdams & Foster, 2000). In 1999, Dr. David Satcher, then Surgeon General of the United States, called suicide a public health crisis and recommended a national strategy for suicide prevention (U.S. Public Health Service [USPHS]). The strategy called for all mental health professionals to receive training in suicide risk assessment and management, that would lead to more awareness and interventions, while advancing knowledge of suicide prevention. Once again in 2012, the U.S. Surgeon General and

the National Action Alliance for Suicide Prevention recommended that mental health providers be trained to recognize, assess, and manage effective clinical care for people at risk of suicide. That same year the American Association for Suicidology (AAS) reported a serious lack of suicide training requirements and preparation in all mental health training programs (Schmitz et al., 2012). In their task force report, AAS determined that all of the mental health disciplines had failed to meet the National Strategy for Suicide Prevention (United States Department of Health and Human Services [USDHHS], 2001) goal of increasing training opportunities for suicide assessment and management. The AAS made several recommendations for mental health training programs: (1) accrediting organizations require suicide specific training and education, (2) state licensure boards mandate suicide specific continuing education credits for licensure renewal, (3) health care systems/facilities show proof of suicide detection, assessment, management, treatment, and prevention, and (4) individuals that do no complete supervised graduate or professional training may not treat suicidal clients (Schmitz et al., 2012). Yet, despite numerous reports and research documenting the importance of training, and the benefit to the client and counselor, accreditation standards have not changed, and counseling programs continue to lack substantial training to prepare suicide competent clinicians.

Vital to effective counselor and client interaction, and suicide interventions, basic counseling skills are typically introduced during their first semester of a master's counseling program. According to Hill (2004), basic counseling skills are defined as verbal responses, non-verbal behaviors, and facilitative conditions made by the counselor in order to develop and maintain a relationship with the client. These counseling skills are often broken down as non-verbals, encouragers, questions, reflections of meaning and/or feeling, summarizing, confronting, goal setting, focusing the session, and facilitating empathy and respect (Hill, 2004; Young,

2013). Through the use of these foundational skills, counselors learn the necessary techniques to communicate and connect with clients, so rapport is built and a relationship of trust and respect are developed. Yet, learning these counseling skills does not imply expertise or competence (Tesluk & Jacobs, 1998), and when encountering a suicidal client these skills alone are not sufficient. Additionally, counselors may overestimate self-reported skill level (Scheerder, Reynders, Andriessen, & Van Audenhove, 2010), necessitating formal, suicide-focused training so practitioners become more comfortable, knowledgeable, and skilled (Jahn, Quinnett, & Ries, 2016).

Consequently, Wachter-Morris and Barrio Minton (2012) argued counselors are intervening without proper preparation. In their study they surveyed 193 counselors who had been employed as a counselor for less than two years and found that more than one third of the participants graduated with zero hours of crisis preparation. Just 40 participants recalled completing a crisis intervention course, 130 participants said a crisis course was not offered in their program, and 23 participants reported not taking a crisis class because it was not required. Despite not completing a formal crisis course, respondents did estimate receiving about six hours of crisis intervention training at some point in their curriculum. Similarly, Barrio Minton and Pease Carter (2011) found that only 24 of 52 CACREP-accredited master's degree programs offered a course in crisis counseling.

When Lund et al. (2017) surveyed 223 counselors working in vocational rehabilitation, more than half of the participants (121) reported working with suicidal clients more than once a year. Although a majority of these clinicians (67%) had received suicide specific training, 48% (107) of the counselors said they did not feel comfortable treating suicidal clients. Additionally, 120 participants said they did not feel competent treating a client in an acute suicidal crisis, and

178 reported they would not bring up suicide because they feared it might exacerbate the problem. Similarly, when Gibbons and Studer (2011) surveyed 90 school counselors they found 30% of the participants did not provide suicide awareness training in their schools because they lacked a suicide training model. The same school counselors also commented on their own need for additional training and tools to help with prevention and intervention.

While no specified, required, or recommended curriculum is in place for suicide training, CACREP (2016) accreditation standards call for counselor education programs to infuse "suicide prevention models and strategies, and procedures for assessing risk of suicide (p. 13)." Most suicide literature uses the term "gatekeeper" to identify someone trained to identify and intervene with anyone who may be at risk for suicide. Coined by Snyder in 1971, "gatekeeper" training consists of a wide range of strategies that vary in length and content, but encompass an overarching goal of increasing participant's knowledge, attitudes, and skills to identify someone at risk of suicide. However, the majority of gatekeeper training programs focus on teaching participants to refer the suicidal person to a professional helper (i.e. counselor, therapist, or social worker).

Several gatekeeping programs and tools are more prevalently used to train mental health clinicians working with an at-risk person. Question, Persuade, and Refer (QPR; Quinnett, 2012) is one of the most widely implemented suicide intervention (SI) models (Wyman, et al., 2010). Typically a one-hour, face-to-face training, QPR consists of three steps: (1) identify warning signs and ask about thoughts of suicide, (2) persuade the person-at-risk to take positive, life-saving action, and (3) refer the suicidal person to a helping professional. Known as a suicide *prevention*, not intervention, training, provides little to no skill practice (Cross, Matthieu, Lezine, & Knox, 2010; Wyman et al., 2010). According to Wyman et al., (2010) QPR also fails to

adequately address the importance of empathetic communication, which is essential for addressing emotional distress associated with suicidal thoughts and actions. Further, these types of gatekeeper models often conceptualize suicide prevention as a linear process whereby the counselor's role is to identify and refer (Rodgers, 2010), or question, persuade, and refer (QPR; Chen, Moore, & Gibbs, 2009; Quinnett, 2007).

Several mnemonic devices have also been suggested for use when assessing clients for suicide: SAD PERSONS, IS PATH WARM, and SLAP. SAD PERSONS scale (SPS; Patterson, Dohn, Bird, & Patterson, 1983) is a 10-item scale, with each letter corresponding to a suicide risk factor: Sex, Age, Depression, Previous Attempt, Ethanol or Drug Abuse, Rational thing loss, Social support lacking, Organized plan, No spouse, and Sickness. A systematic review of the literature revealed that SPS is not reliable to guide client care (Bolton, Spiwak, Sareen, 2012), and cannot predict or assess suicide or suicidal behavior (Katz et al., 2017; Warden, Spiwak, Sareen, & Bolton, 2014). Created by AAS (2003) in an attempt to simplify the signs of suicide and considered a comprehensive mnemonic (Jackson-Cherry & Erford, 2014; McGlothlin, 2008), IS PATH WARM stands for Ideation, Substance abuse, Purposelessness, Anxiety, trapped, Hopelessness, Withdrawal, Anger, Recklessness, and Mood changes. Yet, this 10-item tool has not been validated, and may not be appropriate for indicating suicidality (Lester, McSwain, & Gunn, 2011), and does not provide guidance for an intervention. A much shorter mnemonic device, SLAP (Specificity, Lethality, Accessibility, and Proximity of help) may also be used to assess suicidal risk, and help counselors determine next steps, but there is no research to validate the usefulness of this tool. Furthermore, in a moment of crisis it is unknown if a counselor in training could actually recall these mnemonics, much less use them as an assessment.

Most gatekeeper trainings are brief and focused on diagnostic criteria, rather than intervention or skill development. Researchers have consistently reported that skill practice, role playing, and active learning are missing from the majority of suicide trainings (Coleman & Del Quest, 2015; Cross, et al., 2010; Pasco et al., 2012; Wyman et al., 2008), indicating that counselors in training infrequently practice intervening with those at risk prior to working with suicidal clients, and therefore do not develop the skills necessary. More clock hours, interactive demonstrations, formal training, didactic coursework, and experiential opportunities (i.e. role-playing, practice, mentoring, supervision) are necessary components to help beginning counselors develop counseling skills for suicide interventions (Dexter-Mazza & Freeman, 2003; Kaslow, 2004; Kleespies et al., 1993; Sharpless & Barber, 2009; Tesluk & Jacobs, 1998). Opportunities to watch trainers and instructors put content into practice, and the actual practice of suicide specific skills through simulations during training has the potential to strengthen attitudes, confidence and comfort, while assisting in the transfer of knowledge from the classroom into counseling sessions (Cross et al., 2007; Davis et al., 1999; Gould, et al., 2013; Jahn, Quinnett, & Ries, 2016; Rodgers, 2010; Wyman et al, 2008). When Coleman and Del Quest (2015) evaluated three suicide prevention training programs, all three produced significant effects in attitude, but only participants that completed Applied Suicide Intervention Skills Training (ASIST) showed a significant increase in asking directly about suicide, a critical prevention behavior.

Applied Suicide Intervention Skills Training (ASIST)

ASIST is a 14- hour, two-day, interactive workshop that teaches suicide skills, uses simulations and role-play scenarios to teach suicide intervention (Lang et al., 2013). While a majority of suicide intervention programs provide on average one hour of training (Suicide

Prevention Resource Center, 2009), ASIST has adopted a longer training time to allow participants more time for hands-on skill practice and skill development (Rodgers, 2010). An evidence-based suicide intervention model, ASIST is used in several states and crisis centers across the nation, has been adopted by the U.S. Armed Forces and the Centers for Disease Control, and it has been endorsed by the Substance Abuse and Mental Health Service Administration (SAMHSA). The overall goal of ASIST is to "train participants who are willing, ready, and able to provide life-assisting, suicide first aid" (LivingWorks, 2014, p. 2). This goal is accomplished through a comprehensive workshop that unfolds as participants explore feelings, attitudes and beliefs about suicide and learn the Pathway for Assisting Life (PAL).

Before trainees learn PAL and begin their skill development and practice, ASIST trainers lead a discussion addressing personal attitudes and beliefs about suicide (Rodgers, 2010). Participants are asked to speak openly about their thoughts, feelings, and experiences with suicide, and gain awareness on how their beliefs impact their responder behavior in working with those at risk. Lang, Ramsay, Tanney, and Kinzel (2007), creators of ASIST, argued that, "looking at attitudes toward suicide is the first step in learning the knowledge and skills to work with persons at risk of suicide" (p. 73). Understanding attitudes and beliefs about suicide is required as our personal judgments can help or hinder our ability to effectively respond (Angermeyer, Matschinger, and Riedel-Heller, 1999; Law, Rostill-Brooks, and Goodman, 2008; Sethi and Suppal, 2006). Without understanding how attitudes and beliefs influence one's responder behavior, we are limited in our ability to respond (Lang et al., 2013; Turley, 2009; Rodgers, 2010).

Following the exploration of beliefs and attitudes toward suicide, ASIST trainers use several levels of interactive simulations to immerse participants in hands-on active learning and

practice. The four interactive levels of training include (1) trainer to trainer, (2) trainer to audience, (3) trainer to trainees, and (4) trainee to trainee (Rodgers, 2010). Research has shown that exposure to multiple interactive simulations, as opposed to strictly didactic learning, has the potential to change behaviors as well as training effectiveness (Cross, et al., 2007; Davis, et al., 1999). ASIST intentionally scaffolds the suicide intervention model (SIM), teaching content, using simulations to practice each component of the model, followed by role play and group supervision to help participants tie each phase of the training together.

Pathway to Assisting Life (PAL)

PAL emphasizes three core phases: connecting with suicide, understanding choices, and assisting life. Each phase of PAL offers three caregiver tasks and three person at-risk tasks. Unlike other suicide interventions, PAL discourages immediate referrals and promotes direct suicide intervention between the caregiver and the person at-risk of suicide (Rodgers, 2010). This model follows the research of Snyder (1971), who emphasized the importance of making a connection with the person at risk, not simply passing them off to someone who may be more educated or comfortable with suicide. Rodgers (2010) purported that the quality of the interaction between the caregiver and the person-at-risk is essential and has the potential to reduce the risk of suicide through connection and safety planning. Similarly, the interpersonal theory of suicide also supports the notion that "pulling together," not feeling isolated, and perceived belonging can drastically decrease suicidality (Joiner, Jr., Hollar, & Van Orden, 2006).

SIM Phase I. In the connecting with suicide phase, the person at risk has two needs, for their invitations to be explored and for someone to directly ask about suicide. Invitations are defined as "signs of distress that invite help" and are divided into four categories: actions, words,

physical, and feelings (LivingWorks, 2013). Actions can include, but are not limited to, giving away possessions, withdrawal, misuse of alcohol/drugs, reckless behavior, and self-mutilation (LivingWorks, 2014, p. 111). Words might include statements such as "*no one can do anything to help me now*" and "*I cannot do anything right anymore."* Physical symptoms can include loss of appetite, disturbed sleep, lack of interest in appearance, change/loss in sex interest, and physical health complaints. Feelings such as worthlessness, loneliness, helplessness or hopelessness are also invitations and should be explored for more meaning. This phase also instructs caregivers to clearly ask about suicide, to be direct and use the word "suicide", which is aligned with best practices (Gould et al., 2005; Mathias et al., 2012) so the person at risk knows it is okay to talk about suicide, and to clearly say that suicide needs to be addressed. Asking directly can result in a sense of relief for the person at risk and a reduction in suicidal thoughts or behaviors (Gould et al., 2013; Mathias et al., 2012).

SIM Phase II. The next phase, understanding suicide, includes two needs that the person at risk has-- to share their story of suicide (e.g. the stressful events that have piled up, etc.) and supporting their turning toward life, and away from death. At this point in the model it is critical for the counselor to not only hear the client's story, but deeply understand what the person at risk is trying to say, and why they want to die by suicide (LivingWorks, 2014). Exhausting reasons for dying has been found to be effective in identifying a reason to live (Rodgers, 2010). It is through hearing the story that caregivers may begin to support a turn toward life or help the person-at-risk identify a small bit of hope, which moves them from being focused on the past to engaged in the present moment. This small hope, is often experienced as uncertainty, or ambivalence about dying. ASIST is the only model that teaches how to effectively work with ambivalence (Gould et al., 2013). In Gould's (2013) double blind hierarchal linear model study

of more than 1500 calls made to the national suicide prevention lifeline, crisis phone counselors trained in ASIST were found to effectively identify and work with ambivalence, whereas those trained in other models were not.

Further, ASIST is the only model that provides a third option for persons at risk (Lang et al., 2013). To live or to die, can be a tough choice, however persons at risk can decide to 'stay safe-for-now', so that there is time to explore what has come up for them in the uncertainty. Persons at risk may say something like, "*it is all so confusing*", "*if I could only find a way to do x*", etc. Suiciding does not give one this option, however staying *safe for now* provides an opportunity to explore a reason to live that emerged during the intervention.

SIM Phase III. The final phase, assisting life, enables the caregiver to help the client develop a "safeplan" to reduce the risk of suicide, and confirm whether or not the client understands and is committed to safety for now. Co-construction of a safe plan allows caregivers to consider present and future risk, available resources, supportive networks, and the person-at-risk's immediate needs. This level of connection and support offered by PAL is in line with Durkheim's social integration theory of suicide: the more a person feels connected and accepted, the lower the chance of suicide (1897/1951). A comprehensive screening and intervention model, PAL may sufficiently reduce risk on its own (Gould et al., 2013; Rodgers, 2010). PAL may also reduce the need for referral to another resource (Cornell, Williams, & Hague, 2006; McAuliffe & Perry, 2007; Rodgers, 2010), as each phase presents counselors with a road map to directly assess the suicidal person's willingness to access specialized supports as well as harm reduction strategies.

The model is unique because unlike other suicide interventions, PAL promotes direct suicide intervention between the caregiver and the person at-risk of suicide (Rodgers, 2010).

Snyder emphasized that this interaction "has to be genuine" (p. 40). The concept of being genuine is not new to counseling. Also known as congruence, this is one of the three core facilitative conditions introduced by Carl Rogers (1957). These core facilitative conditions, congruence, positive regard, and empathy, are often considered essential for growth and change in the therapeutic relationship (Young, 2013). PAL is also unique as the focus is on the person at risk's needs, and on providing a third option, to stay safe for now. Safety for now has been argued to often lead to long term safety.

Shannonhouse and colleagues (2017) found those trained in ASIST increased knowledge about suicide, developed more constructive attitudes and beliefs after receiving ASIST training, and increased suicide intervention skills. Those trained in ASIST have also been found to utilize suicide intervention skills, specifically one's ability to talk directly about reasons for dying, identify ambivalence in the person-at-risk, conduct a lethality assessment and develop measurable and agreed upon safe plans with persons-at-risk of suicide in the moment needed the most (Gould et al., 2013). Finally, ASIST is the only evidence-based intervention model in suicide.

Implications for Counseling

Suicide is an inevitable crisis that nearly all counselors will encounter. The type of training that counselors receive can have a significant impact on the clients they counsel. Helping CIT enhance skills and knowledge related to suicide interventions could mean the difference between the life and death of a client. While basic counseling skills can help facilitate a working therapeutic relationship between client and counselor, these skills alone are not enough to help beginning clinicians intervene with a suicidal person. Inserting a few hours of suicide training into 60 credit hour counseling programs maybe insufficient (Barrio Minton and

Pease Carter, 2011; Binkley and Leibert, 2015) and potentially sends students into clinical settings where they are underprepared and lack the necessary and sufficient skills. While actual clinical practice is where counselors learn to implement their skills, this does not reduce the need for hands-on, real-play, role-play scenarios that allow counselors-in-training to practice suicide intervention skills prior to working with clients. Through the completion of ASIST, novice counselors have the opportunity to thoroughly explore their suicide knowledge, while watching and participating in multiple simulations that help transfer content into practice.

According to Paulson and Worth (2002), suicidal clients reported that connecting to another person, feeling listened to/understood, and finding interventions to confront suicidal behaviors are reaffirming and integral. They also found that clients wanted a counselor to help them understand their choices and offer feedback. ASIST is grounded in these same concepts. Through connecting, understanding, and assisting a person at risk when they need it the most, counselors-in-training will be positioned to carefully and competently support a person who is contemplating death by suicide. Sending our future counselors through a thorough, rigorous, and skill focused suicide intervention program has the potential to not only save the lives of clients, but help develop more confident, competent, and compassionate mental health caregivers.

Considering the numerous studies and research that focus on suicide, little research can be found on the use of suicide intervention programs/strategies in clinical field work, much less the use of ASIST by master's students in their first semester of clinical work. Thus, further data is needed to understand if and how PAL is being used with suicidal clients, as well as non-suicidal clients. Because ASIST emphasizes the importance of hearing a person's story, it is possible that the skills taught in ASIST may help counselors-in-training become more aware of not only suicide, but other mental health issues. Connecting, understanding, and assisting are all

important elements of counseling, so ASIST has the potential to help counselors-in-training become more adept at identifying suicidal clients through enhanced counseling skills.

Additionally, research is also needed to better understand how training impacts and influences the development of counseling skills for CIT. If we are asking, or even requiring, CIT to participate in standardized and manualized trainings, it would be helpful to know if CIT feel more prepared and skilled to interact with clients once they have completed training. Further research may help counselor education programs and supervisors better direct students to particular training programs or workshops that show evidence of increased skill development and interventions.

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2 EVALUATING APPLIED SUICIDE INTERVENTION SKILLS TRAINING (ASIST) WITH COUNSELORS-IN-TRAINING: ENHANCING SENSITIVITY, AWARENESS, AND INTERVENTION SKILLS WITH SUICIDAL AND NON-SUICIDAL CLIENTS

Suicide is individual and complex, and anyone can be at risk. Suicide is the tenth leading cause of death in the United States and someone dies by suicide every 11.7 minutes (Drapeau and McIntosh, 2017). In 2015 the Center for Disease Control (CDC) reported more than twice as many suicides (44,193) in the United States, as there were homicides (17,793). Thoughts of suicide are prevalent in 4.0% of the population, with 8.8% of adults aged 18- 25 having serious thoughts of suicide, and 7.5% of adults who reported two or more racial identities are more prone to suicidal thoughts (Substance Abuse and Mental Health Agency [SAMHSA], 2010). For every death by suicide, more than 30 others make an attempt to kill themselves (McIntosh, 2009), and it is estimated that an attempt is made every 29 seconds (Drapeau & McIntosh, 2016). Each year, more than 800,000 individuals die by suicide around the world, making it a global and national crisis (Institute of Medicine [IOM], 2002; World Health Organization [WHO], 2014). Suicide does not discriminate across populations, people of all ages, genders, and ethnicities can be at risk. The likelihood that counselors will encounter a client with suicidal behaviors is inevitable (Schwartz & Rogers, 2004).

Research highlights the prevalence of suicide for certain populations. People in the military (Anglemyer, Miller, Buttrey, & Whitaker, 2016; Bush, Reger, Luxton, Skopp, Kinn, Smolenski, & Gahm, 2013; Zamorksi, 2011), veterans (Kaplan, Huguet, McFarland, & Newsome, 2007; Matarazzo et al., 2014; U.S. Departments of Veterans Affairs, 2017), people with disabilities (Gianini, Bergmark, Kreshover, Elias, Plummer, O'Keefe, 2010; Khazem, Jahn, Cukrowicz, & Anestis, 2015), individuals with major depression (Khan et al., 2008) and other mental disorders (Nock, Hwang, Sampson, & Kessler, 2010), as well as the LGBTQ

communities (Clements-Noelle, Marx, & Katz, 2006; Hottes, Bogaert, Rhodes, Brenan, & Gesink, 2016; Pelts & Albright, 2015) are often cited as more likely to die by suicide. However, studies show it is not necessarily depression or mental illness that leads a person to suicide (Campos, et al., 2016), but their response to the environment (McLaughlin, Hatzenbuehler, & Keyes, 2010; Oswalt & Wyatt, 2011) their perceived burdensomeness and thwarted belongingness (Joiner, 2005), and sometimes failure to integrate into society (Durkheim, 1897; Joiner, 2005). Therefore, anyone can be at risk of suicide.

While it is important for CIT to be aware of the various warning signs and risk factors for particular groups, reducing suicide to specific populations becomes problematic, it is too simplistic to think that only particular subsets of people are at risk of killing themselves. CIT need skills and tools to help them look for the meaning behind stressful events, to look beyond the demographic characteristics of a person, or group membership, and observe the expressions of pain, the comments, and the actions of the person sitting in front of them. Failure to look beyond particular characteristics and signs may results in overlooking suicidal clients. A more focused and intentional suicide intervention training may be able to help CIT more accurately identify suicidal clients, and feel more comfortable, competent, and confident when intervening. Paulson and Worth (2002) interviewed suicidal clients to better understand perceptions of the counseling process, and how to better facilitate the treatment process. Through cluster mapping, clients indicated they wanted to work with a counselor who confronted the idea of suicide and helped them take action, as well as allowed them to acknowledge their feelings and allowed them the space to feel. This indicates the need for a suicide intervention model that helps CIT appropriately intervene, while also allowing the client to share their story and feelings.

Counselors-in-training (CIT) continually report feeling underprepared, nervous, incompetent, and anxious to work with clients expressing suicidal behaviors (Hedin, Lipchitz, Maltsberger, Haas, & Wynecoop, 2000; McAdams & Foster, 2000; Menninger, 1991). The lack of suicide intervention skills training for CIT is problematic as research has shown that clients feel isolated, ashamed, and alienated when counselors do not know how to respond and intervene (Paulson & Worth, 2002). Between 1999 and 2014, suicide rates increased 24% for males and females aged 10 to 74, with the rate of increase higher after 2006 (Curtin, Warner, & Hedegaard, 2016). Despite the rise in suicide, counselor education programs continue to offer little to no time for specific, in depth training related to suicide intervention skills (Barrio Minton & Pease Carter, 2011; Wachter & Barrio Minton, 2012; McFoster & Adams, 2000). This lack of training leaves CIT underprepared and overwhelmed if faced with a client considering suicide (Knox, Burkard, Jackson, Schaack, & Hess, 2006). Additionally, CIT frequently fear that directly saying the word "suicide" or asking, "are you thinking of killing yourself?" may plant the idea in a client's head, but there is no evidence to support this notion (Cukrowicz, Smith, & Poindexter, 2010; Deeley & Love, 2010). Research has shown that addressing the topic of suicide in an open and forward manner does not increase the likelihood of suicide (Mathias, Furr, Sheftall, Hill-Kapturczak, Crum, & Dougherty, 2012), nor is it iatrogenic (Dazzi, Gribble, Wessely, & Fear, 2014; Law, Furr, Arnold, Mneimne, Jaquett, & Fleeson, 2015). In fact, Dazzi, Gribble, Wessely, & Fear (2014) reported that directly addressing suicide has the potential to reduce rather than increase suicidal ideation.

The only evidence based suicide intervention training program (Rodgers, 2010) that promotes directly addressing suicide is Applied Suicide Intervention Skills Training (ASIST; LivingWorks, 2013; Rodgers, 2010). Recognized by the Substance Abuse and Mental Health

Services Administration (Rodgers, 2010) and used in the U.S. Military (Mojica, 2010; Rodgers, 2010), ASIST is a 14-hour, interactive workshop that teaches participants to connect, understand, and assist individuals at risk of suicide, through a tripartite model (Livingworks, 2013). ASIST emphasizes that all persons can be at risk of suicide, and the key to helping thwart suicide is through connecting with a person, hearing their personal story, and understanding the reasons for dying. Unlike other suicide intervention programs, ASIST is a longer training, intentionally developed to allow participants more time for skill practice and development (Rodgers, 2010). According to the Suicide Prevention Resource Center (2009), most suicide intervention programs are two hours or shorter, and have little to no practice and role-play components. Shannonhouse and colleagues (2017) found those trained in ASIST increased knowledge about suicide, developed more constructive attitudes and beliefs after training, and increased suicide intervention skills. ASIST is the only evidence-based training adopted by the U.S. Armed Forces, several states, and national crisis call centers (Gould, Cross, Pisani, Munfalsh, & Kleinman, 2013). Scholars (Gould et al., 2013; Griesbach, Dolev, Russell, & Lardner, 2008; McAuliffe & Perry, 2007; Shannonhouse, Lin, Shaw, Wanna, & Porter, 2017; Turley et al., 2010) have found those trained in ASIST have increased self-reported comfort, competence and confidence when responding to a person-at-risk.

The ASIST suicide intervention model is grounded in the Pathway for Assisting Life(PAL; LivingWorks, 2013). PAL emphasizes three core components: connecting with suicide, understanding choices, and assisting life. This model follows the research of Snyder (1971), who emphasized the importance of making a connection with the person at risk, not simply passing them off to someone who may be more educated or comfortable with suicide. Each phase of PAL offers two caregiver tasks and two person at-risk tasks. The model is unique

because unlike other suicide interventions, PAL discourages referrals and promotes direct suicide intervention between the counselor and the person at-risk of suicide (Rodgers, 2010). Snyder (1971) emphasized that this interaction " has to be genuine" (p. 40).

Phase one, connecting with suicide, involves exploring invitations (i.e. actions, physical appearance, words, and feelings) and asking directly about suicide. Phase two consists of hearing the client's reasons for dying and supporting a reason for living. The final phase of PAL is assisting life, which includes developing and co-constructing a safety plan. The development of a temporary, short-term plan is considered a collaboration between the counselor and client, and is not an imposition by the counselor. Overall, the details of the safety-plan must come from the client and be agreed upon by the client. The goal is to help disarm the active suicide and assist the person at risk in identifying internal and external supports (LivingWorks, 2013). This structure provides autonomy and flexibility for the unique needs of each person, allowing them to make changes based on personal context (Friedan, 2010).

Research on ASIST

The effectiveness of ASIST has been tested in different contexts, and several studies showed quantitative pre-post differences in counselor's suicide intervention skills (Gould et al., 2013; Shannonhouse et al., 2017; Shannonhouse et al., 2017), and participants' self-reported *comfort* in responding, and *confidence* at attempting response to a person-at-risk (Griesbach, Dolev, Russell, & Lardner, 2008; Rodgers, 2010; Turley et al., 2000). Recipients of ASIST have also self-reported increased levels of *competency*, which have been substantiated through objective assessments of simulated interventions (Illich, 2004; Tierney, 1994; Turley et al., 2000). An increase in suicide knowledge, prevention/intervention skills, and more helpful

attitudes and beliefs have also been reported upon completion of ASIST (Organizational Research Services, 2002; Shannonhouse et al, 2017; Smith, Silva, Covington, & Joiner, 2014).

In 2013, a National Suicide Prevention Lifeline Study (Gould, et al., 2013) resulted in ASIST being adopted by the Substance Abuse and Mental Health Services Administrations (SAMHSA) and the National Registry of Evidence-based Programs and Practices (NREPP). This double-blind monitored study analyzed over 1,500 calls to 17 crisis centers, over the course of 19 months. Using multilevel modeling, to account for the hierarchical structure of the data, callers that talked with ASIST trained counselors were more likely to feel less depressed, less suicidal, less overwhelmed, and more hopeful by the end of the call (Gould, et al., 2013). Gould et al. (2013) linked these caller outcomes to ASIST related interventions used by the counselor. Those trained in ASIST have also been found to utilize suicide intervention skills, specifically one's ability to talk directly about reasons for dying, identify ambivalence in the person-at-risk, conduct a lethality assessment and develop measurable and agreed upon safe plans with persons-at-risk of suicide in the moment needed the most (Gould et al., 2013).

Researchers (Cross, Matthieu, Lezine, & Knox, 2010; Pasco, Wallick, Sartin, & Dayton et al., 2012) have reported that participants who complete ASIST show generalization of gains in affect, knowledge, and skills in their work. ASIST has been explored in K-12 schools (Shannonhouse, Lin, Shaw, and Porter, 2017), examined with college staff (Shannonhouse, Lin, Shaw, Wanna, Porter, 2017), the U.S. Army (Smith-Osborne, Maleku, and Morgan, 2017), as well as crisis call centers (Gould et al., 2013), but it has not been explored with CIT in the clinical setting. A majority of studies examining the benefits and use of ASIST are focused on changes in comfort, competence, and confidence when intervening with suicidal individuals, as well as changes in attitudes and beliefs about suicide, but there is limited research on the transfer

of training into actual practice. If counselor educators want CIT to attend this evidence based training, or if programs adopt it into their curriculum, we need to understand if ASIST trained CIT are actually reporting and observing more clients with suicidal behaviors than non-ASIST trained CIT. ASIST emphasizes carefully listening to a person's story, identifying invitations for help, and asking direct questions, therefore it seems plausible that CIT who have completed the workshop may also be more in tune with identifying signs of other specific issues and concerns, while also more frequently using basic counseling skills to acquire information. The emphasis on connecting, understanding, and assisting a person when they need it the most is akin to establishing a therapeutic relationship, attentively listening, and helping someone identify goals for a plan, so it may be possible for this intervention to be useful in non-suicide interactions.

However, little is known about the transferability of ASIST concepts and strategies for counselors-in-training when working with clients that are suicidal. The goal of this study is to examine if ASIST results in higher reports of suicidal behavior, enhances counselor-trainees' sensitivity and awareness to other mental health issues, and broadens the self-reported use of counseling skills. Because ASIST is grounded in connecting, understanding, and hearing a person's story, while using helping skills, it is possible that counselors may find this intervention applicable when responding to other mental health issues. This will be the first study to evaluate the utilization and generalizability of ASIST by master's counselor-trainees in their first semester of fieldwork experience.

This research study will explore the generalizability of ASIST, by analyzing self-reported data from counselors-in-training (CIT's) who have and have not been trained in the ASIST model. Therefore, in order to explore CITs sensitivity and awareness to suicide and other mental health issues and needs, as well as counseling skills used with clients, this study will measure

CIT's self-reported (a) acknowledgement and awareness of clients with suicidal behaviors, (b) awareness of mental health issues and needs in clients, and (c) use of a broad range of counseling skills. The following research questions are explored:

Research Question 1: Do CIT who have successfully completed ASIST training have higher reports of clients with suicidal behaviors than their non-ASIST trained peers?

Research Question 2: Do CIT who have successfully completed ASIST training report higher levels of mental health issues and needs in their students/clients than their non-ASIST trained peers?

Research Question 3: Do CIT who have successfully completed ASIST training report use of a broader range of counseling skills than their non-ASIST trained peers?

Method

Participants

A priori power analysis conducted using G*Power 3.1 indicated that a minimum sample size of 34 would be sufficient to predict a medium effect size with 2 groups. This assumed the model would be tested at $\alpha = .05$ and $1 - \beta = .80$. This study employed purposeful sampling instead of randomization, therefore self-selection bias and sample homogeneity were potential limitations.

The participants for this study were counselors-in-training (CIT). Specifically, participants were enrolled in a CACREP accredited master's program in clinical mental health counseling, clinical rehabilitation/rehabilitation counseling, or school counseling, completed an introductory skills course and prerequisites for clinical experience, and were enrolled in their first semester of practicum and/or internship.

A sample of 54 participants was recruited for this study. There were 29 experimental group participants and 25 control group participants. Over the five data collections points, 27 experimental participants completed the survey all five times, one person completed the survey 4 times, and another completed it 3 times. A total of 22 control participants completed five surveys, two completed four, and one completed 3. Of the 54 participants, 38 of them reported an age range of 21 - 53 (*Mode* = 23, *SD* = 6.76). Females comprised the majority of participants with 79.6% (n = 43) of the sample, men represented 14.8% (n= 8) of participants, 3.7% (n = 2) identified as gender queer/gender non-conforming, and one participant identified as transgender. In terms of race and ethnicity, approximately 65% (n = 35), self-identified as Caucasian/White, 20.4% (n = 11), identified as Black or African American, 9.3% (n = 5) were Hispanic or Latino, one individual identified as Asian American, and one individual identified as Native Hawaiian or Pacific Islander. Straight/heterosexual participants comprised 66.7% (n = 36), 18.7% (n =10) bisexual/pansexual/omni-sexual, and 13% (n = 7) gay/lesbian. Additionally, 13% (n = 7) of participants identified as living with a chronic illness or disability (CID), while the majority or participants, 85%, (n = 46) did not.

Across both groups, 59.3% (n = 32) of the participants were enrolled in clinical mental health counseling, 29.6% (n = 16) were in clinical rehabilitation counseling, and 11.1% (n = 6) were in school counseling programs. Participants were completing their practicum/internship experiences at a variety of locations. A majority of participants, 22.2% (n = 12), reported working at a community agency, 16.7% (n = 9) were at a college counseling center, 13.1% (n = 7) reported their site was at a public school, 13% (n = 7) were in addiction services, 11.1% (n = 6) were in a vocational rehabilitation agency, 5.6% (n = 3) were at an eating disorder clinic, and the remainder of participants reported a site location in a hospital (n = 2), homeless shelter (n

=2), private practice (n = 2), psychiatric inpatient hospital (n = 2), college career services (n =1), and college disability services office (n = 1).

Table 1

Demographic Data for Participants

	Experimental (N = 29)		Control (N = 25)	
Age				
Range	21 - 37		21 - 53	
M	26.25		27.89	
Mode	23		23	
SD	3.89		9.01	
	N	%	N	%
Gender				
Female	23	79.3	20	80.0
Gender Queer/Gender Non-Conforming	2	6.9		
Male	4	13.8	4	16.0
Transgender			1	4.0
Racial/Ethnic Identification				
Asian American			1	4.0
Black/African American	6	21.4	5	20.0
Caucasian/White	20	71.4	15	60.0
Hispanic/Latino	1	3.6	4	16.0
Native Hawaiian/Pacific Islander	1	3.6		
Sexual Orientation				
Bisexual	3	10.7	2	8.0
Gay/Lesbian	4	14.3	3	12.0
Heterosexual	19	67.9	17	68.0
Pansexual/Omni-sexual	2	7.2	3	12.0
Chronic Illness Disability				
Yes	3	10.7	4	16.0
No	25	89.3	21	84.0
Master's Program				
Clinical Mental Health	19	65.5	13	52.0
Clinical Rehabilitation	4	13.8	12	48.0
School Counseling	6	20.7		
Clinical Fieldwork Location				
Addiction Services	4	13.8	3	12.0

Career Services (College)	1	3.4		
College Counseling	6	20.7	3	12.0
Community Agency	7	24.1	5	20.0
Disability Services Office (College)	1	3.4		
Eating Disorder Clinic	1	3.4	2	8.0
Homeless Shelter	1	3.4.	1	4.0
Hospital	1	3.4	1	4.0
Private Practice	1	3.4	1	4.0
Public Elementary School	2	6.9	1	4.0
Public Middle School	1	3.4		
Public High School	3	10.3		
Vocational Rehabilitation			6	24.0

Procedures

This was an ex post facto quasi-experimental study with a matched control group. Experimental and control participants were matched based on stage of program (first fieldwork placement), counseling program track, and location of clinical fieldwork. Participants were asked to complete an online survey, every two weeks, for a total of five data collections. Collecting data five times over the duration of a semester allowed a more comprehensive view of the number of suicidal clients CIT encountered and to see if there were patterns in variables over time. Approval from the institutional review board (IRB), at the researcher's institution, was secured prior to the start of the study.

Experimental Group

Experimental participants had successfully completed the 14-hour, 2-day Applied Suicide Intervention Skills Training (ASIST) workshop. Participants for this group were recruited first. A list of ASIST trained CIT was secured through the certified ASIST master trainer at the researcher's institution. The researcher then contacted potential participants in person and via email and asked ASIST trained CIT to participate in the study. The researcher also contacted ASIST trained CIT at other CACREP accredited, peer institutions that offered the ASIST

workshop. Additionally, the researcher secured permission from department faculty to visit classes, share the details of the study, and solicit participants. The researcher also talked to and emailed potential participants that were former classmates, students, or supervisees, and asked if they would be interested in participating in the research study.

Control Group

Control participants did not complete or participate in ASIST training or any similar intensive formal training on suicide or any other manualized treatment method. In order to recruit a matched control group by site, experimental participants were asked to recommend someone from their practicum/internship site to participate in the study. The primary researcher provided experimental participants with a recruitment flyer that listed the necessary requirements for control group participants. The researcher explained the minimum requirement for the control group and asked the experimental participants to share the recruitment flyer with other interns at their site. The recruitment flyer listed the name of the study, specific requirements for being a control group participant, confirmation of IRB approval, potential risks and benefits to participants, institutional affiliation, as well as the name and contact information of the primary researcher. Experimental participants forwarded the names and contact information of interested participants to the primary researcher. The researcher also visited classes and contacted former classmates, students, and supervisees, to recruit participants.

As potential control group participants were identified the researcher made individual contact with each person and determined if they met the following criteria: a) enrolled in clinical mental health counseling, clinical rehabilitation/rehabilitation counseling, or school counseling master's program, b) competed an introductory skills course and prerequisites for clinical experience, c) enrolled in their first semester of practicum and/or internship, and d) had not

completed an intensive, formal suicide training program, or ASIST. Control participants that met these criteria were asked to participate in the study. Every effort was made to recruit control group participants with coursework, academic experience, and training (except for ASIST) similar to experimental group participants. Potential participants were also asked to forward the recruitment information to fellow students in their master's program. Recruitment for the control group also occurred through class announcements, emails, and in person contact from the researcher. Additional control group participants who met the necessary study criteria were solicited from CACREP accredited institutions through email.

All participants completed an 11-item screening survey, either via pen and paper, electronically, or on the phone, to confirm eligibility for the study (see Appendix A). Participants provided information about: (1) CACREP program status, (2) specific program of study, (3) credits completed, (4) courses completed, (5) specialized training completed, (6) suicide training, (7) counseling experience, (8) status of practicum/internship, (9) practicum/internship hours completed, (10) location of practicum/internship, and (11) primary client population. Responses to the survey were used to match experimental and control group participants. Two additional screening questions included: (12) contact information for potential study participants, and (13) preferred participant incentive. Two incentives were offered, either an Amazon gift card or a donation to the Georgia Crisis and Access Line, with five dollars offered for each survey completed, participants could receive a maximum reward of 25 dollars.

All potential participants were required to complete the initial screening survey. Once the primary researcher reviewed the pre-requisite data and matched pairs, if participants were selected for the study, they were notified via email, phone, or in person. If participants agreed to take part in the study they were informed that all responses from survey data would be de-

identified and they would be assigned a code to ensure confidentiality. Once participants were enrolled in the study, the researcher assigned a unique two-digit code to each individual, which was attached to their name and email address, so a final incentive could be awarded at the conclusion of the study. The spreadsheet with the codes and identifying information was stored in a separate file on a secure computer. Each unique code was entered into the online survey platform so participant responses could be grouped together.

Data Collection

Data collection took place beginning the last week of October and concluded in the third week of December, with a total of five electronic surveys sent to each participant. The demographic and data collection tool were formatted into a questionnaire using Qualtrics, a secure, online survey platform, which generated an individualized link for each participant, to ensure responses were attached to the correct participant code. At the beginning of each survey participants had to consent to participate in the survey, by checking "agree". Participants completed the demographic and data collection tool for survey one. Surveys two through five only consisted of survey questions. Participants receive follow-up emails if they had not completed their survey within twenty-four hours, and again after three days.

In an effort to avoid attrition, an incentive was provided to participants to complete all five data collection points. Participants were offered the option to receive a monetary incentive of five dollars per survey, for a total of 25 dollars if they complete all five surveys over the duration of the fall semester. Either an Amazon gift card or a charitable donation to the Georgia Crisis and Access Line were available. At the conclusion of the study, the researcher used the unique identification code to document the completion of the surveys during the course of the semester and awarded electronic gift cards or the charitable donation to participants.

Measures

Demographic Survey. Demographic data collection included: (1) age, (2) ethnic or cultural identity, (3) gender, (4) sexual orientation, and (5) identification as someone with a chronic illness disability (CID). This data was only collected in survey number one (see Appendix B).

Suicidal Behaviors. Participants were asked to respond "*Yes*" or "*No*" to the following questions: (1) Thinking back over the last two weeks, did any of your students/clients appear at risk of suicide, (2) say they were thinking of killing themselves/ending their life/dying by suicide, or (3) complete suicide? Person experience with suicide was captured with the following question: (4) have you had a personal experience with suicide? (see Appendix C). Response options were: (a) no, (b) self, (c) family member, (d) friend, (e) significant other, or (f) acquaintance (i.e. classmate, community member, extended family, neighbor, etc.).

Clinical Activity Survey. Participants were asked to report the number of clients seen and issues/disorders observed by entering numeric values: (1) How many clients did you see in the last two weeks?, (2) Indicate how many clients you saw in the past two weeks with the following concerns: (a) ADHD, (b) Anxiety, (c) bipolar disorder, (d) depression, (e) developmental transition , (f) disability or chronic health condition, (g) feeding/eating disorder, (h) homicidal, (i) learning disability, (j) personality disorder, (k) relational issues, (l) schizophrenia/severe mental illness, (m) school concerns, (n) spouse/partner issues, (o) substance-related and addictive disorders, (p) suicide, (q) trauma/PTSD, (r) work/employment issues, and (s) other, please specify. For these questions participants were asked to enter a numeric response (see Appendix D).

Counseling Skills Survey. To collect data on skills participants used a 7-point Likert scale ranging from 1 (*Never*) to 7 (*Always)* to answer the following question: Thinking back over the last two weeks, please indicate how many time you use the following counseling micro-skills: (a) active listening, (b) confrontation, (c) empathy, (d) encouragers, (e) goal setting, (f) immediacy, (g) non-verbals, (h) paraphrasing and summarizing, (i) questions, (j) reflecting feeling, (k) reflecting meaning, (l) respect, (m) supported change talk (see Appendix E).

Pathway to Assisting Life Survey. Six statements were grounded in the PAL model (LivingWorks, 2016). Generic ASIST language was used to evaluate counselor skill in each of the phases of engaging with clients, in an effort to explore the transferability of ASIST specific skills to other mental health issues in various settings. Connecting phase statements included, "Asked clients to elaborate on specific actions, feelings, or words used during the session, and/or specifically asked about physical appearance." Understanding phase statements included "Used a reflection of feeling or meaning to help my client feel completely heard and understood." For the assisting phase, statements included, "Asked my client to repeat the plan and any actions associated with the plan, to assess their commitment to the plan." Participants were asked to rate their use of each intervention on a 7-point Likert scale from 1 (*Never*) to 7 (*Always*) (see Appendix F).

Results

Preliminary Analysis of Experimental and Control Groups

Overall, the two groups were comparable in terms of age, race, gender, sexual orientation, program of study, and clinical fieldwork setting. Missing data and outliers were first evaluated. None of the participants were missing extreme amounts of data, so all 54 participants recruited for the study were included in the data analysis. Little's MCR test produced a non-

significant result ($\chi 2 = 200.343$, df = 4,651, Sig. = 1.000), which indicated that data was missing at random. As assessed by an inspection of boxplots, four participants reported observing clients with suicidal behaviors that were more than 3 standard deviations above the mean, so they were removed from any analysis of suicide due to extreme outliers. These four outliers included two experimental participants that reported seeing 45 and 75 clients with suicidal behaviors, and two control participants that reported seeing 7 and 15 suicidal clients over the course of a semester. There were nine outliers and extreme points for direct client hours and number of clients seen, as evidenced by boxplots. These nine participants were removed from any analysis involving accrued individual hours or individual clients. These participants reported seeing zero clients, or direct client contact hours that far exceeded what other participants self-reported.

Result of Levene's test indicated that data met the homogeneity of variance assumption for clients with observed suicidal behaviors ($p = .056$), with skewness and kurtosis values falling between -.858 and .452. The Kolmogorov-Smirnov test was used to test for normality of client hours (Field, 2014). The direct client hours and total number of clients were normally distributed for the control and experimental groups ($p > .05$).

Experimental participants reported seeing 8 - 85 clients (*M* = 42.22, *SD* = 24.13, *Mode* = 67), and control participants reported seeing 2– 79 clients (*M* = 36.31 clients, *SD* = 24.16, *Mode* = 52). Clients could include a person presenting for individual counseling, clients presenting for intake, and clients in groups. Experimental participants reported accumulating 52 – 194 direct client hours (*M* = 111.42, *SD* = 32.03), and control participants accumulated 22 – 208 direct client hours (*M* = 102.00, *SD* = 53.04). There were no significant differences between the groups for number of clients seen and direct hours. A one-way analysis of variance (ANOVA)

found the effect of group on number of clients seen to be non-significant, $F(1,47) = .725$, $p = .399$. Similarly, there was no significant effect of group on the number of direct hours accumulated over the course of the semester, $F(1,44) = 1.388$, $p = .245$.

In terms of suicide, school counselors reported seeing more students/clients with suicidal behavior than clinical mental health or rehabilitation counseling students, but there was not a significant difference, $F(2,46) = .760$, $p = .474$

Table 2

Means and Standard Deviations of Clients with Suicidal Behaviors by Program

	M	*SD*
Clinical Mental Health CIT	1.61	2.08
Rehabilitation CIT	1.47	2.10
School CIT	2.67	2.16

Note. Abbreviations: CIT = counselors-in-training

Main Analysis

Research question one aimed to understand if ASIST trained CIT reported more clients with suicidal behaviors than non-ASIST trained CIT. In terms of suicidal behavior over the course of the semester, experimental participants reported seeing 0 – 7 (M = 2.33, SD = 2.20) suicidal clients, and control participants saw a range of 0 – 5 (M = .96, SD = 1.64) suicidal clients. Observation of suicidal clients was totaled across the five administrations of data collection to obtain these figures.

Table 3

Means and Standard Deviations of Clients with Suicidal Behaviors

	M	*SD*
Experimental	2.33	2.20
Control	.96	1.64

A one-way ANOVA was conducted to test the difference between ASIST and non-ASIST trained participants reported observations of suicidal behavior. There was a statistically

significant difference at the $p < .05$ level between the experimental and control groups, $F(1, 48) = 6.110$, $p = .017$.

Table 4
One-way Analysis of Variance Summary Table for Clients with Suicidal Behavior

Source	*df*	*SS*	*MS*	*F*	*p*	η^2
Between Groups	1	23.54	23.54	6.11	.017*	.11
Within Groups	48	184.96	3.85			
Total	49	208.50				

Note. $*p < .05$

In an effort to understand if the six school counseling students in the experimental group was a confounding variable, that was impacting the significance level for recognition of client suicidal behavior, the six school counseling participants were removed for statistical analysis. Removal of these six school counseling students also resulted in a statistically significant difference at the $p < .05$ level between the experimental and control groups, $F(1, 42) = 4.710$, $p = .036$. The six school counseling students were only removed for the statistical analysis of research question 1, but are included in the statistical analysis for the remaining research questions.

Table 5
One-way Analysis of Variance Summary Table for Clients with Suicidal Behaviors (no school counseling participants)

Source	*df*	*SS*	*MS*	*F*	*p*	η^2
Between Groups	1	18.03	18.03	4.71	.036*	.10
Within Groups	42	160.77	3.83			
Total	43	178.80				

Note. $*p < .05$

Two additional questions were used to explore suicidal behaviors: 1) “Thinking back over the past two weeks of your clinical practicum/internship, did any of your clients appear at

risk of suicide?" and 2) "Thinking back over the past two weeks, did any of your clients say they were thinking of killing themselves, ending their life, or dying by suicide?" Participants had the option to respond "yes" or "no." Experimental participants reported seeing more clients who appeared at risk of suicide, as well as more clients that stated they wanted to die by suicide.

Table 6

Observed Frequencies of Client Suicidal Behavior

	Experimental		Control	
	Yes	No	Yes	No
Client appeared at risk of suicide	53	89	31	89
Client stated they wanted to die by suicide	49	93	18	102

Note. Groups are unequal.

The nonparametric Cochran Q Test was statistically significant for clients stating that they wanted to die by suicide, $\chi^2(4) = 14.387$, $p = .006$, $r = .29$.

In order to understand if awareness of suicide changed over the course of the semester, a between-subjects analysis of variance was conducted to assess the impact of ASIST versus non-ASIST trained CIT, across the five data collection points. There was no significant interaction between experimental and control group participants over time, Wilks' Lambda = .88, $F(4, 44) = 1.55$, $p = .21$, partial eta squared = .12. There was no main effect for time, Wilks' Lambda = .87, $F(4, 44) = 1.69$, $p = .17$, partial eta squared = .13.

Table 7

Means and Standard Deviations for Experimental and Control Groups and Five Data Collection Times

Data Collection Time	Experimental	Control
Time 1		
M	4.19	.82
SD	10.81	1.30
Time 2		
M	.63	.09
SD	1.04	.29
Time3		

M	.78	.55
SD	2.06	1.22
Time 4		
M	.48	.41
SD	1.37	1.71
Time 5		
M	.56	.14
SD	1.37	.47

Research question two explored the types of mental health issues encountered by participants. The means and standard deviations were examined for 19 mental health categories. Participants were asked to self-report a numerical value for the clients they encountered with each of the listed issues and needs. Means and standard deviations were calculated for the experimental and control groups. Overall, anxiety and depression were the most commonly observed mental health issues for experimental and control groups. The experimental group reported anxiety (*M* = 24.86, *SD* = 19.88) and depression (*M* = 22.66, *SD* = 19.32) as top issues. The control participants also reported seeing more clients with anxiety (*M* = 17.80, *SD* = 16.10) than depression (*M* = 15.88, *SD* = 17.10).

Other mental health issues and concerns that ranked at the top of the list for the experimental group included substance use (*M* = 18.34, *SD* = 32.69) and school concerns (*M* = 19.62, *SD* = 25.40), and relational issues (*M* = 13.00, *SD* = 13.67). Work and employment issues (*M* = 11.48, *SD* = 21.73) along with disability (*M* = 11.24, *SD* = 20.96), and substance use (*M* = 10.04, *SD* = 24.19) were among the more frequently observed issues for clients of the control participants.

Table 8

Means and Standard Deviations for Mental Health Issues and Disorders

	Experimental (N = 29)		Control (N = 25)	
	M	*SD*	*M*	*SD*

ADHD	4.97	6.01	4.96	5.91
ASD			.36	1.60
Anxiety	24.86	19.88	17.80	16.10
Bipolar	4.83	10.55	4.78	9.78
Depression	22.66	19.32	15.88	17.10
Developmental Transition	9.10	8.34	4.08	5.10
Disability	5.93	8.61	11.24	20.96
Domestic Violence			2.72	13.60
Eating Disorder	7.86	23.15	4.36	13.26
Homicidal	.86	3.89		
Learning Disability	3.38	5.89	7.64	13.96
Personality Disorder	3.21	6.31	4.68	8.01
Relational Issues	13.00	13.67	7.48	11.33
Schizophrenia	2.97	11.49	3.12	7.28
School Concerns/Issues	19.62	25.40	4.24	5.99
Sex/Gender/Identity Concerns	.14	.44	.04	.20
Spouse/Partner Concerns	6.41	9.71	3.92	8.32
Substance-Related and Addictive Disorders	18.34	32.69	10.04	24.19
Trauma/PTSD	12.52	19.58	7.96	10.40
Work/Employment Issues	6.86	10.98	11.48	21.73

Note. ADHD = attention deficit hyperactive disorder; ASD = Autism spectrum disorder; PTSD = post-traumatic stress disorder

In order to assess the differences between experimental and control groups a one-way ANOVA was conducted. No statistical significance was found for anxiety, $F(1, 52) = 2.02$, $p = .162$, or depression $F(1, 52) = 1.84$, $p = .181$. There was a statistically significant difference at the $p < .05$ level for developmental transitions and school issues. The assumptions of homogeneity of variance was violated for developmental transitions and school issues; therefore, the Welch F-ratio is reported. There was a significant effect at the $p < .05$ level for

developmental transitions, *Welch's F*(1, 47.07) = 7.254, *p* = .010, and school concerns/issues, *Welch's F*(1, 31.58) = 9.986, *p* = .003.

Table 9

One-way Analysis of Variance Summary Table for Mental Health Issues and Concerns

Variable and Source	*SS*	*MS*	*F*(1,52)	*p*	η^2
Anxiety					
Between Groups	669.59	669.59	2.02	.16	.04
Within Groups	17,281.45	332.34			
Depression					
Between Groups	616.29	616.29	1.84	.18	.03
Within Groups	17,449.19	335.56			
Developmental Transition					
Between Groups	334.17	334.17	6.77	.010*	.12
Within Groups	2,567.70	49.38			
School Issues/Concerns					
Between Groups	3176.11	3176.11	8.72	.003*	.14
Within Groups	1,8931.39	364.07			

Note. Abbreviations: CIT = counselors-in-training; *$p < .05$

Research question three explored specific counseling skills used by CIT in counseling sessions. In order to understand what counseling skills are being used with clients, CIT were asked to self-report their use of 13 microskills. When participants ranked their use of counseling skills, experimental and control groups reported using most skills *frequently* (5) and *very frequently* (6). Experimental participants rated themselves highest on active listening skills (*M* = 6.70, *SD* = .47), empathy, (*M* = 6.62, *SD* = .59), and respect (*M* = 6.48, *SD* = .99). Control participants also reported using the same skills most frequently, active listening (*M* = 6.74, S*D* = .363), empathy (*M* = 6.53, *SD*, .53), respect (*M* = 6.60, *SD* = .50). Both groups rated themselves lowest on confrontation and immediacy.

Confrontation was the only counseling skill that resulted in a significant difference between groups. A one-way ANOVA found the effect of ASIST on confrontation skills was not significant, $F(1,52) = 3.731$, $p = .059$.

Table 10

Means and Standard Deviations for Counseling Skills

	Experimental		Control	
	M	*SD*	*M*	*SD*
Active Listening	6.69	.48	6.74	.36
Empathy	6.62	.59	6.54	.53
Respect	6.48	.99	6.60	.50
Non-Verbals	6.46	.72	6.14	.77
Encouragers	6.26	.62	6.26	.67
Open Ended Questions	6.09	.71	6.19	.65
Reflecting Feeling	5.91	.96	5.86	.93
Reflecting Meaning	5.52	.91	5.46	1.01
Change Talk	5.32	1.09	5.40	.84
Goal Setting	5.28	.68	5.48	.87
Immediacy	4.73	1.09	4.78	.95
Confrontations	4.49	.91	3.98	1.06

Note. Experimental (N = 29); Control (N = 25)

Although not a specific research question, this research also sought to understand if the pathway for assisting life (PAL) model was being used in counseling sessions. Participants used a 7-point Likert scale to rate their use of each skill: 1 =*never*, 2 = *very rarely*, 3 = *rarely*, 4 = *occasionally*, 5 =*frequently*, 6 = *very frequently*, 7 = *always*. When comparing the groups on the use of PAL, experimental participants rated themselves using all six steps more than the control group. Experimental participants reported that they *very frequently* asked directly (M = 6.17, SD = .73) and *very frequently* heard the story (M = 6.14, SD = .81. Control participants also reported asking directly (M = 5.88, SD = .66) and hearing the story (M = 5.75, SD = .80), but rated these skills as being used *frequently.*

Table 11

Means and Standard Deviations for Pathway for Assisting Life (PAL)

	Experimental		Control	
	M	*SD*	*M*	*SD*
Explore Invitations	5.80	.89	5.19	1.05
Ask Directly	6.17	.72	5.88	.66
Hear Story	6.14	.81	5.75	.81
Support the Turning	5.41	1.01	5.11	.81
Develop a Safe Plan	5.39	.93	4.86	1.02
Confirm Actions	4.50	1.37	4.10	.1.03

There were significant differences between groups for exploring invitations and developing a safe plan. A of a one-way ANOVA found the effect of ASIST on exploring invitations to be significant, $F(1,52) = 5.380$, $p = .024$. Similarly, there was a significant effect for developing a safe plan, $F(1,52) = 4.125$, $p = .047$.

Table 12

One-way Analysis of Variance Summary Table for Pathway for Assisting Life (PAL)

Variable and source	*SS*	*MS*	*F*(1,52)	*p*	η^2
Explore Invitations					
Between Groups	5.00	5.00	5.38	.02*	.09
Within Groups	48.33	.93			
Ask Directly					
Between Groups	1.12	1.12	2.33	.13	.04
Within Groups	25.02	.48			
Hear Story					
Between Groups	2.07	2.07	3.17	.08	.058
Within Groups	33.90	.65			
Support the Turning					
Between Groups	1.20	1.20	1.41	.24	.03
Within Groups	44.35	.85			
Develop a Safe Plan					
Between Groups	3.91	3.91	4.13	.05*	.07
Within Groups	49.26	.95			
Confirm Actions					
Between Groups	2.22	2.22	1.49	.229	.03

Within Groups	77.74	1.50

Note. $*p < .05$.

Discussion

This study investigated how Applied Suicide Intervention Skills Training (ASIST) may heighten CIT awareness and sensitivity when working with clients who present suicidal behaviors or other mental health issues. More specifically, this study sought to better understand if participants that have completed the 2-day, 14-hour suicide intervention training are noticing more clients with suicidal behaviors, have an increased awareness of mental health issues and concerns, and are using a broader range of counseling skills than their non-ASIST trained peers. Results from this study will help build more research and evidence for the potential impact and use of ASIST, and how it may be beneficial to counselors, counselor educators, and clients. Suicide is devastating, so preparing future counselors to know the signs of suicide, and how to intervene is crucial. This is the first study to evaluate the use of ASIST in real-time, and it will help us begin to learn how CIT are or are not using the intervention with suicidal and non-suicidal clients. Teaching CIT the pathway for assisting life may help reduce the stress and anxiety that comes when faced with a person contemplating suicide, and it may save lives.

The first research question sought to explore if ASIST trained participants reported seeing more clients with suicidal behaviors than the non-ASIST trained CIT. This question was statistically supported in favor of ASIST trained CIT. ASIST trained CIT reported seeing more suicidal clients than non-ASIST trained CIT. On average, experimental participants reported seeing two suicidal clients to every one suicidal client seen by control participants. Because ASIST focuses on exploring invitations (i.e. words, feelings, behaviors, and physical changes in persons at-risk) the results of this study indicated that experimental participants appear to be

more aware of the signals for potential suicidal behavior. Overall, school CIT reported seeing more students with suicidal behaviors than the clinical mental health or rehabilitation counseling CIT, which is expected considering the large student caseloads carried by school counselors (Downs et al., 2002; McCarthy, Van Horn Kerne, Calfa, Lamber, & Guzman, 2010). However, removal of school CIT from the SPSS analysis for suicidal behaviors also produced a statistically significant result, indicating that regardless of setting, CIT trained in ASIST are noticing more clients with suicidal behaviors. That both of these findings are statistically significant is consistent with research on the value of formal training in identification and interventions around suicide (Gould, Cross, Pisani, Munfakh, & Kleinman, 2013; Neimeyer & Pfeiffer, 1994; Schmitz et al., 2012). A major component of ASIST training is connecting with suicide through verbal, non-verbal, direct, and indirect invitations being emitted by the person at-risk (LivingWorks, 2013; Rodgers, 2010). ASIST training is designed to heighten awareness of signs of suicide, therefore making the person leading the intervention more likely to notice, understand, explore, and intervene.

In order to further assess observed suicidal behaviors, participants were asked to report "yes" or "no" to the following questions: 1) "Thinking back over the past two weeks of your clinical practicum/internship, did any of your clients appear at risk of suicide?" and 2) "Thinking back over the past two weeks, did any of your clients say they were thinking of killing themselves, ending their life, or dying by suicide?" On average, experimental participants reported seeing 102 clients who had some form of suicidal behavior, compared to the control group which reported seeing 49 clients with suicidal behavior. As previously noted, experimental and control participant were seeing approximately the same number of clients over the duration of the study, so these results suggest that non-ASIST trained CIT may be missing opportunities

to intervene with clients experiencing suicidal behaviors. Consistent with the literature, ASIST trained participants seem to demonstrate behavioral changes that make them more aware of invitations/signs of suicide (Gould et al., 2013). Isometsä (2001) has reported that only one-third to one-half of suicidal clients specifically verbalize suicidal intentions, indicating that non-ASIST trained participants potentially missed invitations from their clients, and lost an opportunity to intervene.

If ASIST trained participants are more likely to be aware of the signs of suicide, then this finding seems of major importance because persons at-risk are being overlooked, or the lack of training may deter CIT from attempting an intervention. The reported results from this particular question indicated that 31 clients appeared at risk and 18 stated they wanted to die, and the CIT working with these clients did not have any formal suicide intervention training. This finding indicates there were 49 interactions between a CIT with no formal suicide intervention training and a person at-risk, which leads to questions about the type of interaction and intervention that may or may not have occurred.

Research question two sought to examine mental health issues and concerns observed by CIT. Anxiety and depression were the most frequently observed issues by ASIST and non-ASIST trained participants, but there were not statistically significant difference between the groups on these issues. Across the 21 issues and disorders, there were statistically significant differences for developmental transitions (i.e. birth, graduation, grief/loss, marriage, divorce, etc.) and school concerns/issues. These results included six school counselors, so a heightened awareness of these particular issues may be a result of the volume of students seen by school counselors and the concerns of school aged children, rather than the result of ASIST training. Considering the statistically meaningful results found for suicidal behaviors with and without the

school counselors, it is surprising that depression was not statistically significant, since it is often thought to be one of the determinants of suicidality. However, as purported by ASIST (LivingWorks, 2013)and other studies (Joiner, 2005; Rodgers, 2010), depression is not a necessary, or consistently reliable factor for suicidal behavior. Feelings of not belonging, perceived burdensomeness, and a host of other life factors (i.e. financial issues, loss of employment, bullying, acquiring an illness, etc.) are all potential factors that may lead someone to consider suicide. Using depression as the benchmark for suicide means ignoring potential factors that are causing significant distress for clients. Alternatively, non-ASIST CIT may be recognizing depression in their clients but not pursuing the issue further to determine any potential suicidal ideation.

Across the two groups, experimental participants reported seeing more mental health issues/concerns in 12 out of 21 categories. This could point towards a heightened sensitivity and awareness of ASIST trained CIT versus non-ASIST trained CIT. But the differences were not significant, so research question two was not generally supported by the results of this study.

This study also examined the use of 13 counseling skills by CIT. Active listening, empathy, and respect were ranked as the most used skills by ASIST and non-ASIST trained participants. In line with the core conditions of counseling, active listening, empathy, and respect are often cited as basic skills needed to facilitate the therapeutic relationship (Hill, 2004; Rodgers, 1957; Young, 2013). While this finding is not new, having CIT self-report the use of these skills is encouraging. Literature points to the importance of the relationship over the technique (Erskine, 1998; Ilgen, Tiet, & Finney, 2006; Young, 2013), which is also in line with the message of ASIST. Taking time to hear a person's story, to understand their situation, helps

to build a relationship of trust and respect so there can be an intervention (LivingWorks, 2013; Rodgers, 2010).

Both groups report they were only using confrontation and immediacy occasionally when working with clients. These findings are developmentally appropriate for beginning CIT. Confrontation and immediacy are considered more advanced skills that most CIT practice infrequently or feel uncomfortable using in session (Lonborg, Daniels, Hammond, Houghton-Wenger, & Brace 1993; Turock, 1980; Wheeler & D'Andrea, 2004; Young, 2013). However, of the 13 counseling skills that were explored, confrontation was the only one that resulted in near statistical significance ($\alpha = .05$). Despite the absence of statistical significance, it is important to note that ASIST emphasizes the importance of hearing the story of a person at-risk, and directly asking about suicide. This direct approach to asking about suicide is an essential and critical step in the PAL model. The ability of CIT to directly address the invitations presented by the client, whether suicidal or non-suicidal, has the potential to reduce stigma, discomfort, and fear in clients (Angermeyer, Matschinger, & Riedel-Heller, 1999; Snyder et al., 2017). The thorough role-play scenarios incorporated into ASIST training, coupled with the repeated practice of directly asking about suicide, helps CIT improve the necessary skill of immediately addressing client issues.

Though not included in the three specific research questions, this study also explored the use of the six tasks of the Pathway to Assisting Life. In general, experimental participants rated themselves using PAL more than the control group, across all six tasks. In particular, exploring invitations and developing a safe plan showed statistically significant results. This means ASIST trained CIT are more likely to pay close attention to verbal, non-verbal, physical, and other clues or actions exhibited by the client. This provides support for the transferability of ASIST training

to the fieldwork experiences of CIT. Additionally, the experimental group also reported frequently developing a safe plan with clients. During the assisting phase of PAL, participants are taught to make safety an immediate priority. Rather than focusing on a long-term plan, or trying to quickly solve the issue, ASIST emphasizes the need to help a client use internal and social resources to provide individual solutions to unique needs (LivingWorks, 2013). Similarly, within the field of counseling we teach CIT to use skills such as open-ended questions, reflecting feeling and meaning, as well as paraphrasing and summarizing to explore comments made by our clients, to better understand what they are communicating. It appears that ASIST may emphasize these skills and offer additional practice and guidance. Finally, in line with the counseling literature, clients are considered the expert on what resources, skills, and actions they need to take, when facing concerns or issues (Bedi, Davis, & Arvay, 2005; Fitzpatrick, Janzen, Chamodraka, & Park, 2006; Simpson & Bedi, 2012). ASIST models this same principle and asks that the CIT and client work together, to construct a feasible and reasonable plan that helps a client take action, relying on their own internal strength, while knowing they have support.

Finally, one of the most unique aspects of this study is the real-time data collected over the duration of the semester at five different time points. Rather than ask CIT to recall their client interactions at the end of the semester, and risk participants under or over estimating their self-report data, the researcher asked CIT to report over time, which may have resulted in a more accurate snapshot of counselor/client interactions. Rarely do studies collect real-time data about counseling skills used in sessions with clients or mental health issues observed in clients. Collecting data in real-time, over the course of a semester, can help supervisors gain insight into the types of issues faced by CIT and may prove beneficial to supervisors as they organize supervision sessions.

Implications for Counselors-in-Training and Counselor Education

One death by suicide is too many. Because most CIT will encounter clients with suicidal thoughts and behaviors, and because counselor educators will supervise CIT working with suicidal clients, it is clear that suicide intervention training is warranted. The results from this study indicate that ASIST trained CIT reported more clients with suicidal behaviors that non-ASIST trained CIT. Furthermore, the results from this study indicated that first semester practicum/internship students are seeing a bevy of suicidal students and clients. Waiting for these CIT to receive training during their first clinical experience is detrimental to our ethical practices, the wellness of our clients, and the development of novice counselors. Although ASIST has been evaluated through crisis call centers (Gould et al., 2013), SAMHSA, adopted by NREPP and the U.S. Military, this is the first study to collect real-time data from ASIST trained participants who are in their first semester of clinical fieldwork. Further research and more participants are needed to fully explore the impact and implications of ASIST on clinical practice.

Although the results from this study did not find an overwhelming amount of statistical significance for heightened awareness and sensitivity to other mental health issues, experimental participants did report higher observations in 12 out of 21 behaviors, which indicates that ASIST has the potential to help CIT become more inclined to notice behaviors based on invitations and various verbal and non-verbal signs presented by the client. If ASIST has the potential to heighten suicide awareness, as well as general mental health awareness, ASIST should be offered in clinical counseling programs across the country, as a supplement to the minimal crisis and suicide training currently offered to most CIT.

It is also important to note that first semester, non-ASIST trained CIT may be missing significant suicidal behavior and other mental health issues. Non-ASIST trained CIT are noticing clients with suicidal thoughts and behaviors, but what intervention, if any, are they using, and how comfortable and confident are they with the interaction? Since we know that interaction with a suicidal client is nearly inevitable, offering thorough intervention training prior to practicum/internship seems like best practice. Finally, ASIST trained CIT may be more comfortable with confrontation, which may help CIT more quickly identify client concerns and issues.

Limitations and Future Directions

The findings from this study are not without limitations. First, all of the responses were self-reported. Participants may have been hesitant to report certain information, may have over or under-estimated clinical hours accumulated, and may have inaccurately reported types of issues seen and skills used. Several of the participants reported an accumulation of direct clinical hours that far exceeded what would actually be possible to accrue in the course of a semester, potentially skewing the data. Other participants reported what appeared to be extreme observed numbers for particular mental health issues and concerns, making it unclear if they were counting every client at their site, rather than clients they directly served. Some participants may have been worried about social desirability and altered answers to better reflect what they think the researcher wanted or where they wished to be in their clinical development. The majority of participants rated themselves very high on use of counseling skills, which seems inflated based on their lack of experience and practice. Although all participants were de-identifed, the potential for linkage to responses could have resulted in more self-preserving and enhancing responses.

There was not a one to one match for the clinical sites of the programs of study. The imbalance in clinical setting and the types of clients seen could have impacted the results. Not having a control group match for the school CIT was also a major limitation and did not allow for equal comparison in a setting where more students are seen on a daily basis than most clinical settings. Other limitations include the measures used in this study. None of the instruments were valid or reliable because to date no scales have been developed to specifically evaluate ASIST or the use of ASIST with suicidal clients. Additionally, asking participants to quantify number of clients seen and particular mental health issues assessed is no easy feat. Participants were asked to report the number of individual clients seen, but it is unclear if they reported clients from individual counseling sessions, clients from groups, or other client interactions. Solidifying a way to secure a more accurate reflection of number of clients seen could help us better understand caseloads during the first clinical semester. There was also some issue surrounding reported mental health issues and concerns. Some participants reported seeing high volumes of particular disorders, which seemed unlikely considering their self-reported direct client hours. This made it unclear if participants were reporting issues for individual clients versus clients in groups or clients enrolled at their respective facility.

This is also a one-sided study, with no input from clients that interacted with the CIT. In an effort to better understand how ASIST versus non-ASIST trained clinicians are intervening with clients, it would be helpful to hear from the actual clients. Although there are ethical implications and considerations with this type of research, hearing from clients would provide valuable insight and direction. Furthermore, this is the first study to evaluate the use of ASIST on non-suicidal clients, so further research is needed to determine how to explore the generalizability of the Pathway to Assisting Life to other mental health issues and concerns.

Conclusion

Considering the stigma and taboo of suicide, inserting ASIST into counseling curriculum may prove beneficial for CIT, counselor educators, and clients. While clients may be afraid to talk about suicide for fear of rejection, hostility, judgment, anxiety, and avoidance (CITATION) some counselors fear that the mention of suicide will increase the risk of client suicide (Mathias et al., 2012), despite literature refuting this claim (Cukrowicz, Smith, & Poindexter, 2010; Deeley & Love, 2010). Counselor educators need to continually refute this claim and emphasize the importance of comfort when addressing suicide. The increase in suicide in the U.S. (Drapeau and McIntosh, 2017) and worldwide (WHO, 2014), the fear of encountering a client with suicidal behavior (Jahn, Quinnett, & Ries, 2016; Pope & Tabachnick, 1993), and the continual recognition of inadequate suicide intervention training for CIT (Barrio Minton & Pease-Carter, 2011; Lund, Schultz, Nadorff, Galbraith, & Thomas, 2017; Schmidt, 2016) make it imperative for mental health professionals to learn how to understand, connect, and assist with suicide. Though there have been numerous studies evaluating ASIST and calling for more suicide intervention training in the counseling curriculum, the counseling field continues to lag behind when it comes to thoroughly understanding how a standardized, and manualized suicide intervention training can help reduce the fatality of suicide. Despite the limitations of this study, there is evidence that ASIST results in positive outcomes and in the identification of suicidal behaviors.

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APPENDICES

Appendix A

Inclusion and Matching Criteria Survey

Please circle/fill-in your answer for each question. Thank you.

1. **Is your counseling program CACREP accredited?**

   Yes
   No

2. **What is your specific program of study?**
   a. Clinical Mental Health Counseling
   b. Clinical Rehabilitation Counseling/Rehabilitation Counseling
   c. School Counseling
   d. Other: please specify

3. **Approximately how many credits have you completed in your current counseling program?**

4. **Have you completed any of the following courses?** (circle all that apply)

   Assessment /Appraisal
   Ethics
   Crisis Intervention/Crisis Counseling
   Advanced Counseling Skills (i.e. motivational interviewing)
   Basic Counseling/Helping Skills

5. **Have you completed any prior suicide trainings or other formal/manualized counseling system training (i.e. workshops on suicide, specific counseling techniques and or interventions such as DBT, ASIST, CBT, etc.)?** (circle all that apply)

(a) I have had no prior training in suicide response.
(b) I have had training in suicide response through a course lesson in my master's program.
(c) I have had training in suicide response both through a course lesson in my master's program and an experience outside of my program.
(d) I have attended and successfully completed Applied Suicide Intervention Skills Training (ASIST).
(e) I have had training in suicide response through an experience outside of my master's program (not related or required by my program).
(f) I attended an intensive suicide workshop (not ASIST) that was at least 8 – 16 clock hours (i.e. QPR, Sources of Strength, Signs of Suicide, Lifelines, AMSR, etc.).
(g) Other, please specify:

6. **Tell us about your experience as a counselor:** (circle all that apply)

   (a) My current practicum/internship site is my first experience as a counselor.
   (b) Prior to this semester, I held a practicum/internship position as a counselor.

(c) Prior to enrolling in my master's program, I worked in a counseling agency.
(d) As an undergraduate I was a peer counselor on campus or in a community agency.
(e) I have been a camp counselor.
(f) I have previous volunteer experience as a counselor.
(g) Prior to pursuing my current master's degree, I worked in school where I often served as a counselor to students.
(h) Prior to pursuing my current master's degree, I worked in a community agency where I often served as a counselor to clients.
(i) I have worked/volunteered at a suicide hotline or call center.

7. Are you currently enrolled in:

a. Practicum
b. Internship
c. Both
d. Other: please specify

8. Where are you completing your practicum or internship?

Abused and Battered Women's Shelter
Addiction Treatment Services
Career Services (college)
Children's Home/Children's Treatment Facility
College Counseling Center
Community Agency
Disability Services Office (college)
Homeless Shelter
Hospital
Private Practice
Public Elementary School
Public Middle School
Public High School
Private Elementary School
Private Middle School
Private High School
Psychiatric Hospital (Inpatient)
Psychiatric Hospital (Outpatient)
Rehabilitation Clinic/Hospital
Religious Organization
State agency
Substance Abuse Clinic
Vocational Rehabilitation Agency
Other, please list:

9. **What population does your practicum or internship site primarily serve?** (circle all

that apply)

ADHD
Anxiety
Bipolar Disorders
Depression
Developmental Transitions (i.e. graduation, birth, marriage, divorce)
Disability or Chronic Health Related Issues
Feeding/Eating Disorders
Grief/Loss
Homicidal
Learning Disability
Personality Disorders
Relational Issues (i.e. spouse/partner, family, friends)
Schizophrenia/Severe Mental Illness
School Concerns/Issues
Substance-Related and Addictive Disorders
Suicide
Trauma/PTSD
Work/Employment Issues
Other, please specify:

10. How would you like to receive your $ incentive?

a. Amazon Gift Card
b. Donate to GCAL (Georgia Crisis and Access Line)

11. Is there another intern at your site that we could ask you to participate in the study?

Appendix B

Demographic Survey

What is your age in years?

What is your ethnic or cultural identity?

- Hispanic or Latino
- Black or African American
- Caucasian/White
- Asian American
- American Indian or Alaska Native
- Native Hawaiian or Pacific Islander
- Biracial
- Other, please specify:

What is your gender identity?

- Male
- Female
- Transgender
- Gender Queer/Gender Non-Conforming

Which of the following describes your sexual orientation?

- Gay
- Lesbian
- Straight (heterosexual)
- Pansexual/Omni-sexual
- Other, please specify:

Do you identify as a person with a chronic illness, medical condition, or disability?

- Yes
- No

Appendix C

Suicidal Behaviors

1. Thinking back to the start of your clinical practicum/internship, did any of your clients appear at risk of suicide?

    - Yes
    - No

2. Since the start of your clinical practicum/internship, did any of your clients say they were thinking of killing themselves, ending their life, or dying by suicide?

    - Yes
    - No

Appendix D

Clinical Activity Survey

Since the start of your clinical practicum/internship, please indicate how many clients you have seen with the following concerns. Only enter a numerical response in the text box, if you have seen clients with that concern.

ADHD
Anxiety
Bipolar Disorder
Depression
Developmental Transitions (e.g. birth, graduation, grief/loss, marriage, divorce, etc.)
Disability or Chronic Health Issue
Feeding/Eating Disorder
Homicidal
Learning Disability
Personality Disorder
Relational Issues
Schizophrenia/Severe Mental Illness
School Concerns/Issues
Spouse/Partner Issues
Substance-Related and Addictive Disorders
Suicide
Trauma/PTSD
Work/Employment Issues
Other, please specify:

Appendix E

Counseling Skills Survey

Thinking back over the beginning of your practicum/internship, please indicate how often you used the following counseling microskills.

Never, Very Rarely, Rarely, Occasionally, Frequently, Very Frequently, Always

Active Listening Skills
Confrontation
Empathy
Encouragers
Goal Setting
Immediacy
Nonverbals
Paraphrasing/Summarizing
Questions
Reflecting Feeling
Reflecting Meaning
Respect/Unconditional Positive Regard
Supported Change Talk

Appendix F

Pathway to Assisting Life (PAL) Survey

Since the start of your clinical practicum/internship, please indicate how often you have used the following interventions with clients.

Never, Very Rarely, Rarely, Occasionally, Frequently, Very Frequently, Always

1. Asked clients to elaborate on specific actions, feelings, or words used during the session, and/or specifically asked about physical appearance.

2. Used closed and open-ended questions to directly ask about my client's issues and concerns.

3. Used a reflection of feeling or meaning to help my client feel completely heard and understood.

4. Assisted my client to help her/him identify sources of support and hope in her/his life.

5. Helped my client develop a temporary, or short-term plan, to deal with their specific issue or concerns.

6. Asked my client to repeat the plan and any actions associated with the plan, to assess their commitment to the plan.