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# The Development of Self-Efficacy to Work with Suicidal Clients

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## The Development of Self-Efficacy to Work with Suicidal Clients

### **Abstract**

Suicide is a public health crisis which counselors must be prepared to address. In this grounded theory study, the researchers advance a model to show how counselors develop self-efficacy to work with suicidal clients. Counselor educators may use this model to improve programmatic training and supervision of students.

### **Keywords**

Counselor Education, Suicide, Self-Efficacy, Supervision, Grounded Theory

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## The Development of Self-Efficacy to Work with Suicidal Clients

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*Suicide is a public health crisis which counselors must be prepared to address. In this grounded theory study, the researchers advance a model to show how counselors develop self-efficacy to work with suicidal clients. Counselor educators may use this model to improve programmatic training and supervision of students. Keywords: Counselor Education, Suicide, Self-Efficacy, Supervision, Grounded Theory*

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Suicide is a growing health crisis in the United States. In 2014, 9.4 million adults in the United States had serious thoughts of suicide, 2.7 million made a suicide plan, and 1.1 million attempted suicide (Lipari, Piscopo, Kroutil, & Kilmer Miller, 2015). A third of people who die by suicide have contact with a mental health professional in the year before their death and 20% have contact in the last month of their life (Luoma, Martin, & Pearson, 2002). Amongst adults in mental health treatment in 2014, almost 14% had serious thoughts of suicide, over 4% made suicide plans, and 1.8% made a suicide attempt (Lipari et al., 2015). These data highlight the importance of mental health professionals being prepared to work with suicidal clients.

Researchers have used the rise in statistics like these to suggest that virtually all counselors will work with a suicidal client at some point in their career (Binkley & Leibert, 2015). Twenty-five years ago, a client suicide was already considered “an important occupational hazard for psychotherapists” (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989, p. 294), and in 2016 the suicide rate in the United States hit a 30-year high (Curtin, Warner, & Hedegaard, 2016). Given the likelihood that mental health professionals will encounter clients with suicide concerns, it is essential that research examine how counselor education programs can prepare counselors to work with suicide as a clinical issue.

Recognizing counselors have a role in meeting the needs of the rising number of suicidal clients in the population, there have been calls for strengthening the standards for counselors in suicide and crisis intervention skills (Binkley & Leibert, 2015; Liebling-Boccio & Jennings, 2013). Despite these calls, the Council for Accreditation of Counseling and Related Educational Programs (CACREP) changed the standards related to suicide competencies when moving from the 2009 to the 2016 standards. The 2009 standards included both competency- and knowledge-based standards for working with suicide, whereas the 2016 standards contain only knowledge-based standards (CACREP, 2009, 2016).

There is no question that education is a critical component in providing suicide intervention skills to students (Sawyer, Peters, & Willis, 2013; Wachter Morris & Barrio Minton, 2012), but with this limited mandate from counseling’s major accreditor, counselor

education programs may not be providing students the necessary skills to competently work with suicidal clients (Barrio Minton & Pease-Carter, 2011; Pisani, Murrie, & Silverman, 2015; Schmidt, 2016; Schmitz et al., 2012; Wachter Morris & Barrio Minton, 2012). Clinical mental health counselors have reported training they received on suicide intervention and management skills as being minimal or non-existent (Wachter Morris & Barrio Minton, 2012). Research has also suggested school counselors often struggle in completing a suicide risk assessment (Schmidt, 2016).

Suicide education influences self-efficacy and self-efficacy impacts performance in working with clients. Sawyer and associates (2013) conducted a quantitative study (N=34) and found education can impact a student's self-efficacy to work in crisis situations. Jahn, Quinnett, and Ries (2016) surveyed 289 practitioners and found respondents who reported their suicide-focused training was sufficient exhibited less fear and more comfort in working with suicidal clients. Both Schmidt (2016) in a quantitative study (N=339), and Oordt, Jobes, Fonseca, and Schmidt (2009) in a quantitative study (N=82) found training in suicide assessment is linked to preparedness and confidence levels when conducting suicide risk assessments.

Wachter Morris and Barrio Minton (2012) utilized a quantitative design (N=193) in determining that counselors-in-training who have not had suicide-specific training report lower self-efficacy for working with suicide issues than students who have had academic preparation. Douglas and Wachter Morris (2015) used a quantitative study (N=324) to find clinicians who possess a low degree of self-efficacy are more likely to perform poorly because of doubt about their ability. Self-efficacy has been deemed just as important to students' progress as the formal assessment of their abilities (Kamen, Veilleux, Bangen, VanderVeen, & Klonoff, 2010).

There is a small body of research examining counselors' development of self-efficacy to work with suicide issues. Some researchers have advocated for providing training on suicide skills prior to students' practicum experience (Binkley & Leibert, 2015; Wachter Morris & Barrio Minton, 2012). Others have explored specific areas of study that contribute to student competency and self-efficacy (Douglas & Wachter Morris, 2015; Sawyer et al., 2013). Still others have focused on supervisory competencies for working with counselors with suicidal clients (Hoffman, Osborn, & West, 2013). While research has begun to establish the training needs of counselors, no studies could be found that explored the process through which counselors develop self-efficacy to work with suicidal clients. With an understanding of this process, counseling programs can be purposeful in developing strategies to better prepare counselors for this work. Therefore, this research team posed the following question: What is the process through which counselors develop self-efficacy to work with suicide as a clinical issue?

## Method

The goal of the study was to explore how counselors develop self-efficacy to work with suicidal clients. The authors chose a grounded theory methodology to allow participants to share their experiences and to generate a theory illustrating the contributing factors to counselor self-efficacy. As grounded theory utilizes an inductive approach (Heppner & Heppner, 2004), the construct of self-efficacy was deconstructed based on the participants' responses, values and experiences. Data analysis allowed the researchers to generate a theory describing the process of how the participants developed self-efficacy to work with suicidal clients.

## Research Team

The research team consisted of four women, two men and one faculty advisor in a doctoral program of counselor education and supervision in rural Colorado. Five members of

the research team identified as White and two as Latina. The research team had over 40 years of combined work experience in community mental health, school counseling, and higher education counseling programs. Expertise within the research team included the lead author being active as a trainer in community workshops on suicide prevention and the second author's experience working with communities affected by mass-casualty tragedies. The remaining four authors work in urban and rural settings where suicide rates are some of the highest in the state.

Prior to collecting data, the research team discussed potential biases regarding the study. Identified biases included the belief that counselors will encounter a client who is suicidal early in their career, often as early as practicum. The team believed that working with clients who are suicidal requires a specific skill-set that can be taught in a graduate program or separate workshop. Finally, the team expected to learn that graduate programs may not be equipping students with the knowledge and competencies to effectively work with clients who are suicidal.

### **Participants and Procedure**

Once institutional review board approval was obtained, participants were recruited through a stratified purposeful sampling procedure using email invitations and screening interviews. Invitations were sent to the local community mental health center and to the on-campus cohort of counseling students at the local CACREP-accredited counselor education program. A total of 70 persons were invited to participate in the study. Invitations were restricted to the general geographic area as the study was constructed around in-person interviews. The main exclusion criteria was a requirement that participants be either a counseling student, or a graduate of a counseling program, thus restricting participation to individuals affiliated with the counseling profession. Selection criteria included level of education and experience with suicide (personal or professional experience). Participant ability to fully participate in the study was the final selection criteria.

The first and sixth authors conducted screening interviews with all respondents to the email invitation which included comprehensive coverage of informed consent. Once eligibility was determined, participants were scheduled for face-to-face interviews. All participants lived and worked in a community with access to suicide-specific skills workshops such as the Applied Suicide Intervention Skills Training (ASIST) and the Assessing and Managing Suicide Risk (AMSR) workshop, although participation in these workshops was not part of the eligibility criteria.

Participants (N=14) included nine students in a CACREP accredited counseling program in Colorado, three unlicensed graduates practicing as counselors and two licensed professional counselors (LPCs) practicing in the greater community. Eight participants identified as Caucasian, four as Hispanic and two as mixed-race. Participant ages ranged from 25 to 62. Counseling experience ranged from less than one year to 30 years. Of the 14 participants, 10 were women and four were men. Participants reported a range of experience working with suicidal clients from no experience to extensive experience. All but one participant reported personal experiences with suicide including family, friends or the participants' own past thoughts of suicide.

### **Data Collection**

Each participant participated in a one-hour, face-to-face interview. The interview team included the first and sixth authors. The interview team rotated roles as lead interviewer and observer where the lead interviewer conducted the interview while the observer noted

behaviors or additional questions to ask the participant at the end of the interview. The remaining four authors were members of the transcription and coding team. Each interview was audio recorded and one member of the transcription and coding team transcribed each interview verbatim.

Interviews were semi-structured with a core set of questions and individualized follow-up questions based on the flow of the interview with the participants. Examples of questions included: “What attitudes and beliefs do you have about suicide and where did those come from?”, “What does it feel like to develop self-efficacy in order to work with clients who are suicidal?”, “How do you evaluate or know you are effective when working with clients who are suicidal?”, and “How ready or prepared are you to work with a client who presents as suicidal?”

Both teams maintained reflexive journals noting personal reactions to each interview. The interview team debriefed after each interview and audio recorded their observations, which were subsequently transcribed and coded. The transcription and coding team kept journals noting observations from the interviews and met on a regular basis to discuss their observations.

## **Data Analysis**

Grounded theory relies on systematic procedures to analyze and develop theory which includes generating categories through coding data in multiple formats (Creswell, 2013). In this study the data included interview transcriptions, interview observations, and research team reflexive memos. The researchers utilized a constant data comparison process to identify and develop categories and themes from the interview data. The research team made use of open coding procedures to initially analyze the transcriptions. Through open coding, the authors identified broad themes and processes (Saldaña, 2013). The research team then used axial coding to identify significant terms, phrases, and statements that were subsequently refined into categories related to the research question. Data was gathered through participant interviews and analyzed until data saturation was achieved. Finally, a theory was developed which incorporated the themes and which illustrated the major influences on self-efficacy and their interplay in the development of self-efficacy to work with suicidal clients.

The researchers achieved data saturation when the constant data comparison process ceased to provide new conceptual categories and conditions (Corbin & Strauss, 2015). The authors noted similarities in participant data between interviews 10 and 12 and the remaining interviews confirmed saturation. While some writers have called for grounded theory studies to utilize between 20 and 60 participants (Creswell, 2013), others are resolute that grounded theory studies should utilize only enough participants to achieve saturation (Mason, 2010). While the research team was confident that saturation had been achieved at 14 participants, the study’s sample size is nevertheless addressed in the Limitations section as a limitation of the study. After axial coding was complete, the researchers engaged in selective coding of the data related to participants’ experiences of self-efficacy to work with clients who are suicidal.

Participants were invited to attend a focus group in person or via the phone. Of the 14 participants, 11 were able to attend a focus group. Three were unable to attend due to unresolvable scheduling conflicts. The participants were emailed the model prior to the focus group meetings to allow them to reflect on it prior to the focus group discussions. During the focus groups, researchers reviewed the results and model and asked for additional thoughts or corrections. Participants confirmed that their experiences of developing self-efficacy to work with suicide issues had been captured and expressed within the categories and themes in the model. Several adjustments were made to the model based on the participants’ feedback.

## **Trustworthiness**

A number of protocols were followed to ensure the trustworthiness of the data. The study was designed around the utilization of a constant comparison procedure of data analysis, an accepted procedure in grounded theory studies (Corbin & Strauss, 2015). All transcriptions were reviewed by one of the interviewers to ensure that the transcriptions were a verbatim reflection of the interviews. The research team met regularly and maintained reflexive journals where observations and concerns were recorded and then discussed at the next meeting. Multiple team members reviewed each transcript to determine if the same experiences were being identified in the data analysis (triangulation). Theoretical sampling techniques were utilized to fine-tune the theory and heuristic as themes and categories led to the development of the theory (Corbin & Strauss, 2015).

The research team also facilitated two focus group sessions for the purpose of presenting the study's findings. The focus groups provided an opportunity to confirm the study's findings with the participants and provided an opportunity for participants to discuss their experiences with each other. This process is referred to as "member checking" and it serves to ensure the credibility of the data (Lincoln & Guba, 1985).

## **Results**

Based on the data collected and the analysis, the researchers developed a model (see Figure 1) to illustrate self-efficacy and the factors which influence it positively and negatively. Bandura stated that self-efficacy is a person's assessment of her or his ability to undertake a course of action related to a specific situation (1982, 1986). The results suggested that a person's assessment of his or her self-efficacy is comprised of multiple internal processes (beliefs, emotions, ability, willingness, attitudes, readiness, and estimated self-appraisal), which are influenced by the external factors of experience, education, and feedback and supervision. These processes and factors are independent but interrelated and can be considered a system that every counselor working with suicide possesses and must negotiate.

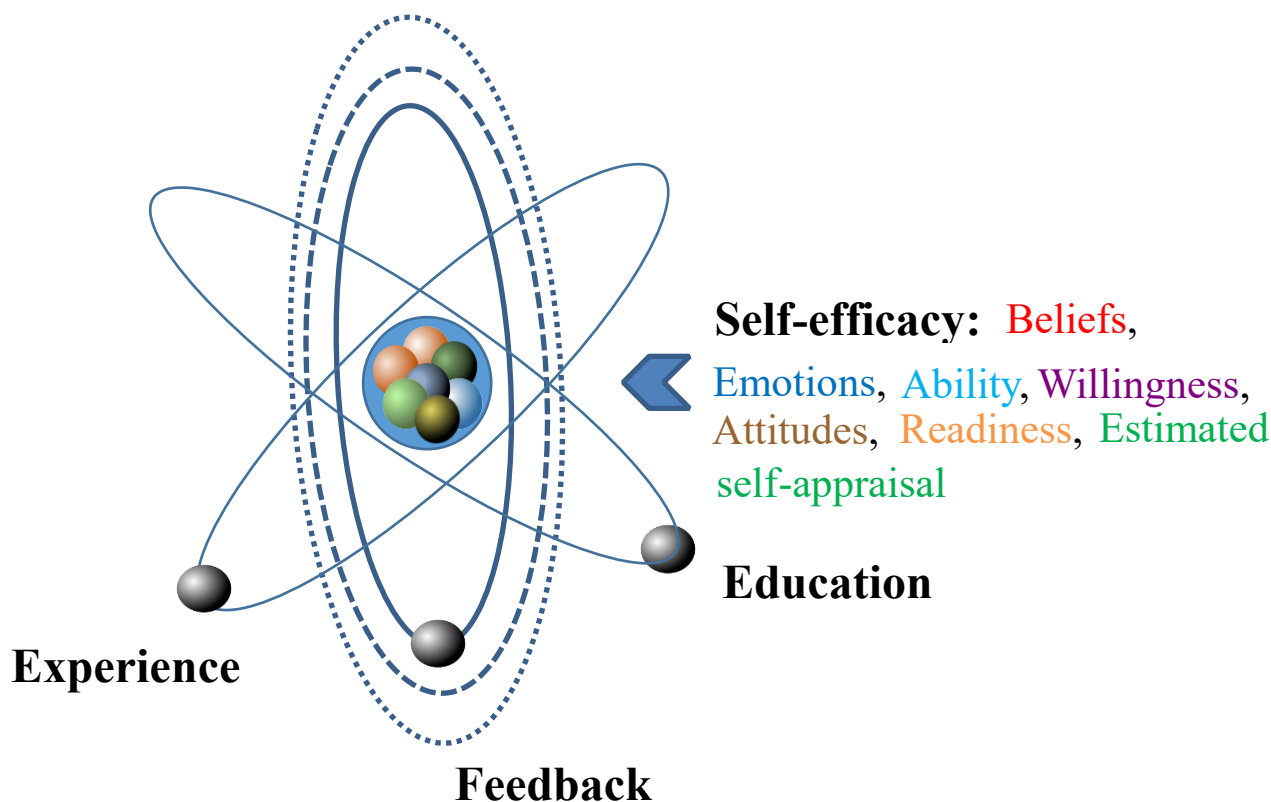
### **The Dynamic Nature of the Model**

In the results of the study, self-efficacy appeared as a complex and dynamic construct involving the individual processes included in the core of the model. The first letters of the internal processes spell out the acronym BE AWARE, symbolic of the importance of counselors engaging in self-exploration on these internal processes. This combination of internal processes is then impacted by experiences, education, and supervision and feedback, which are represented in the model as orbiting external factors. The external factors and internal processes are both overlapping and interrelated, meaning that adjusting the level of one component would likely change the levels of some of the other components.

For example, a counselor's willingness to work with suicidal clients may be impacted by her ability, which in turn may be impacted by her level of estimated self-appraisal. Working with a supervisor (feedback) may adjust the counselor's accuracy in estimating her ability, which in turn could impact her willingness to work with suicidal clients. Higher or lower levels of internal processes can be represented by larger or smaller spheres within the core of the model, suggesting that if these components could be accurately measured in a counselor, any individual could be represented visually by a unique core representing their levels of the seven internal processes. The orbiting external factors similarly can be reflected as being stronger or more positive by a larger orbit, or more negative and weaker by a smaller orbit. The ability to adjust the size of the orbit is represented by the three different sizes of the Feedback orbit in

the model. If these constructs could be accurately measured, a unique model could be constructed for each counselor representing his or her unique self-efficacy to work with suicide issues.

**Figure 1**



To illustrate, one participant spoke about his experiences of two clients dying by suicide early in his career as a counselor. The participant talked at length about how those suicides (external factor; experience) had led him to question his beliefs and his abilities for working with clients who are suicidal (internal processes):

I blame myself for a lot of what happened with those two that passed away. You know, I could've done this, could've done that. I don't want to say I blame myself, but I second-guess myself to this day, so that's where my ambivalence comes from when it comes to working with people [who are suicidal].

Participant interviews also illustrated that self-efficacy is not a destination at which counselors can ever completely arrive. Rather, self-efficacy is in constant motion and can shift based on the external factors of experience, education, and feedback. The internal processes of beliefs, emotions, ability, willingness, attitudes, readiness, and estimated self-appraisal are also in constant motion, impacting one's overall sense of self-efficacy. One participant noted:

I think that it's increased . . . just because, to me, having knowledge is power and so I feel like some of the articles, researching, talking to people who've come in who've had experience working with suicide . . . I feel that it's kind of boosted my confidence.



## The Internal Processes of Self-Efficacy

The information provided by the study's participants suggested that their self-efficacy was comprised of a number of interrelated processes. The first letter of the internal processes spell out the acronym BE AWARE, symbolizing the importance of counselors engaging in self-exploration around their level of these constructs. The internal processes include:

- **Beliefs:** views impacting the expression of attitudes toward suicide and suicidal clients.
- **Emotions:** the counselor's personal feelings related to suicide which need to be recognized and integrated in order to provide empathic care for the suicidal client.
- **Ability:** the counselor's resources, tools, and techniques gained through education or experience to work with suicide as a clinical issue.
- **Willingness:** how disposed or inclined a counselor is to work with a suicidal client regardless of hesitation or in the presence of fear.
- **Attitudes:** one's ever-evolving position incorporating beliefs, education and experience.
- **Readiness:** the counselor's perceived capacity to effectively work with suicide as a clinical issue in reference to knowledge and past experience.
- **Estimated self-appraisal:** the depth and accuracy by which a counselor assesses his or her other internal processes to work with a client presenting as suicidal.

The participants made it clear that they came to their counselor training with a pre-existing level of each of the internal processes. This suggests that for these participants, self-efficacy to work with suicide as a clinical issue was not something created by their counselor training. Rather, it was something that needed to be *assessed and strengthened* through their counselor training. For example, a participant discussed how suicide-specific trainings (external factor - education) impacted her emotions (internal process) about working with suicidal clients:

It [the ASIST and AMSR trainings] definitely took the fear away from it just because of how much practice we had to go through and I think a lot of the fear comes from having no idea what that scenario would be like. So it kind of reduced the fear of the unknown.

In addition to interacting with the external factors, the internal processes also influence each other. One participant reflected on her fear of suicidal clients (internal process—emotion) which impacted her willingness to work with them (internal process—willingness):

I guess in different ways I was freaked out at first, and then reflecting back on it, the feelings that I get are feelings of . . . fear. I don't really know if I would want to do that again [work with a suicidal client]. You know? Which is inevitable. I guess I'm scared because I really want to help and I don't know how. And reflecting back on it, I don't want to feel that incompetent again. I would rather be more poised in a situation like that.

Another participant reflected on her attitude and beliefs (internal processes) about suicide, and what she sees of the attitudes and beliefs of other counselors in her internship site:

I think we all come with baggage on what suicide is, how we feel about suicide, and what we think clients should do if they are suicidal. . . . I think there's a lot of denial out there about us having judgments. Everybody has a judgment about it.

Another participant articulated her estimated self-appraisal (internal process): "I know how to do it. I've seen myself do it many times. So I know I can walk into that situation almost always and have a pretty good outcome."

### **The External Factors**

The external factors included experiences, education, and supervision and feedback. While participants could seek out or avoid these factors, they could not control the quality or the outcome of them. Each participant identified critical experiences, educational opportunities or feedback scenarios that were incorporated into the participant's self-efficacy, as well as the importance of having these factors included in formal counselor training. For example, one participant stated: "We do need more training [on suicide intervention and treatment skills] as beginning counselors. And we need experience in order to work on what we've learned."

The participants referenced several factors which were categorized under the external factor of experience. Participants noted that experience could include life events such as a friend or client's suicide behaviors or the counselor's own personal struggles with suicide. One participant reflected on how the death of a friend (external factor—experience) influenced her beliefs (internal process) about suicide and in part, her decision to become a counselor:

I really wished I would have seen that he was in that much pain or that he would have sought me out to talk about it. But I didn't. I just wished that I would have known what to look for earlier. And then I came here [to begin my master's degree].

The external factor of education was defined by the participants as including their coursework in their master's degree program, additional community trainings such as the Applied Suicide Intervention Skills Training (ASIST) or Assessing and Managing Suicide Risk (AMSR), literature sought out on one's own to learn more about suicide, and on-the-job training. For example, one participant who had previously been in the military used the mental health training she received there to supplement what she was learning in her counseling program:

I was a mental health technician in the [military]. After basic training they send you to your vocational school. So when you got to suicidal clients . . . the thing that stuck out the most that they really try to pound in there is you can't plant the idea for someone to suicide. Meaning don't be afraid to ask directly, "Are you thinking of killing yourself?"

The external factor of Supervision and Feedback was defined by the participants as including observations shared by a supervisor, teaching and guidance from faculty, and verbal or behavioral feedback from clients regarding the counselor's performance. One participant noted how her supervisor helped coach her through the process of working with a suicidal client:

After every session I would brief the case with my supervisor. We would talk about [the client's] inflections, what my sense of the situation was, possible things that might be going on, help in identifying themes that kept coming up

with that particular client, and ways to get her to open up about what was going on in her life.

The participants consistently communicated that the external factors of experience, education, and supervision and feedback are needed to develop strong self-efficacy to work with suicide issues. But simultaneously, if the education, experience, and feedback are poor, the external factors also have the ability to negatively impact a counselor's self-efficacy. This was illustrated by two different participants' reflections on the supervision they had received during their training. The first related that he struggled to find strong supervision (external factor). As a result, he felt unsupported and less willing to work with suicidal clients (internal process):

I haven't encountered a high level of supervisory competence in any of my learning. If I were seeing a client and they did kill themselves, I don't think I would expect any professional person, including my supervisor, to really address it with me.

The second participant was afraid that when she received supervision after working with a suicidal client she would be chastised and/or fired for not doing everything she was supposed to. However, her supervisor identified the things the counselor had done right, and used the counselor's strengths as a foundation for additional learning and improvement:

I guess I just didn't want to get fired. Like "you did this wrong" and I don't really work well with that kind of talking to me that way. So I remember that not happening. This was a first for me coming from my past career. Where no one has ever talked to me like that in a nice way, the way that my supervisor did. And the fact that good things were pulled from it and it wasn't just highlighting the things I may have messed up on.

## **Discussion**

The model presented in this study illustrates counselor self-efficacy to work with suicide as a clinical issue. The model illustrates the interaction between counselors' existing self-efficacy and three major factors that positively or negatively influence this self-efficacy. These findings partner with existing literature to provide insight into why it is important to take a comprehensive approach to identifying students' self-efficacy to work with suicide issues, and how counselor education programs can work to increase students' self-efficacy.

The researchers found the components of self-efficacy were already present in students at the beginning of their programs. Mullen, Uwamahoro, Blount, and Lambie (2015) also found students begin with pre-existing self-efficacy levels which evolve over the course of the program. This substantiates the need to be able to measure baseline levels of self-efficacy through instruments like the Counselor Suicide Assessment Efficacy Survey (CSAES; Douglas & Wachter Morris, 2015). Programs can best help students improve self-efficacy if they know students' baseline levels.

This study's model is similarly supported by studies suggesting factors on the external ring impact students' self-efficacy to work with suicide. Wachter Morris and Barrio Minton (2012) found that content-specific education positively impacted students' self-efficacy to work with suicide issues. Neuer Colburn, Grothaus, Hays, and Milliken (2016) identified supervision in crisis intervention and prevention techniques as critical for supervisee development, and Sawyer et al. (2013) recommended incorporation of experiential activities to increase students' self-efficacy to work in crisis situations. These findings support the need for

the comprehensive and integrated paradigm for increasing suicide self-efficacy provided by this study's results.

### **Implications**

The study's results may add to the field of counselor education in several different ways. First, the results support existing research on when to incorporate training on suicide in the curriculum. The model also affirms the importance of supervision for students working with suicidal clients. Lastly, the results suggest that perceived expectations may impact how new counselors talk about their willingness to work with suicide as a clinical issue.

#### **Training Should Take Place Early and Often in Counseling Programs**

The current study supports existing literature suggesting training on suicide competencies should be introduced early in a student's program (Binkley & Leibert, 2015), with repetition over the course of the program. Many of the participants in this study were working with suicidal clients during their practicum field experiences—long before suicide was ever systematically addressed in their courses. Earlier exposure to suicide competencies could help position students for their field experiences, and repetition throughout the program may help solidify strategies.

#### **Supervision Is Powerful, Dynamic, and Critical**

The literature is plentiful on the power and importance of supervision in preparing counselors for the field. The findings of this study supported this literature within the specific environment of new counselors working with suicidal clients. Specifically, the results suggested that supervision was so powerful and important that positive supervision could reposition a new counselor's perceived "bad" experience with a suicidal client, and negative supervision could undermine a perceived "good" experience with a suicidal client.

One possible implication of the need for supervision is that supervisors are unlikely to be able to take supervisees somewhere they have not themselves gone. Supervisors must therefore be willing to explore their own attitudes, beliefs, and feelings about suicide, and be willing to self-appraise their own willingness, readiness, and ability to work in this area. Just as a counselor must learn to recognize suicide red flags and ask the client directly about suicide, a supervisor must learn to recognize the signs of low suicide self-efficacy in a supervisee and be directive in exploring strategies to improve the supervisee's self-efficacy and performance with clients.

#### **Perceived Expectations Impact New Counselors' Stated Willingness**

New counselors may state their willingness to work with suicidal clients based on how they believe the counseling profession expects them to respond. These perceived expectations may often include an overall expectation of willingness to address suicidal concerns, regardless of how willing the counselor actually feels to address those concerns. These perceived expectations showed up in the study's results when counseling students sometimes expressed more willingness to work with suicide than more experienced and licensed counselors. It also showed up in participants stating they were willing to work with suicide as a clinical issue, but whose body language and subsequent comments strongly suggested that they did not.

Supervisors and educators should be aware of this phenomenon, so they can recognize its occurrence and challenge students and supervisees to work through it. This tendency could

result in under-prepared or incompetent counselors trying to work with a client on suicide issues. It could also result in counselors under-selling their trepidation and hesitancy to their supervisors, resulting in important issues not being addressed in supervision. Supervisors and educators have the ability to help set reasonable and accurate expectations for supervisees and students which may help frame the experience of working with suicidal clients in a more productive way.

### **Limitations and Future Research**

The results of this study may not be applicable to all counselors in all situations because of the methodology and limitations related to the study's participants. All of the participants lived in a rural area of Colorado. All of the counseling student participants were enrolled in a single university. Although the results are based on a geographically-focused sample, the participants represented diversity in race, gender, and sexual identity and possessed diverse levels of experience ranging from students to licensed professionals.

Due to the rural area, many participants were known to the first and sixth authors. This limitation was addressed in the interview process by utilizing co-interviewers and by alternating the lead interview role with an observatory role in interviews where there was a stronger outside relationship with the participant. Three participants were unable to participate in one of the two focus groups due to scheduling incompatibility, meaning that these participants did not participate in member checking or provide feedback on the conclusions and the model.

As analysis began on the interviews, the transcription and coding team expressed concerns about periodic leading questions they felt were being utilized by the interview team. As a result of these discussions, the interview team made adjustments to the interview protocol and included examination of any leading questions as part of the debrief session.

While some researchers have stated that grounded theory studies should utilize between 20 – 60 participants (Creswell, 2013), the research team felt that saturation had been reached when themes and ideas were becoming redundant and repetitive. According to Green and Thorogood (2004), the concept of saturation describes when research categories are fully explored, differences between categories are defined, and the relationships between categories are established and tested. Mason (2010) stated that pre-establishing a number of participants in a qualitative study is not consistent with the principles of qualitative inquiry, and Charmaz (2006) suggested that small studies with modest claims may achieve saturation more quickly than studies aiming to describe processes that span disciplines.

Qualitative research is typically not concerned with generalizability (Creswell, 2013). However, future studies could sample participants from a broader range of communities across the country as it's possible that some counselors may not feel adequately prepared to work with suicidal clients while simultaneously having limited or no access to voluntary trainings that could help remedy the deficit. Exploring and understanding counselors' experiences working with suicidal clients will aid in developing better education, training and supervision, and aligns with the American Counseling Association's 20/20 Vision which includes strengthening counselor identity and promoting client welfare (Kaplan & Gladding, 2011).

Building off the limitations of this study, it may be important for future studies to consider quantitative and mixed methodologies which could validate and help generalize the findings of this study. Future studies could utilize an experimental design whereby two counseling programs who handle training in suicide competencies differently are compared in a pre-test/post-test design. Additional recommendations include a deeper exploration of the impact of supervision on new counselor self-efficacy and an exploration of ways counseling programs could improve their coverage of suicide prevention, intervention, and treatment.

## Conclusion

As access to mental health care improves and public awareness campaigns increase the overall awareness of suicide and suicide risk, more people are likely to seek out assistance when they are feeling suicidal. Counselor education programs have the opportunity and responsibility to prepare students to assess and intervene when a client discloses that they are suicidal. This study's model provides greater understanding of the factors impacting how counselors develop self-efficacy to work with suicidal clients and can aid counselor education programs in being purposeful with how students are trained to work with the growing population of suicidal clients.

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