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A Phenomenological Investigation of Counselors' Perceived Degree of Preparedness When Working with Suicidal Clients

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A PHENOMENOLOGICAL INVESTIGATION OF COUNSELORS'

PERCEIVED DEGREE OF PREPAREDNESS WHEN WORKING WITH

SUICIDAL CLIENTS

by

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ABSTRACT

A PHENOMENOLOGICAL INVESTIGATION OF COUNSELORS' PERCEIVED DEGREE OF PREPAREDNESS WHEN WORKING WITH SUICIDAL CLIENTS

Heather Danielle Dahl
Old Dominion University, 2015
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Little is known of counselor perspectives of their training and level of preparedness when working with suicidal clients. Although professional standards and guidelines regarding counselor competency in this area exists, training may not be occurring throughout a trainee's program, or is occurring inconsistently. The purpose of this phenomenological inquiry was to understand the essence of counselors' perceived degree of preparedness working with suicidal clients, and to provide clinical and training recommendations in this subject area. Using individual semi-structured interviews, 10 participants were recruited, using maximum variation and criterion sampling who had previous experience working with suicidal clients. The results of the study identified four structural themes and 15 textural themes were identified that answered the research questions. Findings highlighted participant insight training preparedness, components of preparedness, assessment and intervention knowledge, and training recommendations for suicide prevention and assessment. Master's level training implications for counselor education programs and post-master's training in the area of suicide prevention and assessment are presented, along with future research directions.

Keywords: suicide prevention and assessment, counselor preparedness, counselor training

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CHAPTER ONE

STATEMENT OF THE PROBLEM

In this chapter, I will introduce the current state of suicide rates and trends and give a brief overview of suicide prevention and assessment training. I will then describe the purpose of this study and identify the research questions. Finally, I will define important terms and identify the delimitations of this study.

Introduction

According to the National Institute of Mental Health (2007), suicide is the tenth leading cause of death in the United States, with an overall suicide rate of 11.3 per 100,000 deaths. For every documented suicide in the United States, there are an estimated 11 suicide attempts. Further, those who attempt or complete suicide often have exhibited some form of help-seeking behaviors at one time (Barnes, Ikeda, & Kresnow, 2011; Meyer, Teylan, & Schwartz, 2014). The National Institute of Mental Health (2007) reported the following as evidence-based risk factors for suicide: depression and other mental disorders or a substance-abuse disorder, prior suicide attempts, firearms in the home, incarceration and exposure to the suicidal behavior of others, and family history of mental disorder, substance abuse, suicide, and violence (including physical or sexual abuse). Thus, understanding suicide prevention and suicide risk assessment is a necessity for counselor competency.

Cultural factors such as gender, race/ethnicity, sexual identity and age play a role in suicide risk assessment. McIntosh and Drapeau (2014), in partnership with the American Association of Suicidology, reported additional suicide statistics that provide some indication of suicide risk factors. In 2011, males had a suicide rate of 20.2 per

100,000 deaths as compared to females at 5.4 per 100,000 deaths. Whites had the highest suicide rate as compared to non-White persons (14.5 versus 5.8 per 100,000 deaths, respectively). Persons age 65+ were the highest age population at risk, at 15.3 per 100,000 deaths, with middle aged persons 45-64 years being the lowest at 18.6 per 100,000 deaths. With regards to group data per 100,000 deaths, White males had the highest rate of suicide (23.0), followed by Native Americans (all genders; 10.6), non-White males (9.4), Black males (9.0), and White females (6.2). The lowest rate per group was Black females (1.9) and all non-White female populations (2.5) (McIntosh & Drapeau, 2014). Gender and sexually diverse populations have been shown to have an increased risk for suicide attempts, being six times more likely to attempt than those who identify as heterosexual (Fergusson, Horwood, & Beautrais, 1999).

Unfortunately, part of counselor preparedness for working with suicidal clients can involve processing the client completion of said suicide. Wurst, Kunz, Skipper, Wolfersdorf, Beine, and Thon (2011) surveyed 177 therapists from 77 institutions on their reactions to 152 clients who completed suicide. Participants with an average of 12.4 years (*SD* = 8.35) professional experience indicated they had emotional responses immediately after the suicide of a client and 3 out of 10 participants still experienced severe emotional distress in a six month follow-up. Thus, vicarious trauma is something that can happen with any counselor that is working with a client in crisis or had previously experienced crisis; it occurs when a therapist has a traumatic reaction to client-presented information. To this end, if a counselor does not have adequate training, the possibility of negative outcomes can have an effect on the counselor as well as the client.

Training standards and ethical codes related to suicide assessment and intervention fall under suicide assessment, crisis intervention, or areas of competence in the American Counseling Association Code of Ethics (ACA, 2014), and Council for Accreditation of Counseling and Related Education Programs Standards (CACREP, 2009). The ACA Code of Ethics describes disclosure when a client is in serious and foreseeable harm in B.2.a., the boundaries of competence for a counselor in C.2.a., and the development of knowledge and skills of counselor trainee education in relevant knowledge areas in F.8.a (ACA, 2014b). CACREP (2009) standards specifically notes the inclusion of suicide and crisis intervention training for counselor education, and specifically address training in suicide assessment and management across the specialty areas of (a) addiction counseling, (b) clinical mental health counseling, (c) marriage, couples, and family counseling, and (d) school counseling.

Although professional standards and guidelines regarding counselor competency exist, training is not occurring throughout a trainee's program, or is occurring inconsistently (Bongar, & Harmatz, 1989; House, 2003). House (2003) noted that for 89 CACREP-accredited school counseling programs, only 4% met all of the 15 areas of suicide prevention training identified in the study. These training areas included suicide risk (n= 83; 93.3%), behavioral risk factors (n= 86; 96.6%), cultural differences in suicide attempts (n= 62; 69.7%), gender differences in suicide attempts (n= 67; 75.3%), gay and lesbian issues in suicide attempts (n= 59; 66.3%), general risk factors (n= 83; 93.3 %), in-school peer group training in suicide issues (n= 32; 36%), psychoeducation for school students (n= 40; 44.9%), post intervention (n= 39; 43.8%), school-based prevention programs (n= 52; 58.4%), parents (n= 40; 44.9%), referral sources (n= 52;

58.4%), situational risk factors (n= 82; 92.1 %), specific intervention techniques (n= 55; 61.8%), verbal risk factors (n= 85; 95.5), and others (n= 5; 5.6%). Furthermore, one program reported no training coverage in the topic of suicide at all. This research indicates an inconsistency in training content in CACREP accredited programs, and warrants further research.

Research regarding suicide intervention training in counseling programs in other countries also exists. Reeves, Wheeler and Bowl (2004) surveyed 24 British-accredited counseling programs. Of those surveyed, 47.8% stated that their program did not include skill development as a suicide assessment education. Further, one third of those surveyed "did not feel that counseling as a profession was responding well to the challenges of working with clients at risk both of suicide/self-injury and violence to others" (p. 242).

Further, conceptual works propose various training models and best practices for suicide intervention. Neimeyer (2000) described a training agenda for counseling psychologists in working with suicidal clients and recommended a well-rounded approach, but there is not necessarily a clear cut training program for counselors that include established core competencies. Pisani, Cross, and Gould (2011) identified the following 12 evidence-based suicide risk and assessment prevention training workshops available for mental health professionals providing training options for both graduate training programs and counseling centers: (a) Assessing and Managing Suicide Risk, (b) Chronological Assessment of Suicide Events, (c) Collaborative Assessment and Management of Suicidality, (d) Question, Persuade, Refer, Treat, (e) Recognizing and Responding to Suicide Risk, (f) Risk Assessment Workshop, (g) Skills-Based Training on Risk Management, (h) Suicide Assessment Workshop, (i) Suicide: Understanding and

Treating the Self-Destructive Process, (j) SuicideCare: Aiding Life Alliances, (k) The Air Force Managing Suicidal Behavior Project, and (l) Unlocking Suicide Secrets. While counselors may be attending these programs, it is unclear how often they are being utilized by agencies or in counselor education programs.

In addition to scholarship on proposed suicide intervention training models in counseling-related programs and the documented lack or inconsistent training received in counseling programs, there lacks attention to suicide intervention as a unique component of training. Although clients with suicidal ideation present to counseling with varying degrees and type of mental illness (National Alliance on Mental Illness, 2013), suicide prevention and assessment training is often lumped in with crisis intervention curriculum (House, 2003; Westefeld et al., 2000). Crisis intervention can involve self-harm, natural disasters, domestic violence, or suicide intervention to name a few, each having different needs in terms of assessment and treatment (Westefeld et al., 2000).

There are a many different theoretical approaches to crisis intervention across theoretical orientations that propose crisis intervention models (i.e. psychoanalytic, systems, ecosystems, and development) (Miller, 2012). A specific crisis intervention model called *psychological first aid* was developed by Slaikeu (1990) and further expanded by Ruzek, Brymer, Jacobs, Layne, Vernber, & Watson (2007). In this crisis intervention model, the following eight steps are suggested as an outline to working with a client: (a) contact and engage the client, (b) provide safety and comfort, (c) stabilize the client, (d), gather information, (e) provide practical assistance, (f) connect with social supports, (g) provide information on coping supports, and (h) connect the client with collaborative services. Clients who have suicidal ideation may not present overtly, be in

imminent danger, or be in a crisis situation, making this model not necessarily helpful or complete when working with a suicidal client. Thus, suicide prevention and assessment is a topic that warrants individualized attention in counselor education.

Purpose Statement

There is limited research in the area of mental health provider preparedness working with suicidal clients as a whole, and even more limited in quantitative and qualitative data for the prevalence or perceptions of counselors working with suicidal clients. Further, limited empirical research exists that investigate differential training components in suicide prevention and assessment and the necessity of it in counselor training. The purpose of this phenomenological study was two-fold: (a) to understand the essence of counselor perceived degree of preparedness working with suicidal clients; and (b) to provide recommendations and training implications for counselor education programs and clinicians in the area of suicide prevention and assessment.

Research Questions

The following research questions were addressed in this study:

1. To what degree do counselors feel prepared for working with suicidal clients?

2. What are counselors' perceptions of the suicide prevention and assessment training provided in their program?

3. What are counselors' recommendations for effective suicide prevention and assessment training?

Definition of Terms

Counselor is defined by the American Counseling Association as "a professional relationship that empowers diverse individuals, families, and groups to accomplish

mental health, wellness, education, and career goals" (American Counseling Association, 2014, p. 3), counselors are also referred to in this study as clinicians.

Counselor Trainee is someone who is currently enrolled in a master's program training program to become a counselor.

Crisis Intervention is a form of counseling that indicates acute involvement in areas such as self-harm, natural disasters, domestic violence, or suicide intervention (Westefeld et al., 2000). Crisis intervention is typically viewed as occurring after a client perceives an event as traumatic and have not been able to cope with the crisis themselves, seen as three stages: (a) the event, (b) the clients perception, and (c) failure of coping methods (Miller, 2012).

Master's Training Program refers to the preparation program for counselors which prepares graduates to counsel in a professional relationship setting with diverse individuals, families, and groups with the goal of accomplishing mental health, wellness, education, and career goals (CACREP, 2014).

Suicide is a term that indicates a self-harming behavior that leads to voluntary death (Miller, 2012).

Suicide Risk indicates how likely it is that a person will complete suicide.

Suicide Prevention and Assessment describes the initial overview of a person's symptoms related to suicide risk and can involve multiple counseling tools including assessment, intervention and education strategies to encourage reduction of suicide risk. For the purposes of this study, areas of assessment include the AAS and Suicide Prevention Resource Center Taskforces recommended 24 competencies in seven core domains of practice Suicide Prevention Resource Center. (2006).

Delimitations

Delimitations for this study include the requirement that participants in this study must have worked with a suicidal client, have graduated from a master's program in counseling or be enrolled in, or completed, their counseling practicum. This excluded anyone who did not have personal experience working with suicidal clients and may not have been able to speak to the perceived effect that their training has had on their perceived degree of preparedness working with this population.

CHAPTER TWO

LITERATURE REVIEW

In this chapter, I will begin by describing the current ethical codes, training standards, and core competencies in suicide risk and assessment that are related to counselors. I will then explore the relevant literature on the current suicide risk and assessment training programs available for counselors, the current literature surrounding training, and the effect on the counselor. Finally, I will discuss the current literature gaps describing the current state of suicide prevention and assessment training and how this qualitative study will attempt to explore this area further.

Training Standards

Training standards related to suicide assessment and intervention for clinical mental health counselor competence can best be outlined in three sets of standards: (a) ACA Code of Ethics (ACA, 2014b), (b) CACREP Standards (CACREP, 2009), and (c) The American Association of Suicidology (AAS) and Suicide Prevention Resource Center taskforce standards (Suicide Prevention Resource Center, 2006). The following paragraphs will outline each standard that is relevant to the subject of training standards or boundary of competence.

The ACA Code of Ethics has three codes that are relevant to the topic of counselor training. The first code is B.2.a. It describes serious and foreseeable harm and legal requirements and states:

> The general requirement that counselors keep information confidential does not
> apply when disclosure is required to protect clients or identified others from
> serious and foreseeable harm or when legal requirements demand that confidential

information must be revealed. Counselors consult with other professionals when in doubt as to the validity of an exception. Additional considerations apply when addressing end of life issues (ACA, 2014, p. 7).

Standard C.2.a makes direct mention of counselors working in their boundary of competence:

> Counselors practice only within the boundaries of their competence, based on their education, training, supervised experience, state and national professional credentials, and appropriate professional experience. Whereas multicultural counseling competency is required across all counseling specialties, counselors gain knowledge, personal awareness, sensitivity, dispositions, and skills pertinent to being a culturally competent counseling in working with a diverse client population (ACA, 2014b, p. 8).

The final code that is relevant is F.8.a., which specifically speaks to counselor training program information and orientation:

> Counselor educators recognize that program orientation is a developmental process that begins upon students' initial contact with the counselor education program and continues throughout the educational and clinical training of students. Counselor education faculty provide prospective and current students with information about the counselor education program's expectations, including: (1) The values and ethical principles of the profession, (2) The type and level of skill and knowledge acquisition required for successful completion of training... (4) Program training tools, objectives, and mission, and subject matter to be converged (ACA, 2014, p. 14).

These ethical codes summarize three implications for suicide assessment and intervention. First, it is required that a counselor be familiar with confidentiality with regards to a client with an intent to harm themselves or others. Second, an emphasis on counselors understanding their boundaries of competence should be addressed. If a counselor has not received adequate training in an area of practice, it is their duty to act ethically and follow a decision making process. Finally, it is a requirement for counselor educators to "recognize that program orientation is a developmental process that begins upon students' initial contact with the counselor education program.... (ACA, 2014, p. 14) is consistent with Bongar and Harmatz (1989) and their findings that suicide assessment and intervention training begin early and continue throughout the program.

While the 2014 ACA Code of Ethics (ACA, 2014) is an ethical code for counselors in training and counselors, the 2009 CACREP standards relate to counselor training specifically. The first standard that refers to suicide training is Section II, Professional Identity: G.5.g. Section G states that "Common core curricular experiences and demonstrated knowledge in each of the eight common core curricular areas are required of all students in the program" (CACREP, 2009, p.10). Following Section G, Section 5.g is specific to helping relationships, specifically "studies that provide an understanding of the counseling process in a multicultural society... crisis intervention and suicide prevention models, including the use of psychological first aid strategies" (CACREP, 2009, p.11). This section emphasizes the importance of inclusion of crisis intervention and suicide prevention models, but does not provide guidance on what that may look like in a program.

Further mentions of suicide prevention and assessment are made in the sections devoted to addiction counseling, clinical mental health counseling, marriage, couples, and family counseling, and school counseling. The addiction counseling Standard D.4 states, "Demonstrates the ability to use procedures for assessing and managing suicide risk" and also states that counselors screen "for… potential for self-inflicted harm or suicide… (CACREP, 2009, pp.19-20). The clinical mental health counseling, marriage, couples, and family counseling and the school counseling standards also use Standard D.4 (note D.6 for clinical mental health counseling) to state, "Demonstrates the ability to use procedures for assessing and managing suicide risk" (CACREP, 2009, p. 31; p.36; p. 40). These standards clearly state that counseling training programs that are CACREP-accredited must prepare counseling students to assess and manage suicide risk and be able to demonstrate that in their curriculum.

The final set of standards that are relevant in this area is the AAS and Suicide Prevention Resource Center Taskforce includes 24 competencies in eight core domains of practice. The eight core domains each have four competencies associated with the core domain.

> *Working with Individuals at Risk for Suicide:* Attitudes and Approach (a) manage one's own reactions to suicide. (c) reconcile the difference and potential conflict between the clinician's goal to prevent suicide and the client's goal to eliminate psychological pain via suicidal behavior, (d) maintain a collaborative, non-adversarial stance, (e) make a realistic assessment of one's ability and time to assess and care for a suicidal client.

Understanding Suicide: (a) define basic terms related to suicidality (b) be familiar with suicide-related statistics, (c) describe the phenomenology of suicide, and (d) demonstrate understanding of risk and protective factors.

Collecting Accurate Assessment Information: (a) integrate a risk assessment for suicidality early in a clinical interview and continue to collect assessment information on an ongoing basis, (b) elicit risk and protective factors, (c) elicit suicide ideation, behavior, and plans, (d) elicit warning signs of imminent risk of suicide, and (e) obtain records and information from collateral sources as appropriate.

Formulating Risk: (a) make a clinical judgment of the risk that a client will attempt or complete suicide in the short and long term, and (b) write the judgment and the rationale in the client's record.

Developing a Treatment and Services Plan: (a) collaboratively develop an emergency plan that assures safety and conveys the message that the client's safety is not negotiable, (b) develop a written treatment and services plan that addresses the client's immediate acute and continuing suicide ideation and risk for suicide behavior, and (c) coordinate and work collaboratively with other treatment and service providers.

Managing Care: (a) develop policies and procedures for following clients closely, and (b) follow principles of crisis management.

Documenting: (a) document items related to suicidality.

Understanding Legal and Regulatory Issues Related to Suicidality: (a) understand state laws pertaining to suicide, (b) understand that poor or incomplete

documentation makes it difficult to defend against legal challenges, (c) protect

client records and rights to privacy and confidentiality (Suicide Prevention

Resource Center, 2006, p. 1).

Counselor Program Training

Suicide assessment and treatment is a field that has continued to adapt to better

prepare mental health professionals, but may not be disseminated through counselor

training programs effectively (House, 2003). Counselors' perceived degree of

preparedness when working with suicidal clients is an area that has been minimally

explored (Wachter Morris & Barrio Minton, 2012) unlike other mental health disciplines

(see Bongar & Harmatz, 1989; House, 2003; Neimeyer, 2000). Further, available suicide

prevention and assessment training is varied across disciplines and in counselor master's

programs themselves (Bongar & Harmatz, 1989; Wachter Morris & Barrio Minton,

2012). Most research in helping professions recommend early training and throughout the

student's graduate level training (see Bongar & Harmatz, 1989; House, 2003; Neimeyer,

2000; Wachter Morris & Barrio Minton, 2012; Reeves, Wheeler, & Bowl, 2004).

Barrio Minton and Pease-Carter (2011) sought to determine when, where and how

crisis intervention is addressed in CACREP programs and if there is a crisis intervention

course offered, what is the content and how it was executed. Participants included 52

program coordinators from CACREP-accredited master's degree programs, with 48% ($n=$

25) of the programs being 48-semester hours, 28.8% ($n=$ 15) being 60-hours, and 23.1%

($n=$ 12) having another number of semester hours. Results indicated that 76.9% ($n=$ 40)

of programs reported didactic preparation prior to practicum, and 7.7% ($n=$ 4) reported no

preparation in crisis intervention. The top four courses that were mentioned in covering

crisis intervention included helping relationships, professional identity, group work and assessment. Twenty-four programs reported offering an entire course on crisis intervention, with 25 noting it is offered in either core or elective courses. Findings indicated that only half of the programs survey offered full courses on crisis intervention, and didn't delineate between suicide prevention and assessment and crisis intervention.

Furthering research in crisis intervention course preparation, Wachter Morris and Barrio Minton (2012) stated that "Given that most participants reported responding to high-risk crises during their master's-level field experiences (e.g., 86.53% used basic crisis intervention skills, 82.90% worked with suicidal clients), student and new professional counselors may be intervening in crises without adequate preparation" (p. 265). Wachter Morris and Barrio Minton (2012) examined counselor preparation in crisis intervention in CACREP-accredited master's programs and their perceived preparation experience. Participants included 193 professional counselors, with 68.39% (n= 132) graduating from a CACREP-accredited program, with an average age of 36.63 years (SD= 10.76). They assessed formal didactic training using 11 items regarding participation in crisis preparation, 17 items assessing frequency of past preparation, 7 items assessing frequency of current preparation, 11 items assessing self-efficacy of crisis skills and 10 items that were demographics. Results found that 20.73% (n= 40) of respondents had a course in crisis intervention, and 50.77% (n= 98) participants noted an elective workshop option. The majority of participants also reported received "no" or "minimal" crisis preparation, with the majority rating that their current self-efficacy level was between "adequate" and "well." This is the most recent and only known study as of this literature review in the area of counselor preparation specifically.

In contrast to Wachter Morris and Barrio Minton (2012), Bongar and Harmatz (1989) focused on clinical psychology programs and how, if at all, they implement suicide prevention and assessment training in their doctoral programs. Participants included 92 directors of clinical training for programs that were part of the Council of University Directors of Clinical Psychology Programs (80% response rate). Results found that of the respondents, only 35% (n= 32) offered formal training in the area and was often included in a course and not as a separate topic. The majority of those surveyed (52%; n= 47.84) did not find that faculty should be required to have formal training in suicide prevention and assessment areas. Further, it was the opinion of those surveyed that students should receive their training on managing suicidal clients in the following ways: practicum as a part of graduate training (43.5%; n= 42.63), internships (37.0%; n= 34.04), graduate coursework (22.8%; n= 20.98), socialization (14.1%; n= 12.97) and supervised postdoctoral experience (9.8%; n = 9.01). Bongar and Harmatz (1989) noted that the results of the study show that the "preference of the training directors was for a graduate sequence in the study of suicide, as opposed to a postdoctoral experience (either formal or informal)" (p. 212).

Neimeyer (2000) described a training agenda for counseling psychologists in working with suicidal clients drawing on direct experiences and describing his personal suggestion for training based on previous literature. The first recommendation made was furthering personal development of the counselor which includes values clarification, anxiety reduction, and conceptual learning. The second recommendation made was in the target domain of skills development with training goals of (a) prevention including education and outreach, (b) consultation and supervision, intervention, including suicide

risk assessment, and crisis intervention, (c) counseling and psychotherapy, which includes risk management, competency assessment facilitation of decision making, and finally (d) post-intervention, which includes death notification and debriefing, and grief therapy for survivors. Overall, Neimeyer (2000) encouraged a well-rounded training agenda when training in suicide prevention and assessment.

In one of the few studies that directly address educating counselor education students on suicide risk, Juhnke (1994) outlined a four-pronged approach that first involved conducting a clinical interview that was called M.A.P. In this clinical interview, clinicians assess the mental state, affective state, and psychosocial state of the client. Following the clinical interview, Junhke (1994) suggested use of an empirical evaluation, consultation, and finally the use of a suicide assessment training method. Using 59 counseling master's students, participants were randomly assigned either the suicide training or no training, with those receiving suicide risk training displaying significantly better suicide risk identification.

Ellis and Dickey (1998) identified the structure of training programs in the areas of suicide prevention and assessment and post-suicide of a client of psychiatry or psychology interns. The survey was sent to 296 psychiatry and 422 psychology internship and residency programs, with respondents being 247 and 166 who returned the surveys, respectively and results found that only 38% (n= 94) of psychology programs and 47% (n= 78) of psychiatry programs reported having specific instruction on post-client suicide, with 30% (n= 74) and 19% (n= 32), respectively, reporting having any mention of this in their policy and procedure manuals.

Suicide Prevention Training

While education in suicide training for counselor programs and other disciplines has been uneven, there have been efforts to enhance training for practitioners. Pisani, Cross, and Gould (2011) identified 12 evidence-based suicide risk and assessment prevention training workshops available for clinical mental health clinicians. Programs that met the following three criteria were included: (a) a target audience of mental health professionals, (b) program curriculum focused on general clinical competence in suicide risk and assessment, and (c) at least one peer reviewed article evaluating training. Pisani et al. (2011) reviewed program components for all 12 programs that met the criteria listed and conducted a survey with the program developers to further identify peer-reviewed research and other program information. Pisani et al. (2011) found that all programs provided adequate training to their target populations (i.e. mental health professionals, military personal) and usually involved a multi-modal approach to education. The 12 programs are described here.

The Air Force Managing Suicidal Behavior Project

The Air Force Managing Suicidal Behavior Project is a clinical training program that is specific to the U.S. Air Force. The U.S. Department of Defense identified this division a high suicide risk population, specifically with 24-35 year old males who are African-American or White (Knox, Litts, Talcott, Feig, & Caine, 2003). Although the training itself was originally limited to military personnel, it has now been released as a clinical training manual available to the public as a clinical training guide to manage short-term suicidal behaviors (U.S. Department of Defense, 2013). The U.S. Department of Defense (2013) provided many suicide management recommendations including assessment of suicide risk, documentation, community outreach, and a detailed clinical

decision-making framework and decision tree for those working with clients- beginning

with the client having suspected depression or high stress and ending with suggested

interventions. Oordt, Jobes, Rudd, Fonesca, Runyan, and Stea (2005) highlighted the

need for the program in the U.S. Air Force, and formally described the development of

the training program itself. They reported that prior to program implementation,

clinicians that did not have direct training in suicide prevention and assessment felt

anxious and ill-prepared working with that population.

Knox, et al. (2003) program has created a significant difference on the target

population. Knox et al. (2003) examined the U.S. Air Force population suicide rates

between overall U.S. Air Force personnel. The pre-intervention population included all

U.S. Air Force personnel between 1990-1996 and the post-intervention population

included 1997-2002 personnel. Knox et al. (2003) found that the population that worked

with clinicians post-intervention were associated with a 33% suicide risk reduction.

Further, they found reduction in rates of homicide, accidental death, and family violence,

indicating a potentially larger reach to other symptoms.

Certification in the Chronological Assessment of Suicide Events (CASE)

The Chronological Assessment of Suicide Events (CASE) is a certification

program that uses the following four-step method to train clinicians on suicide

assessment: (a) presenting suicidal events in the past 48 hours, (b) recent suicide events,

(c) past two months of suicide events and (d) immediate suicide events (e.g., feelings,

ideation, and intent expressed during session with client) (Shea, 2009, . Developed by

Shawn Christopher Shea, CASE is a small training program that is a one-on-one

approach that and generally taught to graduate students (Pisani et al., 2011). The

program is comprised of training the student to follow a three pronged approach: (a) gather information on warning signs, risk and protective factors, (b) collect information on suicidal ideation, and (c) make a clinical decision regarding the information received (Shea, 1999). The program uses multiple tools of learning including handouts, group discussion, lecture, video demonstrations and role plays. Additionally, students have the option of long-term consultation as needed, and a manual with real-life examples (Shea, 2009). Counselor trainees are not awarded certification until they have demonstrated competency to the trainer through experiential training (Shea, 1999; Shea & Barney, 2007). No empirical research was found on CASE as an effective suicide assessment, but the program addresses many of the training competencies recommended by AAS and Suicide Prevention Resource Center taskforce.

Unlocking Suicidal Secrets

Unlocking Suicidal Secrets is an advanced workshop following completion of the CASE training. In this six hour workshop, Shea (1998) emphasizes the main concepts in CASE in an advanced training with additional lectures and video demonstrations that focus on treatment planning, understanding risk, documentation and focusing on the resiliency of the client and clinician.

Collaborative Assessment and Management of Suicidality (CAMS)

The Collaboration Assessment and Management of Suicidality (CAMS) is a training program that has demonstrated efficacy in multiple populations, including inpatient facilities, outpatient settings, and university counseling centers (Comtois et al., 2011; Jobes, Jacoby, Cimbolic, & Hustead, 1997; Jones, 2012). Developed by David Jobes, CAMS rely heavily on the therapeutic relationship between the counselor and the

suicidal client, with an emphasis on the client understanding her or his suicidal behavior. Assessment and treatment includes a focus on what Jobes (2012) calls suicidal drivers and the elimination of suicidal coping.

A large component of CAMS is the Suicide Status Form-II (SSF-II) as a companion to treatment. A seven-page tool, which has components that include assessing risk and creating a treatment plan, involves continuous core assessment of the following areas: (a) psychological pain, (b) stressors, (c) emotional upsetness, (d) hopelessness, (e) self-regard and (f) overall risk of suicide (Jobes, 2012; Jobes et al., 1997). Along with the Likert scales, there is a safety component that has both qualitative and quantitative elements, asking the client to list protective and risk factors and agreeing to safety by signing and checking yes or no to maintain safety (Jobes et al., 1997). Psychometrics of the inventory showed good convergent and criterion validity and moderate test-retest validity with high-risk suicide inpatient populations (Conrad et al., 2009).

There have been multiple studies demonstrating the overall effectiveness of the CAMS treatment (Conrad et al., 2009, Jobes et al., 1997, Jobes et al., 2004, 2009). For example, Jobes et al. (2009) researched the use of CAMS using 92 participants at a university counseling center and found a significant improvement in SSF-II scores and overall patient improvement. One of the more empirically supported trainings available, this training typically takes six hours to complete in lecture format with a manualized treatment protocol (Pisani et al., 2011).

Question, Persuade, Refer, Treat (QPRT)

Developed by Paul Quinett, the "Question, Persuade, Refer, Treat" (QPRT) program is training program for mental health professionals and others who may come

into contact with suicidal persons (Question Persuade Refer Institute , 2014). The program is designed with the objective of training the clinician in a suicide risk assessment protocol through identification of risk and protective factors, determining level of risk, and documentation (Question Persuade Refer Institute, 2014). Jacobson, Osteen, Sharpe, and Pastoor (2012) sampled social workers using the QPRT program using a randomized trial of the QPRT training. Participants included $n = 112$ social work students with $n = 75$ completing the study. Results indicated that the QPRT training has a significant effect on preparing social work students to be more competent gatekeepers when working as a suicide gatekeeping verses those in the control group.

Assessing & Managing Suicidal Risk

The Assessing & Managing Suicide Risk (AMSR) training program was developed by the AAS & Suicide Prevention Resource Center taskforce based on the aforementioned 24 core competencies and seven areas of practice (Suicide Prevention Resource Center, 2006). As of 2008, the seven hour training, which typically involves lecture, discussions, and readings, has 68 trained instructors and 10,474 trained (Pisani et al., 2011). While the empirical research is scarce for this workshop itself, it is based on the AAS and Suicide Prevention Resource Center Taskforce competencies.

Recognizing and Responding to Suicide Risk

Similar to the AMSR program, the Recognizing and Responding to Suicide Risk (RSSR) is based on the AAS & Suicide Prevention Resource Center taskforce core competencies and seven of practice (Suicide Prevention Resource Center, 2006). Once a trainee enrolls in the program, the trainee completes an online module before engaging in a live workshop and ends with continuing collaborative learning (AAS, 2007). The

overarching goal of RSSR is to aid the trainee in becoming competent in the following three areas: (a) being able to competently conduct a suicide risk assessment, (b) being able to determine level of risk for suicide, and (c) developing a treatment plan and further services that specifically address suicide risk (AAS, 2007).

From these tenets, AMSR was developed by the AAS that includes multiple methods of learning for mental health professionals, with options for specific trainings if desired in adolescent, inpatient, Spanish-speaking, or veteran settings (Pisani, et al., 2011). Wintersteen (2010) trained two primary care facility staff sets using the RSSR program that worked with suicidal youth ages 12-17.9 years and found that rates of inquiry for suicide risk increased by 392%, indicating a significant increase from pre-training levels. Educating the staff on suicide risk assessment and intervention strategies led to staff being more cognizant of the strategies in day to day practice.

Risk Assessment Workshop

Developed by Dale McNiel at the University of California, San Francisco, the Risk Assessment Workshop was targeted specifically for those at risk for suicide and violence and is based on suicide risk and assessment treatment guidelines in the American Psychiatric Association standards (Pisani et al., 2011). The Risk Assessment Workshop training is a five-hour training that uses lecture and case vignettes to increase self-efficacy and effectiveness in suicide risk assessment and intervention as well as enhanced documentation. Noting the limited training that practitioners receive in suicide risk and assessment training, McNiel et al. (2008) randomly assigned 45 psychiatry and psychology trainees to either receive the Risk Assessment Workshop treatment or no treatment. Results found that those who received the training improved significantly in

clinical documentation and could better communicate their clients' suicide risk assessment and treatment.

Skills-Based Training on Risk Management

The Skills-Based Training on Risk Management (STORM) was developed in 2003 and is mainly used in the United Kingdom; it is a skills-based approach to help the trainee develop a skill set to assess and create a safety plan for at-risk clients (STORM, 2014). Training takes place in a six-hour workshop that involves group discussion, role plays, and video demonstrations (Pisani et al., 2011). Gask, Lever-Green, and Hays (2008) examined the experience of 203 mental health clinicians in Scotland and found a significant difference in positive attitudes and confidence of those trained both at post-test and six-month follow-up. These results indicate that the STORM training provided higher confidence and positive attitudes towards suicide risk and assessment in the short-term and long-term..

Suicide Assessment Workshop

The Suicide Assessment Workshop was used as a training method for psychiatry students in the United Kingdom and was developed for three specific populations/settings: (a) deliberate self-harm, (b) hospital setting, and (c) outpatient setting. Fenwick, Vassilas, Carter, and Haque (2004) researched the effectiveness of a half-day versus a full-day training workshop using 99 mental health professionals; they found that both trainings half-day and full-day trainings significantly improved confidence and had a lasting effect on follow-up. The training lasts for six hours and uses group discussion and role plays as dissemination tools, but is not currently training clinicians (Pisani et al., 2011).

Suicide: Understanding and Treating the Self-Destructive Process

Suicide, Understanding and Treating the Self-Destructive Process was developed

by Firestone and Firestone (1998) uses voice therapy and video demonstrations along

with two assessment instruments, the Firestone Assessment of Suicidal Intent (FASI) and

the Firestone Assessment of Self-Destructive Thoughts (FAST). The goal of this therapy

is to identify the continuum of self-destructive patterns in clients through objective

measures (Firestone et al., 1998; Pisani et al., 2011). The five-hour training also has a

multicultural piece, educating trainees on demographic factors that are correlated with

suicide risk. No empirical research was found for this program.

SuicideCare: Aiding Life Alliances

The SuicideCare: Aiding Life Alliances is an advanced training program that is

available to clinicians after they have completed the ASSIST program(Pisani et al.,

2011). In the ASSIST program, the clinician learns basic intervention skills. The

SuicideCare program is primarily community-based and reframes suicide risk from a

low/medium/high assessment to a more detailed matching system with risk assessment

and intervention (LivingWorks, 2014). The eight hour trainings are mainly conducted in

group discussion format and is in addition to the ASSIST program training that they are

required to receive prior to the advanced training. Pearce et al. (2003) conducted research

on 42 university students and found that post-training self-report indicated significant

increase in self-efficacy and understanding of content.

Other Suicide Assessment Tools

Apart from the 12 assessment methods described by Pisani et al. (2011), there are

specific suicide assessment tools and training methods that are utilized in the counseling

profession without much agreement on which is preferable. The tools that are described in this section are specifically used in in determining suicide risk through assessment by specifically targeting common risk factors of suicide. Rosenberg (1999) articulated an integrated training method for training suicide prevention used to determine suicide risk level. Included are considerations for clinical interview (e.g. assessment categories including history, presenting problem), assessing for depression, assessing for suicide, consideration of risk factors (e.g. depression, drug use, hopelessness, impulsivity), determining risk level given previous information gather, and different affectively-based and action-based interventions for the counselor (Rosenberg,1999).

Although there has not been empirical research to support Rosenberg's proposal, research has been conducted for specific tools, such as the mnemonic "IS PATH WARM?" created by Juhnke, Granello, and Lebron-Striker (2007) as a means to assess suicide, which stands for the following: (a) Suicidal Ideation, (b) Substance Abuse, (c) Purposelessness, (d) Anger, (e) Trapped, (f) Hopelessness, (g) Withdrawing, (h) Anxiety, (i) Recklessness, and (j) Mood Change. Developed for use as an immediate assessment and in conjunction with the AAS, clinicians should assess for occurrences of the client's symptoms over the previous three months (Juhnke et al., 2007). In a validity study, Lester, McSwain and Gunn (2011) found that "IS PATH WARM?" did not accurately distinguish levels of suicide risk and recommended hesitancy in future use. A similar mnemonic developed as a suicide assessment tool is "PLAID PALS," which involves the following risk factors in an assessment tool: (a) Plan, (b) Lethality, (c) Availability, (d) Illness, (e) Depression, (f) Previous Attempts, (g) Alone (h) Loss, and (i) Substance Abuse. Assessing more behavioral factors, "PLAID PALS" is recommended by San

Francisco Suicide Prevention (2014), but no research can be found to examine the validity of the tool.

Not all suicide prevention and assessment training have outcomes that are demonstrated to be effective in preparing counselors (Katz et al. (2013). Another assessment that is referenced but with little research on its validity is the suggested assessment of Intent/Plan/Means (Hoff, Hallisey, & Hoff, 2009; Miller, 2012). The overarching purpose of this assessment is to question the client in the following three areas: (a) Thoughts of suicide, (b) Plans related to suicide and (c) Means to complete suicide. Although this is often a suggested and cited assessment, it lacks assessment of the additional risk factors of suicide. With the variety of trainings available for a variety of settings, learning types, and theoretical bases, it gives universities a multitude of training options for graduate students. For a summary of suicide training and assessment programs, see Table 1.

Table 1

Summary of Suicide Assessment and Prevention Training Programs

Name	Target Population	Length of Training (hours)	Method of Instruction	Topics Discussed	Research
Assessing and Managing Suicide Risk	Mental Health Professionals	7	Lecture, group discussion, further reading	Risk assessment, accurate assessment, treatment planning, education on suicide	None
Chronological Assessment of Suicide Events	Mental Health Professionals	6	Lecture, group discussion, video demonstration, role plays, follow-up consultation	Risk assessment, accurate assessment	Shea (2009)

Collaborative Assessment and Management of Suicidality	Mental Health Professionals	6	Lecture with manual	Risk assessment, accurate assessment, treatment planning, documentation, education on suicide	Comtois et al., (2011); Jobes, Jacoby, Cimbolic, & Hustead, (1997); Jones, (2012)
Intent/Plan/Means	Mental Health Professionals	Not reported	None reported	Risk assessment, accurate assessment	None
IS PATH WARM?	Multiple populations	Not reported	Handout	Risk assessment, accurate assessment	Lester, McSwain and Gunn (2011)
MAP	Mental Health Professionals	Not reported	None reported	Risk assessment, accurate assessment	Rosenberg (1999)
PLAID PALS	Multiple populations	Not reported	Handout	Risk assessment, accurate assessment	None

Question, Persuade, Refer, Treat	Multiple populations	8	Lecture with manual	Risk assessment, accurate assessment, treatment planning, documentation, education on suicide	Jacobson, Osteen, Sharpe, and Pastoor (2012)
Recognizing and Responding to Suicide Risk	Lecture,	15	Lecture with manual, group discussion, case vignettes, role plays	Risk assessment, accurate assessment, treatment planning, documentation, education on suicide	Wintersteen (2010)
Risk Assessment Workshop	Mental health professionals	5	Lecture, case vignettes	Risk assessment, accurate assessment, treatment planning, documentation, education on suicide	McNiel et al. (2008)
Skills-Based Training on Risk Management	Mental health professionals	6	Group discussion, role plays, video demonstrations, manual	Management of care, accurate assessment, treatment planning	Gask, Lever-Green, and Hays (2008)
Suicide Assessment Workshop	Mental health professionals	6	Group discussion, role plays	Risk assessment, accurate assessment, treatment planning, education on suicide	Fenwick, Vassilas, Carter, and Haque (2004)

Suicide: Understanding and Treating the Self-Destructive Process	Mental health professionals	5	Lecture, video demonstrations	Accurate assessment, management of care, treatment planning	Firestone and Firestone (1998)
SuicideCare: Aiding Life Alliances	Mental health professionals	8	Group discussion	Risk assessment, accurate assessment, management of care	Pearce et al. (2003)
The Air Force Managing Suicidal Behavior Project	U.S. Air Force Personal	12	Lecture with manual	Risk assessment, accurate assessment, management of care	Oordt, Jobes, Rudd, Fonesca, Runyan, and Stea (2005); Knox, Litts, Talcott, Feig, & Caine, 2003
Unlocking Suicide Secrets	Mental health professionals	6	Lecture, video demonstration	Risk assessment, accurate assessment, management of care, documentation, treatment planning	None

Summary of Previous Research

The above review of literature suggests that, while there are suicide prevention and assessment training programs and tools available, they may lack empirical research and may not be being implemented in effective ways that lead counselors to be prepared to work with suicidal clients. Of the training programs and tools reviewed, only 12 had empirical research support, with one of these programs not indicating favorable training outcomes (Lester, McSwain, & Gunn, 2011). Counselor training in suicide prevention and assessment is limited to falling under crisis intervention (Wachter Morris & Barrio Minton, 2012), or with a school counselor focus (House, 2003). The ACA Code of Ethics (ACA, 2014), CACREP standards (CACREP, 2009) provide some guidelines on counselor preparedness in this area, but do not cover many of AAS and Suicide Prevention Resource Center Taskforce core competencies listed.

Although the literature indicates that counselors are more likely to encounter suicide prevention and assessment training once they have entered into the workforce, it is not clear as to the formality of these trainings and if they are effective in preparing counselors (Bongar & Harmatz, 1989; House, 2003; Neimeyer, 2000; Wachter Morris & Barrio Minton, 2012; Reeves, et al., 2004; Ruddell & Curwen, 2002). Further, there has been no research on counselor preparedness working specifically with suicidal clients, leading to a need to better understand the essence of the counselor experience. Without any research in this area, it is unclear about the implementation of training standards in the counseling field. This qualitative inquiry may provide a better understanding of the counselors' experience in this area, as well as their perceived level of preparedness.

CHAPTER THREE

METHODOLOGY

In this chapter, I describe the research design, role of the researcher, research team, auditor and researcher bias. I then describe the components of sampling and criteria for participant selection, gaining entry into the field, and the measures I took to ensure participant confidentiality and safety. I also discuss the interview process, data analysis, and data management. Finally, I discuss strategies of and threats to trustworthiness.

Research Design

I used a qualitative approach of phenomenology for this study. The tradition was chosen based on my desire to understand the essence of the counselor's perceived degree of preparedness of working with suicidal clients. In phenomenology, the main tenet is seeking to understand the participants' lived experiences while bracketing or setting aside researcher bias (Moustakas, 1994). Through each participant, I attempted to put together the essence of the phenomenon of working with suicidal clients through use of the participant as co-researcher, reflecting on my own experience as the researcher, and using a research team and auditor.

A social constructivist lens was integrated within the phenomenological tradition approach for this study. The social constructivist paradigm is a belief system, which assumes that there are multiple perspectives and therefore an unlimited amount of truth for any one particular topic or person (Hays & Singh, 2012). With regards to ontology, understanding each of the participants' subjective views not only on their prior training but even more importantly, on their level of preparedness is key. Epistemologically, the perspective of the level of preparedness when working with suicidal clients has been

developed based on their interaction within their training programs and working with

suicidal clients. In addition, understanding of this research inquiry is co-constructed

between the participants and me. Regards to axiology, my values and those of the

participants would be present in the study, and my research team and I attempted to

bracket our assumptions and biases to better understand those of the participant. With

regards to rhetoric, the focus was mainly on the participants' voice, with quotes included

in the findings and member checking conducted to portray their perspective in

understanding the findings of the research, along with researcher reflexivity as a way to

maximize the participant voice and perspective. Methodologically, because,

understanding the voice of the participant in elements such as what affects the level of

preparedness and what the implications are for future programs is salient for this study,

qualitative research was the best fit.

Role and Bias of the Researcher and Research Team

Trustworthiness is a vital aspect of all qualitative research, and it was important

for me to understand researcher bias in an attempt to continue to reach for ideal

trustworthiness under the phenomenological tradition. Because this is an underdeveloped

research area in the field of counseling, an important step was to begin with a fresh

perspective, setting aside any prior explanations and biases of counselor training levels in

the minimal literature, and from my own personal experience (Moustakas, 1994). I, the

primary researcher, am a 29-year-old White female of European descent who holds a

master's of science degree in mental health counseling from a CACREP-accredited

program. I am a current doctoral candidate in counseling in a CACREP-accredited

program.

During my master's training, I received suicide prevention training in both my program and at a community mental health center. I have also had direct contact with masters' students in the program I graduated from, and those I currently supervise as a doctoral candidate, and have heard their views on feeling prepared when working with suicidal clients. Students enrolled in counseling master's programs with whom I have come into contact generally did not believe that they were provided adequate training for working with suicidal clients. I saw directly how that transpired into low self-efficacy as a counselor when the possibility of working with a suicidal client arose. I believed that the counselors being interviewed for the purposes of this research would hold similar opinions. I held the belief that more direct suicide prevention training (as opposed to crisis intervention as a whole) would be beneficial for master's students and current counselors. I also believed that a more detailed description in the current ACA and CACREP standards in this area could change how our future counselors' self-efficacy is shaped with regards to suicide prevention.

My own experience with suicidal clients began in my master's program during both practicum and internship settings and since graduating, and I have repeatedly come into contact with clients that presented with either past or present suicidal ideation. With regards to the participants in the study, I may or may not have had interaction with them in the past, depending on the participant. When I had previous experience with the participant, I used reflexive journaling and utilized my research team as a way to minimize my bias when attempting to understand their experiences.

I chose to work with a research team member who participated in individual and consensus coding. She is a 30-year old White female of European descent and holds a

master's of arts degree in community and school counseling and is a current doctoral student in counseling from the same program. In addition to her educational experience, she is a licensed professional counselor and marriage and family therapist in her home state. She has worked with children and families in a community counseling center and has performed telephone crisis work. She has experience supervising counseling students from a variety of counseling programs. The only time she can recollect being trained to work with suicidal clients in her time working in the counseling field was once in her internship during a 30-minute informal training after a crisis scenario the previous week. It was not until she started practicing as a counselor that she identified learning how deal with suicidal clients. She has little formal suicide prevention training, but believes that her training has been adequate. She has no direct experience with a client who has had inadequate care related to suicide ideation and for this reason she is skeptical regarding the need for increased training and standards.

Auditor

As an additional tool of trustworthiness, I used an auditor for this study. According to Hays and Singh (2012), an auditor is a disinterested party that can enhance the trustworthiness of the study by reviewing the audit trail and examining the level of rigor present in the study as well as illuminate any bias and assumptions that are present. The auditor for this study held a similar purpose to this description, looking over the audit trail, specifically looking for potential bias and assumptions made by myself or my research team member. The auditor did not have any stake in the outcome of the study and was not utilized until all data were collected and analyzed. The auditor is a 32-year old biracial (White/Hispanic) female who holds a doctoral degree in Counseling from a

CACREP-accredited program, and has approximately nine years of direct experience working as a mental health counselor for at-risk and suicidal youth and has had advanced training in qualitative methodology.

Participants

For this phenomenological inquiry using maximum variation and criterion sampling, I recruited 10 participants, which falls within the suggested range (i.e. 5-25 participants) of the recommended sample size for this tradition (Hays & Wood, 2011; Polkinghome, 1989). Ten participants were sampled based as a way to best utilize the CACREP vital statistics (2013) as a basis for the maximum variation sampling. Because I operated from a social constructivist paradigm, a diverse sample of participants was actively recruited in an attempt to better understand the meaning of the phenomenon. Specifically, I looked for diversity that was representative of the counselor population in cultural demographics, geographical location, and counseling experience level. To do this, I actively attempted to use the CACREP Vital Statistics (2013) as a guide. I sampled the counseling population using this demographic data to attempt to accurately represent the population to the best of my ability.

Because there is no specific literature researching this topic, counselors and counselors in training were recruited. For a participant to be selected, they must have self-identified as working with a client that they deemed to be suicidal. The definition of a suicidal client was left to the participant to construct and determine if they met the criteria. They must also have had either graduated or currently have been enrolled in a counseling master's program, and had completed their master's program's suicide

prevention training, if any is provided. If the participant is still enrolled in their master's program, they needed to at least be currently enrolled in a practicum course.

Gaining entry. I entered the field initially through CESNET-L and COUNSGRADS listservs. Once a participant responded, the informed consent form and demographic sheet was e-mailed to each potential participant, with a request to fill each out and return to determine eligibility to participate. Two requests for participation were sent out on each listserv, with 12 potential participants being recruited through this format. Of the 12 recruited, five participants followed through with scheduled appointments and were interviewed. Of the seven who did not end of participating, four did not respond to the request to fill-out the demographic sheet to determine if eligible, two did not communicate after returning the demographic sheet, and one did not show for a scheduled interview. I recruited the remaining five participants via direct e-mail communication with CACREP counselor education program directors requesting to distribute my request to current counseling students, alumni, and faculty. One participant was turned away due to not qualifying for the study based on experience level, and two participants were turned away once 10 participants had been recruited and interviewed. Interviews were conducted through video conferencing software or phone. Every attempt was made to conduct the interview via video conferencing, but due to technology issues, I conducted telephone interviews with four of the participants.

Participant characteristics. I asked participants recruited to fill out a demographic sheet that included items assessing age, gender, race/ethnicity, sexual orientation, relationship status, religious/spiritual orientation, geographical location, credentials, highest degree completed, current educational status, approximate number of

clients seen per week, and current work setting. I sought to recruit participants that were

diverse along demographic variables, with gender, race/ethnicity, and geographical

location proportionate to the CACREP Vital Statistics (2013). The following are

CACREP Vital Statistics (2013) percentages for the demographics listed: (a) gender

(female 82.28%, male 17.72%), (b) race/ethnicity (African American/Black 20.74%,

American Indian/Native Alaskan 0.74%, Asian American 1.79%, White 60.43%,

Hispanic/Latino 7.69%, Native Hawaiian/Pacific Islander 0.25%, multiracial 1.8%,

Nonresident Alien 0.89%, Other/Undisclosed 5.67%), and (c) geographic location based

on ACES regions (North Atlantic 17.65%, North Central 25.74%, Rocky Mountain

6.25%, Southern 40.07%, Western 9.56%). Participant characteristics gathered from the

demographic sheet are presented in Table 2.

Table 2

Participant Characteristics

		PA1	PA2	PA3	PA4	PA5	PA6	PA7	PA8	PA9	PA10
Age		29	43	29	24	39	25	39	25	51	36
Gender	Female	X		X	X	X	X		X	X	X
	Male		X					X			
Race/Ethnicity	African American/Black						X				
	Biracial/Multiracial								X		
	Hispanic			X							
	White/European American	X	X		X	X		X		X	X
Sexual Orientation	Bisexual			X		X	X				
	Heterosexual	X	X		X			X	X	X	X
Relationship Status	Divorced			X						X	
	Partnered		X		X	X	X	X			X
	Single	X							X		
Religious/Spiritual Orientation	Atheist			X							
	Buddhist										X^3
	Christian	X^3	X^3		X		X^1	X^2	X^1		
	N/A					X				X	

ACES Region	North Atlantic		X								X
	North Central								X	X	
	Rocky Mountain							X			
	Southern	X			X	X			X		
	Western					X					
Credentials	ACS		X								
	DCC			X							
	LMHC		X	X							
	LMHP							X			
	LPC		X			X		X			
	LPC-CR								X		
	LPCC		X								
	LPC-Intern				X		X				
	LPCMH										X
	N/A	X								X	
	NCC		X	X			X				X
	QMHP						X				
Highest Degree Completed	Bachelors									X	
	Master's	X		X	X	X	X		X		X
	Doctorate		X					X			

Current Educational Status	Doctorate	X		X		X					
	Master's									X	
	N/A		X		X		X	X	X		X
Current Work Setting	Community Mental Health				X		X		X		
	College										
	Private Practice			X		X					X
	University/College	X	X	X					X	X	
Approx. No. of Clients Seen per Week		0	10	10	20	20	5	1-3	8-20	12	30

Note. Data Presented in Table 2 were reported on the Demographic Sheet and reflect participants at the time of the interview. [1] = indicates non-practicing; [2] = indicates somewhat practicing; [3] = indicated practicing; ACS = Approved Clinical Supervisor; DCC = Distance Certified Counselor; LMHC = Licenced Mental Health Counselor; LMHP = Licensed Mental Health Professional; LPC = Licensed Professional Counselor; LPCC = Licensed Professional Clinical Counselor; LPC-CR = Licensed Professional Counselor-Clinical Resident; LPC-Intern = Licensed Professional Counselor - Intern; LPCMH = Licensed Professional Counselor of Mental Health; N/A = Not Applicable; NCC = National Certified Counselor; QMHP = Qualified Mental Health Professional

Measures to Ensure Participant Confidentiality and Safety

It was of the upmost importance that I maintained the participants' privacy, safety and confidentiality throughout the research process. Upon agreement of interest in participation, participants received the informed consent form and demographic sheet and were required to return the document signed before the data gathering began. Before the interview began, I reviewed the informed consent and I made it clear that participation was entirely voluntary and that they may have ended the interview at any time. After each interview was transcribed, I de-identified any identifiable information before I gave it to the research team members. I de-identified participant information for the audit trail. Data were stored on a password-protected computer and a locked cabinet only accessible by me and I will destroy it within 5 years.

Data Source

Following suggested phenomenological data collection methods, I gathered individual interviews as the primary form of data for the study (Hays & Wood, 2011). I conducted all of the interviews, and one individual interview was conducted per participant. Interview length ranged from 30:40 minutes to 68:09 minutes, with an average interview length of 47:46 minutes. Each individual interview was conducted using a semi-structured interview protocol of 13 questions that were developed in an attempt to gain more information in relation to the research questions and purpose. In addition to the questions provided, I asked probing or clarifying questions in areas that I deemed necessary on a participant by participant basis. The participants were also asked to complete a demographic sheet (Appendix B) and an informed consent form (Appendix C) prior to participating in the study. Each was discussed and completed before the

interview protocol began. Each interview was transcribed verbatim, with contact summary forms and reflexive journaling occurring within one to two days after each interview.

Interview protocol. The following protocol was developed based on the AAS and Suicide Prevention Resource Center Taskforce's eight core domains of practice and 24 competencies. Each of the following questions are specifically written to further understand counselor development in these domains of practice:

1. Tell me about your training in suicide prevention and assessment, if any.

    a. (Probe) Master's program

    b. (Probe) Amount of time

2. Can you tell me about training you received, if any, prior to entering the master's program?

    a. (Probe) How would that compare to other training you received?

3. How do you perceive your training experience in the area of suicide prevention and assessment?

    a. (Probe) Specific to master's program?

[Make note of transition from training topic to specific suicidal client experiences]

4. When I say suicidal client, what comes up for you?

5. Tell me about your experience working with suicidal clients.

    a. (Probe) Specific suicide assessments.

    b. (Probe) Specific suicide interventions.

    c. (Probe) Frequency of assessment.

6. Tell me your thoughts or feeling about working with suicidal clients.

    a. (Probe) Specific client example.

7. What, if any, reactions do you personally have to suicide?

8. What, if any, kinds of support have you had when you have worked with a suicidal client?

9. What do you think are legal and ethical issues associated with a suicidal client?

    a. (Probe) Specific client example.

10. Tell me about a time, if any, you felt comfortable with your intervention with a suicidal client.

11. Tell me about a time, if any, you felt uncomfortable with your intervention with a suicidal client.

12. If you could change anything about your suicide prevention and assessment training experience, what would that be?

    a. (Probe) Master's program, post-masters

13. Is there anything else you would like to add?

Negative case analysis was conducted as a form of trustworthiness throughout interviews through use of probing questions as appropriate. The following questions are examples that were used in multiple interviews to demonstrate negative case analysis: (a) Tell me about what, if anything, you weren't trained for working with suicidal clients (b) Tell me about what you weren't prepared for when I mention suicide? (c) Are you aware of other assessments but choose not to use them? and (d) Are you aware of other interventions but choose not to use them?

Data Analysis

I began data analysis immediately after each interview was conducted by completing a contact summary form for each participant, and use of reflexive journaling as needed throughout the interviewing and data analysis process. After each interview was conducted, it was transcribed within one week of the interview, with the transcription being sent to the participant shortly after for member checking. Member checking involved asking for clarification on a specific section, as well as asking the participant to read over the transcription and give feedback. Of the 10 participants recruited, five participants provided feedback, and three participants provided supplemental information. I used reflexive journaling after each interview, and after I coded each individual interview and after each consensus coding meeting as a way to bracket biases and list initial thoughts and feelings that I had during the interview or coding process. This allowed me to reflect on the participants' essence, and not my own biases about their experience. My research team member used reflexive journaling after each individual interview she coded, as well as after our coding sessions. When exiting the field, I prepared and shared an executive brief of the main points of the findings.

I conducted data analysis via horizontalization in a way that best describes the phenomenon (Hays & Singh, 2012; Hays & Wood, 2011). Beginning with the first three interviews, my research team member and I independently coded the transcripts, followed by a meeting where we met to consensus code and begin to identify textural descriptions. It is in this first consensus coding meeting that we developed the initial codebook. We then repeated the same process again on the next three interviews, conducting independent and consensus coding for textural descriptions, and revising the

first codebook. Following the revision of the codebook, we engaged in individual and

consensus coding for the last four interviews, followed by a final consensus coding

meeting. In this meeting, we identified textural and structural descriptions and finalized

the codebook (Appendix D). During this process, I completed within-case displays for

each participant (see Appendix E) and upon completion of the final codebook, created a

cross-case display to better immerse myself in the data. Once the codebook was finalized,

the independent auditor looked over the final codebook's textural and structural

descriptions, and the audit trail. See figure 1 for a flow chart of the data analysis process.

Figure 1. Data analysis.

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┌─────────────────────────────┐
│       Interviews 1-3        │
│  Inidvidual Horizontalization│
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│      Consensus Coding        │
│  Identify Textural Descriptions│
│ Initial Codebook (#1) Developed│
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│       Interviews 4-6         │
│  Individual Horizontalization │
│   Using Codebook #1 as a guide│
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│      Consensus Coding        │
│  Identify Textural Descriptions│
│      Revise Codebook (#2)     │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│      Interviews 7-10         │
│  Indvidual Horizontalization  │
│   Using Codebook #2 as a guide│
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│      Consensus Coding        │
│  Identify Textural Descriptions│
│   Identify Structural Themes  │
│     Finalize Codebook (#3)    │
└─────────────────────────────┘
              ↓
┌─────────────────────────────┐
│     Independent Auditor      │
│   Reviews Final Codebook &   │
│         Audit Trail          │
└─────────────────────────────┘
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Data Management

Data management was used throughout the study as a tool to better understand

the data, beginning with a within case-display and contact summary sheet for each

participant to better understand the data (Hays & Singh, 2012). When all data collection

was complete, these were combined into a cross-case display as a way to potentially

identify further textural and structural descriptions. As mentioned above, data was stored in a password-protected computer and locked cabinet as needed, and all information was de-identified before shared with the research team or added to the audit trail.

Strategies for Trustworthiness

Trustworthiness is of the utmost importance in qualitative research, as it is the way to ensure quality and rigor of the data (Hays & Singh, 2012). Multiple strategies were used to meet criteria's of trustworthiness for this study. I used the following strategies of trustworthiness in the following ways: (a) audit trail in both electronic and paper format where appropriate, (b) triangulation of data sources (i.e multiple participants), investigators (research team), and theoretical perspectives, (c) member checking through follow-up questions and review of transcript following interview, (d) reflexive journaling after each interview, (e) simultaneous data collection/analysis, and (f) thick description. These strategies helped attain the following criteria's of trustworthiness: (a) credibility, (b) transferability, (c) confirmability, (d) authenticity, (e) coherence, (f) sampling adequacy, (g) ethical validation, and (h) substantive validation (Hays & Singh, 2012). Reflexive journaling was used by my research team and me.

Participants were given a copy of the interview and asked to clarify or elaborate on anything that they felt was needed. Some of the questions that participants were asked when the transcript was sent via e-mail were, "As you are reading over your transcript, can you send back any reflections or thoughts you had while you looked over it. Specifically, what, if any, feelings did you have during or after the interview talking about your specific connection to suicide?" or "Could expand on where you use your judgment when assessing risk, and how much that plays into what intervention you use

with the client." Further, when a participant specifically spoke about developing their own formal assessment, I asked the participant if they would be willing to share it with me for the purposes of the study. Participants will be given an executive brief upon completion of study. I had received approval from the Human Subjects Review committee prior to conducting the study, as seen in Appendix A.

Threats to Trustworthiness

As mentioned above, as much as threats to trustworthiness were limited, it is also recognized that complete elimination is impossible. Possible threats to trustworthiness during the data collection and analysis phase includes any biases, beliefs or assumptions of the researcher, research team member, or external auditor that may not have been bracketed properly or we were aware of. Further, the research team may have failed to recognize any textural or structural themes that were important to the results of the study. With regards to each participant, I wanted to provide as safe an environment as possible. However, the participant may still have felt uncomfortable discussing the topic of suicide and may therefore restrict their answers. With regards to participant recruitment, the topic of suicide may have inhibited responses to the request of participation, and therefore those who responded may have a higher level of comfort with the topic than those who did not respond. As always, there may have been other threats to trustworthiness of which I was and am unaware.

CHAPTER FOUR

RESULTS

In this chapter, I will present the four structural themes (i.e. training preparedness, components of preparedness, assessment and intervention knowledge, and training recommendations), and 15 textural themes that address the research questions. Themes identified relate to understanding the essence of counselors' perceived degree of preparedness working with suicidal clients and identifying training recommendations. After identifying the structural and textural themes, I conclude the chapter with a summary of the findings. See table 3 for a list of structural and textural codes.

Table 3

Code List

Structural Codes	Textural Codes
Training Preparedness	Degree of Integration
	Degree of Adequacy
	Source of Integration
Components of Preparedness	Ethical Considerations
	Counselor Dispositions
	External Support
Assessment and Intervention Knowledge	Preference of Assessment
	Frequency of Assessment
	Safety Planning
	Minimizing Risk/Wrong or No Intervention
	Therapeutic Relationship
Training Recommendations	Formal Assessment
	Formal Intervention
	Multicultural Training
	Legal/Ethical Training

Training Preparedness

Participants each gave an overview of their suicide prevention and assessment training in terms of degree of preparedness, ranging reportedly from very inadequate to

specificity. Each textural theme was independent of each other in describing the essence of counselor training: *degree of integration, degree of adequacy,* and *source of integration.*

Degree of Integration

Of the 10 participants, three did not remember any formal training in suicide prevention and assessment in their master's program. Degree of integration was the degree of preparation in suicide prevention and assessment from inadequacy to specificity. A current master's student in her internship at the time of interview, PA9, stated that her formal training was "pretty minimal," and PA6, a master's graduate and practitioner, stated, "I wouldn't say [suicide prevention and assessment training] was in the program, [that there] was ever a specific time where we constantly focused on suicide prevention."

PA8, a master's graduate and practitioner, recalled an elective course/workshop that was not a requirement for graduation:

> Honestly I didn't really get any. There was an elective and if I remember correctly
> it was like a one day workshop elective, not even an entire semester. I mean we
> talked about it throughout other classes, "What if somebody is making a passive
> death wish statement?" and stuff like that. Or some small bits and pieces, but
> never any formal training pertaining directly to suicide; unless you took that
> elective, which I didn't. So I don't have any training from college.

PA4, a current doctoral student, found her master's level training as adequate:

> Yes. Especially, like, the training that...before you start seeing clients, clinically
> in the Master's program. Um, they kind of really go over that and, as far as, like,

the steps to take when your first client is suicidal, I think that's really beneficial that you have some kind of knowledge. You know every situation is going to be different, but you at least have some kind of set things that you can fall back on. I think it makes you feel more confident and less terrified.

Five participants were either currently enrolled in a doctoral program or had previously graduated from one. This level of training for participants was found to be both focused and inconsistent for participants. When doctoral program training included suicide prevention and assessment as an educational component, it was focused on one specific theory or training. PA5, a doctoral student, found her training in her doctoral program to be more focused and detailed than previous training, "We got really specific training in how to do assessments, interviewing and intervention with suicidal clients through that theory, through my practicum courses" and found it a comfort when working with suicidal clients:

> I really perceive it -- particularly from my doctoral program -- in a really positive way. I mean… I think that there was just less fear once I learned more specific interventions for dealing with suicide, not just assessing the risk, but actually learning how to decrease risk. So I think my competency or my self-efficacy totally went up in my doctoral training in the last few years.

Participant one, a current doctoral student, described her doctoral level training as "how to teach it and talk about it with students and supervisees rather than me working with clients" and did not recall specifics to the training.

Degree of Adequacy

While actual educational experiences varied in each participant, overall most of the emotional reactions relating to suicide prevention and assessment training were negative. Degree of adequacy was the satisfaction with training in suicide prevention and assessment. Most participants found their suicide prevention and assessment training to be inadequate, with PA7, a doctoral level graduate and counselor educator, stating, "Master's degree was cursory. I would say it was very basic, not adequate, that's probably the best word I can use to describe that..." and PA2, a doctoral level graduate and counselor educator, stating, "I think with all due respect to my faculty and program, it was minimal." Most participants stated some level of inadequacy when discussing their master's level training in this area. For PA5, a doctoral student, her master's program made her feel more fear than competence:

> I think [master's training] was poor and I do think that most master's program training on suicide is poor. I've been an Adjunct as well and have taught in different programs, and I'd had experience or exposure to them. You know, until CACREP put in the requirements for a specific course on suicide and crisis, I think it was pretty random how much you got. You know? I think mine was definitely not enough for those intervening 9 years that I worked, before I even learned about Joiner. Yeah. It's sort of a little bit too fear-based sometimes, you know, too liability focused. You know? It's a lot about risk, and not enough on client care.

Those participants that recalled pre-master's training spoke of it as cursory and sporadic. When PA4, a doctoral student, recalled training in a job previous to entering her master's program, she described it as more directional, saying:

Uh, I worked at a children's shelter while I was an undergrad and we received,

like, a small training that wasn't very much. Just kind of about if any of the

residents ever got suicidal, kind of like what the steps that you would take…that it

was more like who to call and not as much like, "here's what you do." It was just

kind of like, "here's who you need to call." And there was not really much other

than that.

For some participants, they gave more vague accounts on pre-master's training in

suicide prevention and assessment, such as PA1, a doctoral student who stated, "I took a

counseling theories course in undergrad, and I feel like maybe one class was devoted to

legal and ethical issues and might have discussed that, say, maybe a couple hours in

undergrad." Finally, PA2, a doctoral level graduate and counselor educator, gave an

optimistic account of the state of pre-masters training, specifically at the undergrad level:

If I look back on it, I think it was appropriate for the level of involvement and

care given to the particular roles I was in. I do appreciate how things have

advanced with regards to psychological first aid suicide interventions in the broad

aspects of the skills training and I think where we're at today in helping prepare

people and people with the bachelor's level is much better than when I was first

entering the field.

Source of Integration

When suicide prevention and assessment training was mentioned, the location,

breadth and depth of training was varied. While PA1, a doctoral student, remembered

integration in her training, reporting that "There wasn't like a specific class but there

were sections within each class in my Masters training before practicum and then during

practicum and internship we spoke about it," other participants could not recall a specific time when suicide was a focus of any part of their training. PA6, a master's graduate and practitioner, stated, "I wouldn't say it was in the program it was ever a specific time where we constantly focused on suicide prevention." One participant, PA4, a master's graduate and practitioner, reported having a class in crisis intervention, "In my master's program, we had a crisis intervention class, and a lot of that covered suicide prevention." When asked, other classes that were mentioned as areas where training occurred, formally or informally, most other responses were mental health orientation and introduction to theories.

Practicum and internship was mentioned by four of the participants as one area where they received training, but it was varied on the conceptualization of the training. PA5, a doctoral student, described her training in practicum, "I did learn about how to handle suicide, to some degree, in my practicum, when I was in my Master's class -- in my Master's program. So there was definitely some direct instruction on duty to warn, risk factors, how to communicate to a client who's feeling suicidal." PA1, a doctoral student, described the training she received during practicum and internship, which rejected the idea of formal assessments in a crisis situation and embracing empathic responding:

> I think practicum and internship always at the beginning of the course, though
>
> there is a section that we went over just basics of practicum and internship.
>
> Practicum, I mean, they were hands on with us in the sessions a lot of the time but
>
> just the basic stuff, like going over how to recognize and what to say, but then
>
> there was also a component of 'don't be alarmed if your clients express some

suicidal ideation' and just to be empathetic with them and bear with them as a

person rather than just checking things off the list of recognizing suicidal

thoughts.

Of the participants that had graduated from or were currently enrolled in a

doctoral program, three of the five specifically mentioned training in their doctoral

program. PA1, a doctoral student, was unsure of details relating to training, but stated that

any training received was more related as a supervisor and educator:

> I would say the most frequently talked about in suicide prevention and assessment
>
> would be in the supervision course so as a counselor and educator... my
>
> personalized plan was more teaching and supervision, so it was more how to teach
>
> it and talk about it with students and supervisees rather than me working with
>
> clients.

Overall, participants reported any training received in suicide prevention and assessment

during doctoral program training was viewed as a positive experience.

Components of Preparedness

Participants each described the components of their preparedness in working with

suicidal clients. The following textural themes describe counselor components of

preparedness: *ethical considerations, counselor dispositions,* and *external support.*

Ethical Considerations

Most participants described ethical considerations in suicide prevention and

assessment training. The following subthemes describe the textural theme of ethical

considerations: *training outside the curriculum, documentation,* and *sense of*

responsibility/do no harm.

Training outside the curriculum. Most training was conceptualized as required on-the-job training by the majority of participants. Training was conceptualized as an orientation at the beginning of a job, a yearly refresher training, or random trainings offered while employed. PA8, a master's level graduate and practitioner, who worked at an inpatient facility at the time of the interview, stated that orientation and her job providing training opportunities, "Um, I mean I had to do an orientation phase and a 90-day three month probation period, and we do use various suicide risk assessment tools and we cover it a lot at my job so I feel like I've gotten a lot in the time that I've been working there." Other participants sought out jobs that included crisis counseling, such as PA10, a master's level graduate and practitioner, who worked in crisis services for a period immediately following her master's training:

> I shadowed somebody for a good month either initially just watching them do the assessment and then doing it while being watched and I had really good supervision as well and that's helped. Thank god 'cause it can be a really draining job and I would come out of, 'cause we would go into people's homes to do the assessments and um it wouldn't always be easy, really difficult cases so I had a really, really, good supervisor.

While those mentioned above had specific, in-depth training, others had cursory yearly trainings, such as PA4, a master's level graduate and practitioner, "Um, at my job currently, we're required every contract year to take 3 hours of crisis training, which generally involves a section on suicide and suicide prevention." Of those who had post-masters experience, some actively sought out training outside of on-the-job requirements, such as PA7:

I try to catch [suicide prevention and assessment expert] whenever I'm at the

ACA workshops. They've been great resources, um, and then some of the folks

locally some of the smaller workshops like the one sponsored through the state

those kind of CE workshop things I've done quite a few of those as well.

Most of the participants described continuous education as a component of

training outside the curriculum. It was important to these participants that not only did

they feel prepared to work with suicidal clients, but that they continued to receive some

sort of training or experience, or as PA2, a doctoral level graduate and counselor

educator, explained:

Well I don't think it's ever enough because not being in a position where I'm

constantly working with individuals who are in crisis or who are suicidal, such as

if I worked in a crisis unit or something like that, I really do think if you don't use

it you at least get rusty at it, and I don't mean that as its own technique but the

ingrained process of connecting with somebody and being able to use the skills in

a calm, cool, collected way. I think that can be quite challenging to be effective,

or as effective as you can, or optimal when you're placed in those positions in a

very sparing way.

The majority of participants at one time during their interview discussed self-

driven study as a necessity for their competence that led to increasing preparedness. In a

few cases, self-driven study was the only form of education that the participant received

in the area of suicide prevention as assessment, such as PA9, a current master's student:

Unfortunately, my formal training like in my master's program was pretty

minimal. But my GA ship which happened in my second semester, almost one of

my very first clients was actively suicidal. So I sought out training and literature and requesting [information] from my advisor and my supervisor and another one of my professors. I was given a lot of information so I kind of did a self-study situation with... No, it was more like reading some book chapters that I was provided.

While PA9 sought self-driven study while still in her master's program, other participants sought it post-master's. Half of the participants interviewed mentioned self-study as a form of increasing preparedness, with PA7, a doctoral level graduate and counselor educator, speaking of his training in suicide prevention and assessment, "Combined I think it's pretty good. A lot of it is self-driven; not anything that was required of me."

Documentation. Some participants found documentation an important aspect of preparedness. For PA7, a doctoral level graduate and counselor educator, through the perspective of a current supervisor at the time of the interview, it was important for him to have his supervisee's document assessment of suicide risk at every session:

> To me it better be in your notes that you did that assessment every client every time or we're going to have problem... There's not a lot, I'm pretty hard and fast, I'm pretty open to different perspectives and ideas but not when it comes to suicide assessment. I'm very specific. I want to know in every note and I want to see that you did an assessment whether there's ideation present or not, I want to see that. What did you not see and you better document that...

From the counselor perspective, some participants found documentation to be a necessary factor, and maybe something that prevents future liability, such as PA8, a master's level graduate and practitioner in an inpatient hospital setting:

> Of course the, are they actually suicidal [or] are they actually not, and then if they do attempt to complete suicide then it's a thing of licensing of: well you were the one who assessed them, you were the one who said that they were fine and how can you discharge them and look what happened, so I mean that's always a threat and a reality, I've never had anything like that happen, but it's always one of those cover your butt type things. We document everything, we document if they get food, we document if they're on the phone; we document everything.

Further, PA8, a master's student and practitioner, noted concern for those who did not understand how to document crisis situations correctly:

> I feel like people even in the general counseling community are probably unaware of some of those things and terms and what's happening because you're somebody's counselor and you're like, you need to go over here, you told me you're suicidal and then you call us and you're like, "Hey, so did [Client] ever show up for an assessment?" and we're like, "who is this?" "Well she was in my office and she was suicidal, so I told her to come to you guys [at the hospital]" and we're like, "Ok, did you put them on a pink slip? And did you send them over by police or ambulance or something?" and they're like, "What's a pink slip?" And it's like are you serious? You let somebody who's suicidal just walk out of your office and you told them to come here? Of course they're not here, they went home. They're somewhere else.

Sense of responsibility/Do no harm. Responsibility was identified with most participants. Mainly, participants felt a responsibility or duty to protect their clients and be educated in the area of suicide prevention and assessment. PA7, a doctoral level graduate and counselor educator, described an ethical issue that he encountered, where a client was released to his care after a suicidal attempt and he was not notified until a week later:

> The client I kind of mentioned a little bit before this person was released into my care I think it was a week before I saw I think it was inpatient the police showed up, he had a butcher knife to his throat and was threatening to kill himself, police arrested him. He was inpatient, I want to say a week and a half or so, which is quite a long time for him to be inpatient, was released to my care [and] I didn't see him for a week. I didn't know he was released to my care; no one told me. He was going from inpatient to outpatient -not partial- and so those kinds of things, it does worry you a little bit in terms of our responsibility.... We have a responsibility but we have that right... rights and responsibilities go together. We have the right to treat but we have the responsibility to provide adequate care.

The responsibility that PA7 explained while discussing his experience above is echoed by PA9, a current master's student, "It's scary, that's a scary place to be... you feel responsible and I want to really help and I feel very committed to doing whatever I can to help that person out." When speaking of the duty a counselor has when working with suicidal clients, PA5, a doctoral student, stated:

> I don't think it's black and white. I think a lot of therapists and teachers say a lot of inappropriate things about what is 'ethnical' and what is 'unethical and

ethical.' I think that those are not - you know, those are not really good things to be talking about when we're talking about saving someone's life.

Do no harm was identified through some participants and their complex relationship with their clients. PA3, a doctoral student, recalled an experience where missed risk factors led to a client almost attempting suicide. In this account, the participant used the therapeutic relationship in a way that pushed ethical boundaries:

> My very first client was suicidal and high risk – his father had committed suicide. He had a plan. He was an older male – elderly, so all these demographics and family history and everything. We were able to work through it. I was able to, through the therapeutic relationship, he told me that the night that he was planning to go through with it, his daughter called and it got interrupted or something, and I had done a safety contract with him the week before, so the way I reacted, for some reason, I decided when he told me about it that he was going to do it and I said, 'You have promised me. You broke your promise to me. That you weren't going to do it.' He felt so bad because we had established a good relationship, and he's told me later, 'You're right. I'm really sorry.' That was a changing point for him. Yeah, so I saw him, he told me he was quite serious, I did a safety contract and then when he came back he told me that he had almost followed through with the attempt, so he was going to break the safety contract. I reacted by saying 'well, I'm mad at you.'

While some participants questioned the actual risk of a client who states they are suicidal, PA9, a current master's student, spoke about taking every risk factor seriously, as a way of doing no harm to her clients:

[pause] Well, I feel ethically that suicidal clients should be handled to the best of a counselor's ability and I feel that isn't always the case. Unfortunately I have spoken with people who have some really disturbing views of folks who are suicidal and the kind of just, get your shit together kind of thing, not any kind of empathy for the difficulties that they're dealing with.

Inevitability of working with a client who has some form of suicidal risk was reported by participants. PA6, a master's level graduate and practitioner, described it as an unavoidable situation:

It can pop up at any point, not one person or type of client that is necessarily more suicidal than the next. So to say that you would never work with a suicidal client would be, kind of walking on eggshells hoping, you're not really able to say that.

Additionally, PA4, a master's level graduate and practitioner, described working with a suicidal client as something that could happen at any time:

[pause] Um…[laughs] Almost…being ready for anything. Almost expecting the unexpected is almost like being prepared, I feel like, when it comes to suicide just because, like, literally it could be any situation. Like, it could happen so many various ways that it's just like you just gotta be – you gotta be prepared to be flexible, and you gotta be prepared to be, kind of, on your toes I would say.

A few participants specifically spoke of multicultural issues in a do no harm context. Loss of client empowerment in that there are risks associated with clients admitting to suicidal ideation, was discussed. PA2, a doctoral level graduate and counselor educator, discussed this topic more in depth when discussing a specific client example:

I am pleased that for whatever reason they feel comfortable enough to open up

and allow me into their world that is so painful and discouraging. I feel for them.

At the same time, it's one of those situations where I become overly involved in

taking a little bit more and more of their power away because…when it comes to

controlling a crisis or his suicidal situation, there are levels of empowerment and

ultimately it may come to the point where we totally take a client's freedom away.

I'm really sensitive to that as I'm talking to someone who may be suicidal,

because I want to do everything I can to have a fine balance between me guiding

them and me really forcing them down the road like I did with that young boy –

down the road that hopefully the end of the road is a good situation. I do believe

that it's good in as much as it helps control the suicidality right then and there, but

we also need to think about tomorrow and next week or next month.

Counselor Dispositions

All participants spoke of one or more areas of counselor disposition and the

importance that it played in suicide risk and assessment. Counselor disposition was

defined as the degree in which *counselor intuition, fear and anxiety*, and *personal*

experience affected suicide prevention and assessment.

Intuition. About half of the participants referred to counselor intuition as a form

of clinical judgment in different ways (i.e. had a feeling, unspoken, gut feeling). For PA1,

a doctoral student, her counselor intuition was the basis for rejecting her supervisor's

instructions regarding a client:

We came to the end of the semester and I was supposed to terminate with her

because the session minutes were up, and that's just what I had to do. But I just

had a feeling that she was not ready for terminating, so I kept her despite my

supervisor's instructions to terminate. I didn't terminate. She came in the next

session and said, "This is what I'm going to do when I leave your office. I'm

going to very specifically drive my truck to this place and do this and you're

going to be the last person I talked to in my life." It was like, okay. I was weirdly

calm because I just knew that she trusted me enough to tell me and this was our

opportunity to work together for her to be okay.

Other participants used clinical intuition when determining when to assess risk of

clients, such as PA3, a doctoral student, "I assess, specifically, when I suspect it" and

PA7, a doctoral level graduate and counselor educator, "…Can I help them be successful

in dealing with this ideology and this thought, unspoken thought. It might be opaque, I

can't see it, but as a clinician I'm looking at it and saying, that's suicide."

Fear and anxiety. Most participants indicated that there fear and anxiety in

working with suicidal clients, and there was not always a clear answer, as PA6, a

master's graduate and practitioner described:

That's a loaded one. Um legal and ethical. Um I think that within the position of

being a counselor it's, there's a lot of grey areas. We don't, we tell them

everything you say, here we'll stay here unless you want to harm yourself but in

this case if I have a client that everyday has feelings that they want to commit

suicide or something happens; it becomes very unclear.

When participants spoke of feelings working with suicidal clients, fear was often

identified. For PA3, a doctoral student, when asked what she thought of when I said the

word suicide, she replied, "There's a twinge of anxiety, so even though I have a lot of

experience with it and I think of my most recent conversations about it, my clients that still make suicidal threats sometimes or just the people that have talked about it most recently..." PA6, a master's level graduate and practitioner, recounted the fear of the unknown with suicidal clients:

> Personally, I get really nervous when I have a client that is contemplating suicide. Being that I still, luckily, I haven't had a client commit suicide. I'm still nervous that, even though I know there's nothing at the end of the day that I can't make someone not do something, it just weighs on me. What if they decide to do it today and what if it was something I could have said? I kind of have those "what-if" moments often now that I have active suicidal clients that I work with. So it's definitely in my head constantly; especially when I get a phone call that's not typical, like I don't usually get calls from that home. I get a call, I'm nervous. I'm a little panicky sometimes if something happens if you decide enough is enough.

Of the participants interviewed, one had a direct experience with a client who completed suicide. For PA5, a doctoral student, when asked what she thought when I said the word suicide, stated:

> I think I immediately think of the client that I had that died from suicide. For sure. I mean, yeah. That was a very impactful experience for me. Yeah. Of course, I was thinking about it as we were talking about the training portion of this conversation. Yeah what comes up. Of course, fear comes up. You know? Fear around not knowing or knowing if someone is going to do it or not, which is so challenging to figure out sometimes.

Fear itself was something that PA7, a doctoral level graduate and counselor educator,

found to be a necessary part of working with suicidal clients:

> You know, I think if you're not scared then you're in the wrong business, 'cause
>
> it should be scary. But I also think there should be confidence. Like my feelings
>
> are scared but confident and I've been doing this a while, and I still say scared but
>
> confident. If I ever say not scared, then I think I have a problem.

For PA10, a master's level graduate and practitioner, when asked when she felt

most comfortable with an intervention with a suicidal client, she spoke of the comfort in

not having the fear of the unknown, "The times I feel most comfortable are the times they

go inpatient. I know that sounds terrible, but it's easier if they're more comfortable. I

know I created safety."

As with counselor fear, most participants identified anxiety at the thought of

suicide or suicidal clients. For PA3, a doctoral student, her first suicidal client experience

was a source of anxiety, "That was my first experience with it, and I felt looking back,

like I could have done better, but I think at the time where I was in developing as a

counselor, I think I did pretty good." Other participants found that at the beginning of

their experiences as a counselor, anxiety was caused by fear that a client may become

suicidal while in their care, such as PA6, a master's level graduate and practitioner:

> I think when I started out I was very nervous and kind of, 'oh I don't want to
>
> work with suicide.' Now I see that it's kind of like a cycle and you might work
>
> with a client for a very long time and never suicidal and then it gets to a point
>
> where they are suicidal.

Anxiety was also identified as something that arose in a counselor anytime suicide is brought up, whether in conversation or in a session, such as with participant 4, a master's level graduate and practitioner:

> Um, I think it – it's just kind of stress any time you mention that to a counselor. That's, like, the one thing that you go into counseling and you're like, It's just a scary, ominous word, and I think even being interviewed by a person that, like, knows the procedures as well, it's really nerve-wracking because that probably – that's a case where you're most at risk as a counselor to kind of want to make sure that you're doing that right. And so it is, like, it's a hard topic to talk about I think.

Personal experience. Most participants discussed a personal connection to suicide. Personal experience varied greatly, from participant's own past suicidal ideation, to attempts and completion made by friends, family, and clients. Personal experience was defined as any experience or personal connection that a participant had to suicide. PA5, a doctoral student, reported both familial and client accounts:

> Of course my perception of having maybe -- not necessarily made mistakes, but sort of question how well I handled the case, you know, where the client did die by suicide...I think another factor is probably the fact that I did have a family member -- my father -- attempt suicide, when I was a teenager.

PA7, a doctoral level graduate and counselor educator, recounted a personal connection to suicide as well, "Personal experience with a friend of mine ending her life and professional experiences of friends who ended their lives; clients who tried to take their lives."

The few participants who did not have a personal connection connected to their client experiences as way to better understand suicide. For example, PA1, a doctoral student:

I have never known anybody to commit suicide but it is a very sad thing and it is a very real thing in our society. In a way I think my job has not necessarily desensitized me, but it's made me more comfortable with the topic of suicide and being able to discuss it or deal with it on a broad based spectrum.

External Support

Having some level of support on a professional level was an important component of preparedness for participants. Supervision, consultation, agency support, peer support, and faculty support were the specific areas of professional support that participants found as an important piece. PA5, a doctoral student, found peer support and consultation to be important for processing suicidal client experiences:

My peer consult group knows about my tough clients that I'm dealing with suicide, right now. So that I've consulted in peer consult groups. I've called a peer consult, one-on-one, to debrief a tough session or to go over a plan that I have for a client and kind of check me as far as, 'How does this sound? Where do you think I'm at?' Then I also pay for consultation. So I talk about my tough chronic suicidal cases in consultation. Since I'm licensed, I don't have to have supervision, but I clearly have all these different things built in to help me, because I need it, just like we all do.

PA6, a master's level graduate and practitioner, is a counselor in residency and has found supervision to be an important element of her in-home counseling experience:

Primarily, I have two supervisors soon to be three supervisors that I work with.

One I work with every week and another one I'm going to start working with

once a month, the other two are once a month. Um for a few hours but I do have

weekly supervision where I can just be brief and update on what's happening with

this [suicidal client] and others.

Informal consultation became an important part of doctoral student PA1's training in her

master's program, where she experienced the following atmosphere:

And then in my internship settings in the psych hospital which is where I worked

full-time after I graduated, there was a group of therapists, and we had like four

wings of different types of patients and we all had a large office. So we would

come back and process our sessions periodically through the day, so I knew I

could always go to them to get assistance as well.

Assessment and Intervention Knowledge

Assessment and intervention knowledge is a structural theme that referred to the

level of assessment and intervention knowledge. The textural themes included in this

structural theme are as follows: *preference of assessment, frequency of assessment, safety*

planning, minimizing risk/wrong or no intervention, and *therapeutic relationship.*

When prompted on suicide risk assessments, participant knowledge varied from

little to extensive on different assessment formats (e.g., pen and paper, verbal), formal

assessments, frequency of assessing, and differentiation of self-harm and suicidal

ideation. For example, when asked about specific suicide assessments available, PA1, a

doctoral student, stated:

I have had clients that say they want to die. They don't want to cut off with

people in their lives and deal with their problems anymore. So I listened to that,

and of course reflect on that and process it, but I feel like it crosses the line when

you are talking about not being here, like what that would look like instead of a

desire not to be here. So after they say 'my family might miss me' or 'my partner

is going to pay for treating me badly when I'm not here.' Those are specifics

where I'll say, 'okay, have you thought about how you would commit suicide?

Or when you would do it?' And then, of course, if they say yes I just ask for

more specifics, knowing that that's going to push them to do it. It's just my own

assessment of figuring out how serious they are and then if it gets to that point

where they have a specific plan, then we talk about my legal and ethical

responsibilities of reporting and speaking to supervisors and hospitalization and

all of that.

One participant, PA9, a master's student, created her own assessment because she was

not aware of other options available. When asked specifically about other suicide

assessments she may be aware of but does not use, she stated, "Not that I'm aware of but

I'm sure there's other stuff out there 'cause there's stuff about everything out there."

Some participants discussed the scoring and analysis of results of paper and

pen instrument. PA8, a master's level graduate and practitioner, discussed clinical

judgment and the use of instruments, and when survey outcomes are overridden by

clinical judgment:

It's one that we make as a clinician. We fill out all of the little bubbles based on

the answers and things that they tell us. Even if I were to go over the

questionnaire with you and you know, no [you] don't have a plan of how I would kill myself, I'm not suicidal, my religion views suicide as negative, I care about all of my kids, but you have tons of scars on your arms and you've been cutting for years and you have OD-ed ten times, but you're telling me all of these things, I might still put you as high even though everything in the assessment would indicate, no this person has low suicide risk, they really don't need help but you have such a high attempt past that I would put you at high.

Three participants mentioned self-harm in relation to suicide, and as a measure of suicide risk. For PA6, a master's level graduate and practitioner, suicide risk was higher if a client was exhibiting self-injurious behavior:

I knew enough to kind of pay attention to signs and listen and to look for red flags because they're not going to be as black-and-white as a client saying, 'I'm suicidal today' but adding to marks on their bodies, if they don't typically wear coats but now we're same setting but wearing long sleeves and coats and things and kind of digging little deeper and say, 'What's going on?' 'Why are you covering up your arms?' and things of that nature. I would say that it was pretty fair, overall.

Intervention knowledge varied from few to multiple interventions used with suicidal clients across participants. When asked if she used any interventions when working with suicidal clients, PA4, a master's level graduate and practitioner, replied, "Um… [long pause] Not that I can think of." PA9, a master's student, was aware of the presence of interventions, but said this, "I am aware that there are interventions that I don't use. I just can't afford to go and take classes on those right now." Some

participant's spoke of interventions they were aware of, but did not utilize, such as PA6, a master's level graduate and practitioner, "I know the hotlines; I don't really use those. They're on the form that we provide them, but I don't specifically rely on those as something like, hey this is someone you can reach out to or call... No there's no good reason; I just never thought about it to be honest."

Those participants more knowledgeable on assessments spoke of multiple interventions, depending on the severity of the client, such as PA7, a doctorate level graduate and counselor educator:

> Sure, you know it varies depending on what they say all the way from just checking in to make sure that they're safe and they have the supports that they need in place because I think you can be just as harmful providing too much intervention as you can be providing not enough so I think you have to find the right balance between what does my client need and how can I help them be successful in dealing with this ideology and this thought, unspoken thought it.

PA10, a master's level graduate and practitioner, also used varying interventions based on the severity of the client risk:

> Yeah. So if they were acute, like 'I wanna die, I'm gonna go home and do XYZ,' you're not going home. Depending on your age, depending on who your people are, your support people are, depending on what's going on and what I've already, what we've already advocated, you're not going home. I have called the cops to show up at people's house and escort them to the hospital um they haven't always been happy with me for doing that but I don't really care.

When a participant made contradictions, or made claims about working with suicidal clients, their level of competence in their response was unable to be validated. For example, PA4, a master's level graduate and practitioner, described how she determined client suicide risk:

Um, and in my counseling setting which I probably I have - I see more suicidality, it's essentially, mostly in the first session when you're kind of assessing what's going on and there's been a report of past suicides in kind of evolving...is it a threat now? Is it past the tense? Is it just you think about it sometimes?

Preference of Assessment

While almost all participants mentioned specific suicidal assessments in the course of their interviews, all participants in some way rejected the instructed use of formal assessments, either paper-based or verbal. For PA2, a doctoral level graduate and counselor educator who currently teaches a class on crisis intervention and disaster training, had this to say about the use of assessments:

Yes, but I also add my tinge to it... Very often all of these models, in my opinion, are very technical and they do talk about making a connection with the client but I think so often in a crisis or in a situation where someone is suicidal, we can forget about the stuff that makes the connection and we can focus specifically on the technical aspects of getting information.

Most participants mentioned intent/plan/means, (i.e. an informal assessment where a counselor identifies the client's degree of intent to attempt suicide, if the client has a plan to attempt suicide, and if the client has the means to attempt suicide) as a form of verbal

assessment during the course of their interview. Here PA4, a master's level graduate and practitioner, described her use of intent/plan/means as an assessment method:

> Um, just kind of asking questions as far as like, you know, like "how serious is your intent? Do you have a plan? Did you know how you would do that if you could?" And, you know, kind of seeing if they have the means to follow through with that plan, and just kind of assessing it that way.

For PA10, a master's level graduate and practitioner who had previously worked in crisis services, she discussed not using a formal assessment in private practice:

> Ok so I have an assessment in my head so I don't have a form that I use anymore but I run down the list, well just talk to me about what's going on especially if I have them in my office I know they're gonna be safe in there and so we have the conversation and in my first session I always talk about what I will do and how I will do it as far as content in regards to suicide, self-injury and abuse and I always make sure people know I don't play with those and always managing like you don't have to say this to get my attention, you can just talk to me.

In other participant cases, such as PA1, a doctoral student, they rejected the notion of a formal assessment of any kind:

> I don't think that at this point I would use that. Even at my master's training and internships, I don't remember ever having a specific thing in session. I reviewed a textbook and materials provided for class, but I never used a formalized assessment that I recall.

Finally, some participants specifically mentioned the rejection of formal assessments because they feared damaging the therapeutic relationship. While formal

assessment was left vague during the interview by me, most participants conceptualized formal as a pen and paper format. PA3, a doctoral student, noted that while she did not use an assessment of any kind, if she did, she would not use it in the instructed format:

> Yeah, and if I'm not competent in something, I will go ahead and spend the time on my own to learn about it so that I can carry out the assessment orally, and that's the manner that I prefer, in order to keep the therapeutic relationship.

While participants generally rejected the use of formal assessments, at least three participants created their own, non-validated, suicide risk assessments to use in session. Of those that created assessments, two provided them when asked in member checking. All instruments included both quantitative and qualitative measurements, and lacked a formal scoring system, relying instead on clinical judgment. Here, PA9, a current master's student, describes the assessment that she created:

> Because there, I had no exposure to anything, and the place I was doing my GA ship didn't have anything, I actually created a kind of fill-in-the-blank form that encompassed everything my supervisor had told me, the reading I had done to-date, and my personal experience, so that I have a comprehensive evaluative tool in the moment when I may not be able to think of every single thing that I need to know and I used that at first. I don't use it anymore because I feel more confident since I've had so much experience with it so I used that in the beginning.

As PA9 reported, although she created an assessment, at the time of the interview she no longer used it, as she felt her experience in her practicum and her current enrollment in internship was sufficient experience and now assessed informally.

Of the other two participants that created their own assessments, PA7, a

doctoral level graduate and counselor educator, combined instruments that he had read

specific research on, and added his own qualitative measures:

> One of them has a risk level assessment, I can't recall that specific article but it
>
> talks about assigning risk level, high medium low based on behaviors criteria
>
> present with the client and so I took that along with the "IS PATH WARM"
>
> assessment. I don't remember who... I found one I really liked that has specific
>
> behaviors from "IS PATH WARM" that you look for, and I created my own sheet
>
> that does both so it assigns... it goes through "IS PATH WARM," is it present yes
>
> or no and then what's the evidence that you see. Then at the bottom of the sheet I
>
> put a place for you to determine risk level based on the assessment but also
>
> criteria that I have specifically listed here so low risk ideation, is present, no
>
> formal plan, strong desire to live, has social support it has all this criteria based on
>
> these articles and what it's saying we should do as mental health clinicians in our
>
> evaluations. So I do that, I also have a like a quality sheet that you ask and go
>
> through and ask them questions.

Frequency of Assessment

Most participants varied in their response to how often their clients were assessed

for suicide risk. For PA3, a doctoral student, assessment occurred when a client's

behavior changed, or they had intuition:

> I assess, specifically, when I suspect it. If their level of depression seems to
>
> warrant it... If it's a new client and they're very depressed and even if they don't
>
> mention it I will make sure to ask. "Have you ever thought about hurting

yourself?" If it's a client that I already know and they have a change in their

mood or they say that they've had a particularly bad week, things have changed a

lot or their mood is much worse, then I would ask.

For other participants, it varied based on the client's diagnosis. In the case of PA9, a

master's student, she assessed using a 10 point scale, stating:

It depends on what they're visiting me for. Anyone who's visiting me for

depression, at least every two or three sessions. With my actively suicidal clients,

at least every session. And what I mean by assess is I ask them to tell me where

they are on a 1-10 scale.

Some participants did not vary their assessment procedures in session,

whether it be a low, medium, or high frequency. For PA7, a doctoral level graduate and

counselor educator, it was a simple, "I think every client every time. That's my motto.

Every client, every time, always."

Safety Planning

Safety was found to be a factor for all participants when speaking about suicidal

clients. For PA10, a master's level graduate and practitioner, client safety became the

most important priority:

It's always the safety. So people will get mad, or parents can get angry about

something, um, it's for the safety of your kid. So that's how it is. I always bring

everything into safety, and I kind of blame safety for if you get mad at me. Well I

have to be safe, or I have to manage all of these things and it's not a really fun

position for me to be in, and you're not gonna always like it and then I do a

reframe on it too... I think it brings in the severity because people like to blow it

up, 'oh they always say that', well I don't give a rat's ass that they always say it.

We're gonna talk about it every time they say it. We're talking about it because

I'm not playing that game of 'well the one time you blew off your kid was the one

time they meant it' or yourself or whoever.

Every participant in the study reported use of a safety plan in-session, whether it

was a requirement through their place of work, or a clinical decision. For PA6, a master's

level graduate and practitioner, the safety plan became a large part of her intervention

with the client:

> Everything pretty much goes to the psychiatrist and then the outpatient counselor
>
> and then we conjugate copies of that, I guess that's not really using any of them
>
> other than the safety plan in session... We're automatically trained to do a safety
>
> plan and then just kind of have it on file and then later on if the issue presents
>
> itself. If there's any self-harm or suicidal ideation, then you go back to the initial
>
> safety plan and revamp it to make it, if it needs to make it any more intense,
>
> connect it to any additional services, and then really just find out what's going on,
>
> what's causing the thoughts of suicide.

Others used safety contracts as a resource form, as opposed to a commitment to

not attempt suicide, such as PA7, a doctoral level graduate and counselor educator:

> I want to create a plan with them that acknowledges that they have suicidal
>
> thoughts but I want it to be a resource that talks about what they can do so when
>
> they leave I don't want to be I don't want to foster dependence. I want them to use
>
> their resources to overcome their issues so I put myself out of a job so I have that
>
> but really back in the day we used to create that I blank and you write in the

client's name, promise not to kill myself for one week until I see blank again and then the client would sign it and I would sign it and I think that's horrible.

Minimizing Risk/Wrong or No Intervention

Minimizing client suicide risk was identified through two participants that discussed the possibility of clients using suicidal behaviors as a form of attention seeking, not seeing immediate risk. For example, PA8, a master's level graduate and practitioner, discussed clients with intellectual developmental disabilities, "Sometimes we even get people with developmental disabilities, it's a behavioral thing and they live in group homes or people who know how to play the system of 'oh I'm suicidal I want to go to the hospital because I like the hospital and I like the attention.'" PA8 also discussed suspicion of actual client risk in the following account with a male client:

> Just the other day I had a guy, we work in a 24 hour facility so I might not be the one who does the assessment but I'll read it and get shift report from the previous shift. His assessment said 'client denied SI/HI however said if he goes through withdrawal he will be suicidal' and so then, when I went to do an updated mental status exam with him you know and talk to him I told him you know, you do not get the detox set for the day. I'm on to somebody else so we need to figure out a plan B and then he immediately started endorsing suicide and he said, 'well I've been suicidal this whole time,' and it's like mm, I don't really believe you. Or I get the borderline personality disorder person, 'I'm gonna kill myself. Aren't you just gonna feel so terrible if I kill myself?' It's like you've been here a hundred times, you haven't killed yourself yet, therefore I don't really think you're all that suicidal.

PA4, a master's level graduate and practitioner, described assessing and determining there is no risk, "Generally it's – it's…what I have most experience with is when it's like 'well yeah, sometimes I think it would be easier if I wasn't around.' But they have no actual intent or, um, kind of means to follow through with it."

Therapeutic Relationship

The therapeutic relationship was identified as a factor for all participants when working with clients with a suicide risk. When PA10, a master's level graduate and practitioner, worked with a client who was actively suicidal, they reported reacting in the following way:

> I do a lot of calming stuff I use mindfulness we do a lot of people are impulsive and are really overwhelmed so it's a lot of just de-stressing and calming down reframing refocusing just coming back into the right here right now and how we're gonna cope with it kind of bringing them back in back to reality. I do a lot of that probably more so than anything I'm like ok everything's spinning really fast let's bring it on down. And again much easier in private practice than crisis because I know the people better… Um [pause] so it can be really really rewarding and really really exhausting all in the same day. I think it takes, um, it takes, I guess, I work pretty empathically, I guess, you're putting yourself into this really sitting in for somebody.

While PA10 used her developed relationship with established clients to deescalate, participants such as PA8, a master's level graduate and practitioner, used what they identified as empathic listening to deescalate imminent risk situations:

We're triage center so we don't really do treatment per se, we try to deescalate the

situation, stabilize it and if we cannot, that's when we refer out to a higher level of

care. So we'll do a lot of empathetic listening like, oh I'm really sorry that your

mom died, and your kids got taken away this must be really hard, or you know,

some counseling things it's like well what can you do to make this situation

better, have you tried a hobby, have you tried deep breathing, are you in long term

counseling, so we do some of those things but nothing too majorly intense and it's

for various numbers of reasons (a) we don't have the time (b) if we have several

people on the unit, and (c) sometimes people reject our services even though

they're there or they want help or if they're on involuntary hold they for many

reasons reject our services.

Referring, transferring, calling crisis services, or moving clients to inpatient

facilities was a component of treatment that participants discussed. Participants spoke of

relief when a client was transferred to another clinician or service and the risk was

removed from them. For PA4, this occurred when a crisis client presented themselves at

her office:

Um, let's see. I mean, a few weeks ago we had a client come in and she told her

mom that she just didn't want to be on the Earth anymore. And, you know, she

just didn't feel like it – like living was worth it, or she's just like "I don't feel like

going anywhere." So they brought her in and she wasn't anybody's client, they

just wanted to do a walk-in situation. And so, you know, when you hear it from

the person at the window, the admin person, they're like "oh, someone just said

that they don't want to live anymore, we need to do a crisis session." It's like,

very stressful immediately. Um... After, you know, talking with both the mom
and the child and making sure that, you know, mom was able to – even though the
child reiterated that she wouldn't actually kill herself – that mom could assure me
that she could keep a close eye on her throughout at least that night. And, um, she
said... just reiterated that she didn't actually want to kill herself and I think, you
know, we set up, you know, "if you're feeling this way, we can definitely set you
up with a counselor. You can have someone to talk to, um, kind of on a weekly
basis so you don't get to this point hopefully." And so we kind of signed her –
were able to sign her up for services and get her assigned to a counselor at the end
of that session.

Other participants spoke about the transfer of responsibility in vague way, relating
more to transfer of obligation, such as PA1, a doctoral student:

I feel like it's very sad. I feel sad when I think about suicide but I also have a
feeling of competence for helping people that are thinking about suicide. And
then there's another part of me that's resigned to the fact that I know, as a
counselor, I can't help all people and prevent all suicide, so that's where it's kind
of letting go of that desire to help everyone and prevent everything. It's just not
possible. It maybe sounds kind of cold but...

Training Recommendations

The final structural theme of training recommendations included three textural
themes: *formal assessment and intervention, multicultural training,* and *legal/ethical
training.* The overwhelming recommendation from participants for increased training
competency was that master's programs include a course specifically relating to suicide

prevention and assessment. For PA10, a master's level graduate and practitioner,

addressing unclear areas in suicide prevention and assessment was critical:

> So minimum, have a full course on it. Uh, in regards to the really easy ones, cool,
>
> go through those, but all the grey area one's, procedures resources available not
>
> everybody knows it's available to them, something that really looked at all of that,
>
> and that could coincide with views minimum like 3 months on a crisis unit.
>
> That'd be awesome.

For PA1, a doctoral student, a course that focused on decreasing anxiety was

recommended:

> I don't know. For me, I know like I said earlier, a lot of my colleagues, student
>
> colleagues, were totally freaked out about suicide and having clients that were
>
> suicidal, so maybe a little bit of relationship focusing and anxiety prevention as a
>
> counselor? Maybe that will be helpful. I don't know.

Formal Assessment and Intervention

Overwhelmingly, participants' recommended more formal assessment and

intervention training. PA1, a doctoral student, who did not feel that assessments would be

helpful when the interview began, changed her outlook on the subject by the last

interview question:

> Maybe having a checklist... Maybe I was presented with them and I didn't take
>
> them because I felt I understood the content of what a checklist would be. But, I
>
> would say actually, that knowing in the area – knowing the contact, the hotline
>
> number, or the contact of the security office to the campus or knowing the contact

at the hospital – that way if my supervisor was not in the office and no one was there, I would know exactly what to do on my own.

PA3, a doctoral student, stated that, "I think it would have been helpful for me to have something more formal..." and PA4, a master's level graduate and practitioner, recommended more training on specific assessments available:

Um, probably to get more training on the specific assessments. Like we talked about earlier, I can't even remember the names of them. Um, and so being able to get some more info on those instead of just kind of rushing over it and... There was one chapter, like "oh, you can use these if you want." Um, so getting some more specific training on how to use them and how to implement them I would think would be more beneficial.

PA6, a master's level graduate and practitioner, recommended a greater focus on the subject integrated throughout master's programs:

[pause] I think a greater focus on it within the program or within the classes. It was definitely touched on here and there as we're going along in theories and the other class where we do the practice clients I can't think of it right now but kind of just that goes across the board with everything. Just more of everything!

PA8, a master's level graduate and practitioner, also recommended integration throughout multiple courses, but also expressed surprise over the lack of training guidelines on the subject:

Um, I probably would make [suicide prevention and assessment] built in more things throughout the educational process or make it a mandated class. I know it seems like there are so many things that are mandated, especially when you're

going through your program you're like, 'oh my god is it ever going to end?', but I mean suicide is a big factor, especially depending on what population you're going to work with.

Multicultural Training

A few participants recommended more training in multicultural issues in the suicide prevention and assessment. Specifically, PA5, a doctoral student, recounted a client story that illuminated this need for her own training:

You know, I've called the Crisis Line and had them not come, because they wouldn't guarantee not to call the police, and I wasn't willing to have the police bust in my office. There's a lot of really pragmatic shit that they don't talk to you about in school. You know? No one talked to me about the complexity of having an oppressed client, who is fearful of the police. No one talked to me about that. I had to deal with that on my own and figure out.... That's bullshit, at the end of the day. Like an Instructor makes that sound so easy. But like when you're in the situation -- You know, you might have clients that have experienced racism in the world; who have experienced police brutality; who have experienced marginalization in other ways. Where if they're trans-identified, they're afraid of getting arrested, because they don't know how they'll be treated as a trans[gender] person. There's a lot to think about.

Legal/Ethical Training

One final recommendation identified by some participants was surrounding the legal and ethical issues of clients who present with suicide risk. PA4, a master's level

graduate and practitioner, wondered why her agency had policies on multiple subjects, but not in this area:

> For as far as a professional I'm not sure because I've only ever worked at this one agency, but um, we're like a state funded agency so we have a lot of state paperwork and a lot of state procedures, but it seems like that's the one area where we don't have like a set procedure or a set document that we have to fill-out.

Another legal and ethical issue that a participant encountered and recommended training on was in legal knowledge of working with suicidal clients and documentation. PA8, a master's level graduate and practitioner, recommended more personalized training as a legal/ethical issue when working with certain populations:

> Um I probably would make it built in more things throughout the educational process or make it a mandated class. I know it seems like there are so many things that are mandated, especially when you're going through your program you're like, oh my god is it ever going to end, but I mean suicide is a big factor especially depending on what population you're going to work with. If you want to work with kids you may have suicidal teenagers. If you're gonna work with veterans specifically you might very well have suicidal veterans so I think it should be built-in more and maybe be made a requirement.

Conclusion

This chapter described the results of the study, which resulted in four structural themes, and 15 textural themes. The four structural themes of *training preparedness, components of preparedness, assessment and intervention knowledge,* and

training recommendations were discussed, along with the accompanying textural themes. These structural themes were present with participants across all levels of training and experience.

Research question one, "What are counselor perceptions of the suicide prevention and assessment training provided in their program?" is addressed by the structural theme of *training preparedness*. Participants' experience with training was experienced through degree of integration of suicide prevention and assessment training, degree of adequacy of training from inadequate to specificity, and the source of integration through specific courses in the participants' master's training.

Research question two, "To what degree do counselors feel prepared to work with suicidal clients?" is addressed through structural themes *components of preparedness* and *assessment and intervention knowledge*. In *components of preparedness*, ethical considerations of training outside of the curriculum through multiple methods of learning were presented, along with the sense of responsibility participants perceived towards their clients, and understanding documentation. Counselor disposition, the degree in which intuition, fear/anxiety, and personal experience affected suicide prevention and assessment. Also, the level of external support as a component of preparedness utilized when working with suicidal clients. In *assessment and intervention knowledge*, preference of assessment, frequency of assessment of risk, safety planning, minimizing risk/wrong or no intervention, and the importance of the therapeutic relationship was presented.

Finally, research question three, "What are counselor recommendations for effective suicide prevention and assessment training?" was addressed through the

structural theme of *training recommendations*. Through this theme, recommendations in

formal training in assessment and intervention, multicultural training recommendations,

and legal/ethical training recommendations were made.

CHAPTER FIVE

DISCUSSION

In this chapter, I discuss how the in the context of the current literature, implications for counseling practice and preparation, limitations of the study, and future research directions.

Counselor Preparedness in Suicide Prevention and Assessment Training

The purpose of this study was to understand the essence of counselors' perceived degree of preparedness working with suicidal clients, and to provide both clinical and training recommendations in this subject area. Findings highlighted participant insight on training perceptions, components of preparedness, assessment and intervention knowledge, and training recommendations. Results indicate four structural themes and 15 textural themes.

Participants overall believed that their master's program generally did not adequately prepare them to work with suicidal clients. Participants recalling training or experience with suicidal clients most often referred to their practicum or internship experience as the main source of integration in their master's program. This is consistent with previous research that found training prior to practicum and internship to be limited to crisis intervention, and training in programs in general to be extremely varied and typically minimal in depth and breadth (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012). Wachter Morris and Barrio Minton (2012) found that counselor trainees were typically engaged in crisis intervention field experience while at their practicum and internship sites. Training in master's programs was seen as inconsistent, with 45.07% of counselor trainees identifying their suicidal assessment

training as *good* (Wachter Morris & Barrio Minton, 2012). In contrast, participants in this study overwhelmingly saw their master's training as inadequate. Further, all but two participants found their pre-master's training to be minimal and more directional than master's training, and did not have a direct effect on how they currently treated suicidal clients.

If doctoral level training was present for participants, the degree to which it was integrated and the degree of adequacy was mixed. This is consistent with clinical psychology literature. In their review of clinical psychology programs, Bongar and Hartmatz (1989) found that only 35% of programs had formal training that specifically included suicide in the doctoral level programs surveyed, and the content varied in formality and level of training. This was similar to participants in this study, who either had an extremely positive or apathetic view of their doctoral level training.

The most common form of post-master's training outside the curriculum was on-the-job, training that was required by the agency, hospital, or other company. A situation where the participant was, or had been, employed with, with some participants specifically seeking continuing education opportunities. Participants who actively sought out continued education reported workshops as their most common form of training.

Professional support through a myriad of resources was seen as an important element of preparedness. Participants felt more prepared when they utilized professional support resources, such as supervision, consultation, or peer support groups. Participants conceptualized preparedness as continuous, with education and experience as a determination of counselor preparedness. To participants, preparedness was constantly in motion, and without continued education and experience, a counselor may lose skills that

you may have previously developed. Some participants found that the act of working with suicidal clients increased their preparedness and competence, regardless of the approach to working with a suicidal client.

For participants, their own counseling intuition was referenced as a form of clinical judgment when working with suicidal clients. This intuition was described as a gut feeling, or something that was unspoken that provided the counselor with a clinical decision that they did not have before the intuition. This has not been present in previous literature relating to working with suicidal clients. Counselor fear was also a component seen by participants. In some cases, having fear and anxiety as the clinician was seen as positive; an indication that the counselor is taking the risk seriously. The grey area of working with suicidal clients was discussed as a component of conceptualizing risk, with participants speaking to the unclear nature of assessment.

Feelings toward suicide/suicidal clients were varied by participant and had many components. Anxiety, which is consistent with previous research (Bongar & Harmatz, 1989; Wachter Morris & Barrio Minton, 2012), was brought up repeatedly when discussing suicide, working with suicidal clients, or the thought of working with suicidal clients in the future. Participants also described the inevitability of working with a client who presents with suicide risk and the desire to feel more prepared to effectively work with them. The importance of the therapeutic relationship in working with a client who was suicidal was discussed as a positive tool towards the lowering of suicidal behaviors, risk, and ideation. Participants also reported a loss of empowerment of the client when rights are taken away in a high risk situation, and the role and duty of the counselor to be cognizant of this when working in the crisis situation.

Participants felt an overall responsibility to protect clients through education and experience. That duty translated for participants seeking self-driven study due to what they perceived to be insufficient training in the area of suicide prevention and assessment, consistent with previous research that examined preparedness (Reeves et al., 2004). Having a detailed understanding of how and when to document work with suicidal clients was identified as an element of preparedness as a counselor working with suicidal clients. Documentation was mainly discussed as protecting the counselor from future liability, and also by participants who spoke of a general lack of understanding of documentation when there is immediate risk to the client.

Minimization of risk occurred in some interviews with participants, something not discussed in previous research. Of those interviewed, participants who saw suicidal ideation as potential attention seeking behavior tended to have a more negative view of clients during their interview. Concern for overuse or manipulation of the system arose, and therefore the participants may have be minimizing risk of clients who are presenting with suicidal ideation or risk, and not treating effectively. This minimization of client risk could lead counselors to use the wrong intervention or no intervention at all with clients presenting with suicide risk.

Participants overwhelmingly reported a personal connection to suicide, either through reporting previously having suicidal ideation, or knowing someone who had either attempted or completed suicide. Most participants reported this experience as furthering their desire to work effectively with suicidal clients, and in the ability to work empathically.

Pisani et al. (2011) identified 12 evidenced based suicide risk and assessment

prevention training workshops, finding that all provided adequate training to their respective target populations in assessment and intervention. Crisis intervention models also identified outlined suggested protocols when working with a client in a crisis situation (Miller, 2012; Ruzek, 2007). Participants of this study were generally limited in knowledge of formal assessments, and often conceptualized assessment as pen and paper style only. Further, of those who were familiar with formal assessments, all stated that they changed, added, or created their own assessment tool to use when assessing suicide risk. Those who were not familiar with any formal assessments rejected the use of a formal assessment as potentially damaging to the therapeutic relationship.

While previous research has suggested that suicide risk be assessed through trained verbal, non-verbal, and pen and paper methods (Pisani et al., 2011), it was unique that participants, even those who spoke positively about assessments, did not use any formal assessment strategies. In some cases, the creation of the participant's own suicide assessment instrument came from lack of knowledge of other options available. None of the participants who created their own instrument reported any attempts at validation of their instruments, and some even reported not using the instrument they created, because they felt as though it was not necessary any longer. Participants reported assessing based on the intent/plan/means method, either outright stating it or less formally describing it in speech, without knowledge on efficacy of assessing with this outline. As mentioned in chapter three, this assessment method lacks additional risk factors of suicide that may contribute greatly to determining level of risk.

Participants also reported self-harm as a risk factor for suicide, which has typically been identified as not a risk factor for suicide (Lohmann, 2012). However,

Cooper et al. (2005) found in a cohort study that those who self-harm were 60 times more likely to be at risk for suicide and suggested early suicide prevention intervention after a self-harm episode. In spite of this high risk, Fox and Hawton (2004) urged clinicians to be hesitant in correlating the two distinct subjects.

Participants' knowledge of intervention strategies was greater than they were generally aware of. Of those participants who had more knowledge on interventions, they applied based on severity of risk of the client. Some participants reported an apprehension towards intervening too much or not enough, and spoke of a balance of reducing symptoms of risk with the least restrictive intervention. While some participants were not able to name an intervention when directly asked, all mentioned at least one intervention strategy during the interview. All participants reported use of a safety plan with clients who were deemed a suicide risk. While some participants reported hesitancy in use of one as the sole intervention, others used it because of agency protocol. Other participants found safety plans to be a large part of their intervention strategy. Safety contracts have limited efficacy, and has been demonstrated to be potentially harmful if it is the sole intervention strategy (Edwards & Harries, 2007; Miller, Jacobs, & Gutheil, 1998).

Participants reported safety as the top priority when working with suicidal clients. One way that participants felt more at ease with their intervention strategies was when they had the opportunity to transfer responsibility. This transfer could occur through client referral to a different clinician, calling crisis services, or putting the client in an inpatient setting. Some participants felt more comfortable when the obligation to treat was removed, and the client was no longer under their sole responsibility.

As described in chapter three, Neimeyer (2000) proposed that training goals for counseling psychologists include target domains of personal development and skills development, and encouraged a well-rounded training agenda. His domain areas are somewhat consistent with participants in this study who spoke of anxiety and fear related to working with suicidal clients, and recommendations for more formal learning during their master's program. Further, while only one participant in this study had a client who had completed suicide, this participant specifically spoke to feelings of isolation and lack of closure as a clinician. Neimeyer (2000) recommendations for postvention training for working through the grief and loss of losing a client would appear to be relevant to a potential training agenda for master's students. An area that Neimeyer (2000) fails to cover is that of cultural competence in the area of suicide prevention and assessment, which was an educational recommendation of multiple participants.

Participants most often recommended more formal training in suicide prevention and assessment. Specific suggestions included more integration throughout classes, and a course on suicide prevention and assessment. The biggest recommendation made by participants was for a class to be included in the master's training curriculum that addressed a myriad of topics related to suicide prevention and assessment, including formal assessment and intervention training, multicultural recommendations, and legal and ethical issues. Participants recommended a more structured training that included multiple training components. This echoes recommendations in other research (see Bongar & Harmatz, 1989; Neimeyer, 2000; Pisani et al. 2011), and is inconsistent with crisis intervention training (see Wachter Morris & Barrio Minton, 2012), which typically included suicide under the umbrella with other topics such as disaster and trauma. Post-

masters, participants recommended more agency protocols relating to working with suicidal clients, as it was their desire to follow a protocol that their agency designated.

Implications for Counseling Practice and Preparation

The results of this study indicate a greater need for more immersive training in suicide prevention and assessment. Whether participants currently felt prepared to work with suicidal clients, there was a desire to increase their master's level training in the area. Echoing research by Bongar and Harmatz (1989), this study indicates that training to work with suicidal clients should begin early in a master's student's training and be integrated throughout courses. Specifically, a course that presents training based in a theoretical training program that uses multiple types of training methods, including role-plays, discussion, case studies, lecture, and other experiential activities. Further, there is a greater need for multicultural issues to be integrated throughout training. Formal training in a specific assessment model or workshop would benefit future training programs.

Counseling practice could benefit from more insight into current agency protocols relating to suicide prevention and assessment. Generally, participants desired more in-depth training, and there did not seem to be consistent training across work settings. Counselors should not only be seeking out additional trainings that are evidenced based, but should also be advocating to their agencies to provide consistent, recurring training.

Limitations of Study

Sampling for this study was limited to solicitation of participants through online communication methods. It is possible that those who replied to the call for participants felt more comfortable with the topic of suicide and suicidal clients, which could have an

effect on the overall essence of participant experience. Although I used member checking to increase rigor, I received few responses that answered questions posed, or indication that they had read over their transcript. Since interaction with participants was limited to one interview and member checking, I may have missed gathering additional data that could have helped shape the coding process. The research team of this study lacked diversity, and that could have an impact our data analysis process.

Although participants were sampled based on gender, race/ethnicity, and geographic region represented in the CACREP vital statistics (2013), I was not able to sample every race/ethnicity group represented. Further, the data provided by the CACREP vital statistics (2013) only included students and faculty that graduated from or currently work in a CACREP program. Since I was sampling counselors whether they had graduated from a CACREP program, this limits my sampling strategy. Further, age, years of experience, educational status, and role of the counselor were recorded but not used as sampling criteria.

Future Research Directions

Since counselor preparedness working with suicidal clients has had limited research, there are many possible avenues for future research directions. Degree of integration in master's programs and its interaction with counselor disposition and increased specificity would be valuable. Future research should focus on further exploration of counselor suicide prevention and assessment preparation in the master's setting. I would like to research and develop a training model for CACREP master's programs, possibly through a grounded theory tradition. The gap in counselor preparedness also includes post-master's training. Further research in post-master's

training should involve agency policy, training protocol, and continuing education including multicultural and legal/ethical training. Development of an instrument that measures current counselor competency and knowledge in suicide prevention and assessment would be an important, better understanding the current state of counselor competency. Multicultural training was seen as a weak spot by participants in their knowledge of suicide risk. Assessing cultural competence in relation to suicide prevention and assessment could be an important next step in assessing current state of counselor preparation.

Further, assessment and intervention and components of preparedness have future research implications. Specifically, counselor assessment and intervention strategies that warrant future research could be investigating the connection between minimizing risk/wrong or no intervention and the level of safety planning used with a client and frequency of assessment. Finally, degree of adequacy of training and preference for assessments could lead to a better understanding of if increased specificity leads to more consistent assessment use.

CHAPTER SIX

MANUSCRIPT

A Phenomenological Investigation of Counselors' Perceived Degree of

Preparedness When Working With Suicidal Clients

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To Be Submitted to

Counselor Education and Supervision

Abstract

This phenomenology aimed to understand 10 counselors and counselor trainees'

perceived degree of preparedness and recommendations for working with suicidal clients.

We identified a structural-textural descripton that highlights the perceived amount,

quality, and components of training preparedness, suicide assessment and intervention

knowledge, and recommendations for suicide prevention and assessment.

Keywords: suicide prevention, suicide assessment, counselor preparedness, counselor

training

A Phenomenological Investigation of Counselors' Perceived Degree of

Preparedness When Working With Suicidal Clients

According to the National Institute of Mental Health (NIMH, 2007), suicide is the

tenth leading cause of death in the United States, with an overall suicide rate of 11.3 per

100,000 deaths. For every documented suicide in the United States, there are an estimated

11 suicide attempts. Further, those who attempt or complete suicide often have exhibited

some form of help-seeking behaviors at one time (Barnes, Ikeda, & Kresnow, 2011;

Meyer, Teylan, & Schwartz, 2014).

Given the prevalence of completed and attempted suicides as well as the

potential expression of suicidality within mental disorders, it is inevitable to that

counselors will encounter suicidality in their work. The Council for Accreditation of

Counseling and Related Education Programs Standards (CACREP, 2009) emphasizes

training standards in suicide assessment and management across several specialty areas.

Unfortunately, suicide prevention training tends to be encased within general crisis

intervention training (Wachter Morris & Barrio Minton, 2012), and does not occur or is

inconsistently delivered within counselor education programs (Bongar & Harmatz, 1989;

House, 2003; Wachter Morris & Barrio Minton, 2012).

Although the literature indicates that counselors are more likely to encounter

suicide prevention and assessment training once they have entered into the workforce, it

is not clear as to the formality of these trainings and if they are effective in preparing

counselors (Bongar & Harmatz, 1989; House, 2003; Neimeyer, 2000; Wachter Morris &

Barrio Minton, 2012; Reeves, et al., 2004; Ruddell & Curwen, 2002).

Available literature includes surveying trainees on the perceived infusion of specific suicide prevention competencies (e.g., behavioral and situational risk factors, cultural differences in suicide attempts) within their training program (CITE) as well as post-training gains in suicide prevention and crisis intervention competence (CITE). Although these studies outline traning gaps in counselor education curricula with some competency gains from structured programs external to counselor education programs, there is no research on perceived counselor preparedness for those who have worked specifically with suicidal clients.

The purpose of this phenomenological study is to understand the essence of counselors' perceived preparedness working with suicidal clients, and to provide suicide prevention and assessment recommendations for counselor education programs and clinicians. The following research questions were addressed in this study: (1) To what degree do counselors feel prepared for working with suicidal clients?; (2) What are counselors' perceptions of the suicide prevention and assessment training provided in their program?; and (3) What are counselors' recommendations for effective suicide prevention and assessment training?

Method

Participants and Procedures

Using the CACREP vital statistics (2013) as a guide, the primary researcher (first author) recruited 10 participants using maximum variation and criterion sampling methods to obtain diversity in terms of cultural identity, geography, and counselor experience type.

Of the 10 participants (8 females, 2 males), 7 identified White, 1 Hispanic/Latino, 1 African-American/Black, and 1 multiracial; ages ranged from 24 to 56 years-old ($M = 34$). Further, particiants represented the following Association of Counselor Education and Supervision regions: North Atlantic ($n = 2$), North Central ($n = 2$), Rocky Mountain ($n = 1$), Southern ($n = 4$), and Western ($n = 1$). Participants listed their highest degree completed as bachelors ($n =1$), master's ($n = 7$), and doctorate ($n = 2$), with four currently enrolled in a doctoral program, and one currently enrolled in a master's program. Current work settings of participants included three in community mental health, three in private practice, and five in a university/college setting.

Research Team and Researcher Bias

The research team included two researchers, both White women who were doctoral students at the time of the study. The primary researcher conducted and transcribed all interviews, and the research team member was used for consensus coding An auditor, a biracial female with a doctorate who worked in the community mental health setting, reviewed the audit trail and manuscript at the study's conclusion. Prior to beginning the study, the research team met to bracket their biases and assumptions related to the research topic. The primary researcher believed that more direct suicide prevention training (as opposed to crisis intervention as a whole) would be beneficial for master's students and current counselors. The research team member held the belief that while her formal suicide prevention and assessment training was minimal, she believed that her training had been adequate.

Data Collection Methods

Demographic sheet. Participants completed a demographic sheet that assessed participants' cultural demographics (e.g. age, race/ethnicity, gender, relationship status, sexual orientation), geographical location, and counseling work characteristics (e.g. counseling setting, highest degree completed, number of clients seen per week).

Individual interviews. Following suggested phenomenological data collection methods, the primary researcher conducted a semi-structured individual interview with each participant (Hays & Wood, 2011). Interviews were 30-68 minutes in duration and included approximately 13 questions as well as several probing questions to elicit thick description and initial member checking. Sample questions were as follows: The research team developed the protocol based on the American Association of Suicidology and Suicide Prevention Resource Center Task Force's eight core domains of practice and 24 competencies (Suicide Prevention Resource Center, 2006).

Strategies for Trustworthiness

Multiple strategies were used to meet several criteria of trustworthiness (i.e., credibility, transferability, confirmability, authenticity, coherence, sampling adequacy, ethical validation, and substantive validation; Hays & Singh, 2012, Lincoln & Guba, 1985). Specifically, the research team employed the following strategies: (a) audit trail; (b) triangulation of data sources, investigators, and theoretical perspectives, (c) member checking through follow-up questions and review of transcript following the interview; (d) reflexive journaling after each interview; (e) simultaneous data collection/analysis; and (f) thick description.

Findings

Training Preparedness

Participants each gave an overview of their suicide prevention and assessment training in terms of degree of preparedness, ranging reportedly from very inadequate to specificity. Each textural theme was independent of each other in describing the essence of counselor training: *degree of integration, degree of adequacy,* and *source of integration.*

Degree of Integration

Of the 10 participants, three did not remember any formal training in suicide prevention and assessment in their master's program. Degree of integration was the degree of preparation in suicide prevention and assessment from inadequacy to specificity. A current master's student in her internship at the time of interview, PA9, stated that her formal training was "pretty minimal," and PA6, a master's graduate and practitioner, stated, "I wouldn't say [suicide prevention and assessment training] was in the program, [that there] was ever a specific time where we constantly focused on suicide prevention."

PA8, a master's graduate and practitioner, recalled an elective course/workshop that was not a requirement for graduation, "Honestly I didn't really get any. There was an elective and if I remember correctly it was like a one day workshop elective, not even an entire semester."

PA4, a current doctoral student, found her master's level training as adequate:

Yes. Especially, like, the training that…before you start seeing clients, clinically in the Master's program. Um, they kind of really go over that and, as far as, like,

the steps to take when your first client is suicidal, I think that's really beneficial that you have some kind of knowledge. You know every situation is going to be different, but you at least have some kind of set things that you can fall back on. I think it makes you feel more confident and less terrified.

Five participants were either currently enrolled in a doctoral program or had previously graduated from one. This level of training for participants was found to be both focused and inconsistent for participants. When doctoral program training included suicide prevention and assessment as an educational component, it was focused on one specific theory or training. PA5, a doctoral student, found her training in her doctoral program to be more focused and detailed than previous training, "We got really specific training in how to do assessments, interviewing and intervention with suicidal clients through that theory, through my practicum courses" and found it a comfort when working with suicidal clients:

> I really perceive it -- particularly from my doctoral program -- in a really positive way. I mean… I think that there was just less fear once I learned more specific interventions for dealing with suicide, not just assessing the risk, but actually learning how to decrease risk. So I think my competency or my self-efficacy totally went up in my doctoral training in the last few years.

Participant one, a current doctoral student, described her doctoral level training as "how to teach it and talk about it with students and supervisees rather than me working with clients" and did not recall specifics to the training.

Degree of Adequacy

While actual educational experiences varied in each participant, overall most of the emotional reactions relating to suicide prevention and assessment training were negative. Degree of adequacy was the satisfaction with training in suicide prevention and assessment. Most participants found their suicide prevention and assessment training to be inadequate, with PA7, a doctoral level graduate and counselor educator, stating, "Master's degree was cursory. I would say it was very basic, not adequate, that's probably the best word I can use to describe that..." and PA2, a doctoral level graduate and counselor educator, stating, "I think with all due respect to my faculty and program, it was minimal." Most participants stated some level of inadequacy when discussing their master's level training in this area. For PA5, a doctoral student, her master's program made her feel more fear than competence, "I think [master's training] was poor and I do think that most master's program training on suicide is poor...You know, until CACREP put in the requirements for a specific course on suicide and crisis, I think it was pretty random how much you got. You know? I think mine was definitely not enough for those intervening 9 years that I worked, before I even learned about Joiner. Yeah. It's sort of a little bit too fear-based sometimes, you know, too liability focused. You know? It's a lot about risk, and not enough on client care.

Those participants that recalled pre-master's training spoke of it as cursory and sporadic. When PA4, a doctoral student, recalled training in a job previous to entering her master's program, she described it as more directional, saying, "It was more like who to call and not as much like, 'here's what you do.' It was just kind of like, 'here's who you need to call.' And there was not really much other than that."

For some participants, they gave more vague accounts on pre-master's training in suicide prevention and assessment, such as PA1, a doctoral student who stated, "I took a counseling theories course in undergrad, and I feel like maybe one class was devoted to legal and ethical issues and might have discussed that, say, maybe a couple hours in undergrad."

Source of Integration

When suicide prevention and assessment training was mentioned, the location, breadth and depth of training was varied. While PA1, a doctoral student, remembered integration in her training, reporting that "There wasn't like a specific class but there were sections within each class in my Masters training before practicum and then during practicum and internship we spoke about it," other participants could not recall a specific time when suicide was a focus of any part of their training. PA6, a master's graduate and practitioner, stated, "I wouldn't say it was in the program it was ever a specific time where we constantly focused on suicide prevention." One participant, PA4, a master's graduate and practitioner, reported having a class in crisis intervention, "In my master's program, we had a crisis intervention class, and a lot of that covered suicide prevention." When asked, other classes that were mentioned as areas where training occurred, formally or informally, most other responses were mental health orientation and introduction to theories.

Practicum and internship was mentioned by four of the participants as one area where they received training, but it was varied on the conceptualization of the training. PA5, a doctoral student, described her training in practicum, "I did learn about how to handle suicide, to some degree, in my practicum, when I was in my Master's class -- in

my Master's program. So there was definitely some direct instruction on duty to warn, risk factors, how to communicate to a client who's feeling suicidal."

Of the participants that had graduated from or were currently enrolled in a doctoral program, three of the five specifically mentioned training in their doctoral program. PA1, a doctoral student, was unsure of details relating to training, but stated that any training received was more related as a supervisor and educator:

> I would say the most frequently talked about in suicide prevention and assessment
>
> would be in the supervision course so as a counselor and educator... my
>
> personalized plan was more teaching and supervision, so it was more how to teach
>
> it and talk about it with students and supervisees rather than me working with
>
> clients.

Overall, participants reported any training received in suicide prevention and assessment during doctoral program training was viewed as a positive experience.

Components of Preparedness

Participants each described the components of their preparedness in working with suicidal clients. The following textural themes describe counselor components of preparedness: *ethical considerations, counselor dispositions,* and *external support.*

Ethical Considerations

Most participants described ethical considerations in suicide prevention and assessment training. The following subthemes describe the textural theme of ethical considerations: *training outside the curriculum, documentation,* and *sense of responsibility/do no harm.*

Training outside the curriculum. Most training was conceptualized as required on-the-job training by the majority of participants. Training was conceptualized as an orientation at the beginning of a job, a yearly refresher training, or random trainings offered while employed. PA8, a master's level graduate and practitioner, who worked at an inpatient facility at the time of the interview, stated that orientation and her job providing training opportunities, "Um, I mean I had to do an orientation phase and a 90-day three month probation period, and we do use various suicide risk assessment tools and we cover it a lot at my job so I feel like I've gotten a lot in the time that I've been working there."

While those mentioned above had specific, in-depth training, others had cursory yearly trainings, such as PA4, a master's level graduate and practitioner, "Um, at my job currently, we're required every contract year to take 3 hours of crisis training, which generally involves a section on suicide and suicide prevention." Of those who had post-masters experience, some actively sought out training outside of on-the-job requirements, such as PA7:

> I try to catch [suicide prevention and assessment expert] whenever I'm at the
> ACA workshops. They've been great resources, um, and then some of the folks
> locally some of the smaller workshops like the one sponsored through the state
> those kind of CE workshop things I've done quite a few of those as well.

Most of the participants described continuous education as a component of training outside the curriculum. It was important to these participants that not only did they feel prepared to work with suicidal clients, but that they continued to receive some sort of training or experience. The majority of participants at one time during their

interview discussed self-driven study as a necessity for their competence that led to increasing preparedness. In a few cases, self-driven study was the only form of education that the participant received in the area of suicide prevention as assessment. Half of the participants interviewed mentioned self-study as a form of increasing preparedness, with PA7, a doctoral level graduate and counselor educator, speaking of his training in suicide prevention and assessment, "Combined I think it's pretty good. A lot of it is self-driven; not anything that was required of me."

Documentation. Some participants found documentation an important aspect of preparedness. For PA7, a doctoral level graduate and counselor educator, through the perspective of a current supervisor at the time of the interview, it was important for him to have his supervisee's document assessment of suicide risk at every session:

> To me it better be in your notes that you did that assessment every client every time or we're going to have problem... There's not a lot, I'm pretty hard and fast, I'm pretty open to different perspectives and ideas but not when it comes to suicide assessment. I'm very specific. I want to know in every note and I want to see that you did an assessment whether there's ideation present or not, I want to see that. What did you not see and you better document that...

Sense of responsibility/Do no harm. Responsibility was identified with most participants. Mainly, participants felt a responsibility or duty to protect their clients and be educated in the area of suicide prevention and assessment. PA9, a current master's study, "It's scary, that's a scary place to be... you feel responsible and I want to really help and I feel very committed to doing whatever I can to help that person out." When

speaking of the duty a counselor has when working with suicidal clients, PA5, a doctoral student, stated:

> I don't think it's black and white. I think a lot of therapists and teachers say a lot
>
> of inappropriate things about what is 'ethnical' and what is 'unethical and
>
> ethical.' I think that those are not - you know, those are not really good things to
>
> be talking about when we're talking about saving someone's life.

Counselor Dispositions

All participants spoke of one or more areas of counselor disposition and the importance that it played in suicide risk and assessment. Counselor disposition was defined as the degree in which *counselor intuition, fear and anxiety,* and *personal experience* affected suicide prevention and assessment.

Intuition. About half of the participants referred to counselor intuition as a form of clinical judgment in different ways (i.e. had a feeling, unspoken, gut feeling). For PA1, a doctoral student, her counselor intuition was the basis for rejecting her supervisor's instructions regarding a client:

> We came to the end of the semester and I was supposed to terminate with her
>
> because the session minutes were up, and that's just what I had to do. But I just
>
> had a feeling that she was not ready for terminating, so I kept her despite my
>
> supervisor's instructions to terminate. I didn't terminate. She came in the next
>
> session and said, "This is what I'm going to do when I leave your office. I'm
>
> going to very specifically drive my truck to this place and do this and you're
>
> going to be the last person I talked to in my life." It was like, okay. I was weirdly

calm because I just knew that she trusted me enough to tell me and this was our opportunity to work together for her to be okay.

Other participants used clinical intuition when determining when to assess risk of clients, such as PA3, a doctoral student, "I assess, specifically, when I suspect it" and PA7, a doctoral level graduate and counselor educator, "...Can I help them be successful in dealing with this ideology and this thought, unspoken thought. It might be opaque, I can't see it, but as a clinician I'm looking at it and saying, that's suicide."

Fear and anxiety. Most participants indicated that there fear and anxiety in working with suicidal clients, and there was not always a clear answer, as PA6, a master's graduate and practitioner described:

> That's a loaded one. Um legal and ethical. Um I think that within the position of being a counselor it's, there's a lot of grey areas. We don't, we tell them everything you say, here we'll stay here unless you want to harm yourself but in this case if I have a client that everyday has feelings that they want to commit suicide or something happens; it becomes very unclear.

When participants spoke of feelings working with suicidal clients, fear was often identified. For PA3, a doctoral student, when asked what she thought of when I said the word suicide, she replied, "There's a twinge of anxiety, so even though I have a lot of experience with it and I think of my most recent conversations about it, my clients that still make suicidal threats sometimes or just the people that have talked about it most recently."

For PA10, a master's level graduate and practitioner, when asked when she felt most comfortable with an intervention with a suicidal client, she spoke of the comfort in

not having the fear of the unknown, "The times I feel most comfortable are the times they go inpatient. I know that sounds terrible, but it's easier if they're more comfortable. I know I created safety." As with counselor fear, most participants identified anxiety at the thought of suicide or suicidal clients. Anxiety was also identified as something that arose in a counselor anytime suicide is brought up, whether in conversation or in a session.

Personal experience. Most participants discussed a personal connection to suicide. Personal experience varied greatly, from participant's own past suicidal ideation, to attempts and completion made by friends, family, and clients. Personal experience was defined as any experience or personal connection that a participant had to suicide. PA5, a doctoral student, reported both familial and client accounts:

> Of course my perception of having maybe -- not necessarily made mistakes, but sort of question how well I handled the case, you know, where the client did die by suicide...I think another factor is probably the fact that I did have a family member -- my father -- attempt suicide, when I was a teenager.

PA7, a doctoral level graduate and counselor educator, recounted a personal connection to suicide as well, "Personal experience with a friend of mine ending her life and professional experiences of friends who ended their lives; clients who tried to take their lives."

The few participants who did not have a personal connection connected to their client experiences as way to better understand suicide. For example, PA1, a doctoral student:

> I have never known anybody to commit suicide but it is a very sad thing and it is a very real thing in our society. In a way I think my job has not necessarily

desensitized me, but it's made me more comfortable with the topic of suicide and being able to discuss it or deal with it on a broad based spectrum.

External Support

Having some level of support on a professional level was an important component of preparedness for participants. Supervision, consultation, agency support, peer support, and faculty support were the specific areas of professional support that participants found as an important piece. PA6, a master's level graduate and practitioner, is a counselor in residency and has found supervision to be an important element of her in-home counseling experience:

> Primarily, I have two supervisors soon to be three supervisors that I work with. One I work with every week and another one I'm going to start working with once a month, the other two are once a month. Um for a few hours but I do have weekly supervision where I can just be brief and update on what's happening with this [suicidal client] and others.

Assessment and Intervention Knowledge

Assessment and intervention knowledge is a structural theme that referred to the level of assessment and intervention knowledge. The textural themes included in this structural theme are as follows: *preference of assessment, frequency of assessment, safety planning, minimizing risk/wrong or no intervention,* and *therapeutic relationship.*

Preference of Assessment

While almost all participants mentioned specific suicidal assessments in the course of their interviews, all participants in some way rejected the instructed use of formal assessments, either paper-based or verbal. For PA2, a doctoral level graduate and

counselor educator who currently teaches a class on crisis intervention and disaster training, had this to say about the use of assessments:

> Yes, but I also add my tinge to it... Very often all of these models, in my opinion, are very technical and they do talk about making a connection with the client but I think so often in a crisis or in a situation where someone is suicidal, we can forget about the stuff that makes the connection and we can focus specifically on the technical aspects of getting information.

Most participants mentioned intent/plan/means, (i.e. an informal assessment where a counselor identifies the client's degree of intent to attempt suicide, if the client has a plan to attempt suicide, and if the client has the means to attempt suicide) as a form of verbal assessment during the course of their interview. For PA10, a master's level graduate and practitioner who had previously worked in crisis services, she discussed not using a formal assessment in private practice:

> Ok so I have an assessment in my head so I don't have a form that I use anymore but I run down the list, well just talk to me about what's going on especially if I have them in my office I know they're gonna be safe in there and so we have the conversation and in my first session I always talk about what I will do and how I will do it as far as content in regards to suicide, self-injury and abuse and I always make sure people know I don't play with those and always managing like you don't have to say this to get my attention, you can just talk to me.

In other participant cases, such as PA1, a doctoral student, they rejected the notion of a formal assessment of any kind:

I don't think that at this point I would use that. Even at my master's training and internships, I don't remember ever having a specific thing in session. I reviewed a textbook and materials provided for class, but I never used a formalized assessment that I recall.

While participants generally rejected the use of formal assessments, at least three participants created their own, unvalidated, suicide risk assessments to use in session. Of those that created assessments, two provided them when asked in member checking. All instruments included both quantitative and qualitative measurements, and lacked a formal scoring system, relying instead on clinical judgment. Here, PA9, a current master's student, describes the assessment that she created:

> Because there, I had no exposure to anything, and the place I was doing my GA ship didn't have anything, I actually created a kind of fill-in-the-blank form that encompassed everything my supervisor had told me, the reading I had done to-date, and my personal experience, so that I have a comprehensive evaluative tool in the moment when I may not be able to think of every single thing that I need to know and I used that at first. I don't use it anymore because I feel more confident since I've had so much experience with it so I used that in the beginning.

As PA9 reported, although she created an assessment, at the time of the interview she no longer used it, as she felt her experience in her practicum and her current enrollment in internship was sufficient experience and now assessed informally.

Frequency of Assessment

Most participants varied in their response to how often their clients were assessed for suicide risk. In the case of PA9, a master's student, she assessed using a 10 point scale, stating:

> It depends on what they're visiting me for. Anyone who's visiting me for depression, at least every two or three sessions. With my actively suicidal clients, at least every session. And what I mean by assess is I ask them to tell me where they are on a 1-10 scale.

Some participants did not vary their assessment procedures in session, whether it be a low, medium, or high frequency. For PA7, a doctoral level graduate and counselor educator, it was a simple, "I think every client every time. That's my motto. Every client, every time, always."

Safety Planning

Safety was found to be a factor for all participants when speaking about suicidal clients. For PA10, a master's level graduate and practitioner, client safety became the most important priority:

> It's always the safety. So people will get mad, or parents can get angry about something, um, it's for the safety of your kid. So that's how it is. I always bring everything into safety, and I kind of blame safety for if you get mad at me.

Every participant in the study reported use of a safety plan in-session, whether it was a requirement through their place of work, or a clinical decision. For PA6, a master's level graduate and practitioner, the safety plan became a large part of her intervention with the client:

Everything pretty much goes to the psychiatrist and then the outpatient counselor

and then we conjugate copies of that, I guess that's not really using any of them

other than the safety plan in session... We're automatically trained to do a safety

plan and then just kind of have it on file and then later on if the issue presents

itself. If there's any self-harm or suicidal ideation, then you go back to the initial

safety plan and revamp it to make it, if it needs to make it any more intense,

connect it to any additional services, and then really just find out what's going on,

what's causing the thoughts of suicide.

Minimizing Risk/Wrong or No Intervention

Minimizing client suicide risk was identified through two participants that

discussed the possibility of clients using suicidal behaviors as a form of attention seeking,

not seeing immediate risk. For example, PA8, a master's level graduate and practitioner,

discussed clients with intellectual developmental disabilities, "Sometimes we even get

people with developmental disabilities, it's a behavioral thing and they live in group

homes or people who know how to play the system of 'oh I'm suicidal I want to go to the

hospital because I like the hospital and I like the attention.'" PA8 also discussed

suspicion of actual client risk in the following account with a male client:

Just the other day I had a guy, we work in a 24 hour facility so I might not be the

one who does the assessment but I'll read it and get shift report from the previous shift.

His assessment said 'client denied SI/HI however said if he goes through withdrawal he

will be suicidal' and so then, when I went to do an updated mental status exam with him

you know and talk to him I told him you know, you do not get the detox set for the day.

I'm on to somebody else so we need to figure out a plan B and then he immediately

started endorsing suicide and he said, 'well I've been suicidal this whole time,' and it's like mm, I don't really believe you. Or I get the borderline personality disorder person, 'I'm gonna kill myself. Aren't you just gonna feel so terrible if I kill myself?' It's like you've been here a hundred times, you haven't killed yourself yet, therefore I don't really think you're all that suicidal.

PA4, a master's level graduate and practitioner, described assessing and determining there is no risk, "Generally it's – it's…what I have most experience with is when it's like 'well yeah, sometimes I think it would be easier if I wasn't around.' But they have no actual intent or, um, kind of means to follow through with it."

Therapeutic Relationship

The therapeutic relationship was identified as a factor for all participants when working with clients with a suicide risk. When PA10, a master's level graduate and practitioner, worked with a client who was actively suicidal, they reported reacting in the following way:

> I do a lot of calming stuff I use mindfulness we do a lot of people are impulsive and are really overwhelmed so it's a lot of just de-stressing and calming down reframing refocusing just coming back into the right here right now and how we're gonna cope with it kind of bringing them back in back to reality. I do a lot of that probably more so than anything I'm like ok everything's spinning really fast let's bring it on down. And again much easier in private practice than crisis because I know the people better… Um [pause] so it can be really really rewarding and really really exhausting all in the same day. I think it takes, um, it

takes, I guess, I work pretty empathically, I guess, you're putting yourself into this really sitting in for somebody.

Training Recommendations

The final structural theme of training recommendations included three textural themes: *formal assessment and intervention, multicultural training,* and *legal/ethical training.* The overwhelming recommendation from participants for increased training competency was that master's programs include a course specifically relating to suicide prevention and assessment. For PA10, a master's level graduate and practitioner, addressing unclear areas in suicide prevention and assessment was critical:

> So minimum, have a full course on it. Uh, in regards to the really easy ones, cool, go through those, but all the grey area one's, procedures resources available not everybody knows it's available to them, something that really looked at all of that, and that could coincide with views minimum like 3 months on a crisis unit. That'd be awesome.

Formal Assessment and Intervention

Overwhelmingly, participants' recommended more formal assessment and intervention training. PA1, a doctoral student, who did not feel that assessments would be helpful when the interview began, changed her outlook on the subject by the last interview question:

> Maybe having a checklist... Maybe I was presented with them and I didn't take them because I felt I understood the content of what a checklist would be. But, I would say actually, that knowing in the area – knowing the contact, the hotline number, or the contact of the security office to the campus or knowing the contact

at the hospital – that way if my supervisor was not in the office and no one was

there, I would know exactly what to do on my own.

PA8, a master's level graduate and practitioner, also recommended integration

throughout multiple courses, but also expressed surprise over the lack of training

guidelines on the subject:

Um, I probably would make [suicide prevention and assessment] built in more

things throughout the educational process or make it a mandated class. I know it

seems like there are so many things that are mandated, especially when you're

going through your program you're like, 'oh my god is it ever going to end?', but

I mean suicide is a big factor, especially depending on what population you're

going to work with.

Multicultural Training

A few participants recommended more training in multicultural issues in the

suicide prevention and assessment. Specifically, PA5, a doctoral student, recounted a

client story that illuminated this need for her own training:

You know, I've called the Crisis Line and had them not come, because they

wouldn't guarantee not to call the police, and I wasn't willing to have the police

bust in my office. There's a lot of really pragmatic shit that they don't talk to you

about in school. You know? No one talked to me about the complexity of having

an oppressed client, who is fearful of the police. No one talked to me about that.

I had to deal with that on my own and figure out.... That's bullshit, at the end of

the day. Like an Instructor makes that sound so easy. But like when you're in the

situation -- You know, you might have clients that have experienced racism in the

world; who have experienced police brutality; who have experienced marginalization in other ways. Where if they're trans-identified, they're afraid of getting arrested, because they don't know how they'll be treated as a trans[gender] person. There's a lot to think about.

Legal/Ethical Training

One final recommendation identified by some participants was surrounding the legal and ethical issues of clients who present with suicide risk. PA4, a master's level graduate and practitioner, wondered why her agency had policies on multiple subjects, but not in this area:

> For as far as a professional I'm not sure because I've only ever worked at this one agency, but um, we're like a state funded agency so we have a lot of state paperwork and a lot of state procedures, but it seems like that's the one area where we don't have like a set procedure or a set document that we have to fill-out.

Discussion

Findings that include four structural themes (i.e., training preparedness, components of preparedness, assessment and intervention knowledge, and training recommendations) and 15 related textural descriptions help to identify training experiences, degree of preparedness, and recommendations from those with direct experience working with suicidal clients. No matter the highest education level obtained, participants' experience with suicide prevention and assessment training varied in terms of the degree and source of integration. Further, ethical considerations of training outside of the curriculum through multiple methods of learning were presented, along with the

sense of responsibility participants felt towards their clients, and understanding documentation. In addition, the preference for type and frequency of suicide risk assessment, safety planning, minimization of risk/wrong or no intervention, and the importance of the therapeutic relationship was noted. Finally, formal training in assessment and intervention, multicultural training recommendations, and legal/ethical training recommendations were discussed.

Participants overall believed that their master's program generally did not adequately prepare them to work with suicidal clients, with most training in their practicum and internship courses. This is consistent with previous research that found training prior to practicum and internship to be limited to crisis intervention, and training in programs in general to be extremely varied and typically minimal in depth and breadth (Barrio Minton & Pease-Carter, 2011; Wachter Morris & Barrio Minton, 2012). If doctoral level training was present for participants, the degree to which it was integrated and the degree of adequacy was mixed. This is consistent with clinical psychology literature in which only 35% of programs had formal training that specifically included suicide in the doctoral level programs surveyed, and the content varied in formality and level of training (Bongar & Hartmatz, 1989).

The most common form of post-master's training outside the curriculum was on-the-job, training that was required by the agency, hospital, or other company. Participants who actively sought out continued education reported workshops as their most common form of training. Further, professional support (e.g., supervision, consultation, or peer support groups) was seen as an important element of preparedness. To participants, preparedness was constantly in motion, and without continued education and experience,

a counselor may lose skills that you may have previously developed. Some participants found that the act of working with suicidal clients increased their preparedness and competence, regardless of the approach to working with a suicidal client.

Participants noted several factors associated with the quality of suicide prevention. These include counselor intuition, anxiety and fear, therapeutic relationship, actively seeking continuing education, minimization of risk, personal connection to suicide, and presence of self-injury. These findings are somewhat consistent with previous research, as anxiety (Bongar & Harmatz, 1989; Wachter Morris & Barrio Minton, 2012) actively seeking professional support (Reeves et al., 2004), and the role of self-injury (Cooper et al., 2005) have been evident prior to this study.

Although structured training workshops (Pisani et al., 2011) and crisis intervention models (Miller, 2012; Ruzek, 2007) exist, participants of this study were generally limited in knowledge of formal assessments and often utilized their own developed tool. Further, some participants spoke of a balance of reducing symptoms of risk with the least restrictive intervention. Many participants identified safety planning as an intervention they often use; previous literature, however, notes safety planning as potentially harmful if it is the sole intervention strategy (Edwards & Harries, 2007; Miller, Jacobs, & Gutheil, 1998). In general, they often recommended more formal training specifically in suicide prevention and assessment using multiple points of entry for learning; this echoes recommendations in other research (see Bongar & Harmatz, 1989; Neimeyer, 2000; Pisani et al. 2011). Post-masters participants recommended more agency protocols relating to working with suicidal clients, as it was their desire to follow a protocol that their agency designated.

Implications for Counseling Practice and Preparation

The results of this study indicate a greater need for more training in suicide prevention and assessment. Whether participants currently felt prepared to work with suicidal clients, there was a desire to increase their master's level training in the area. Echoing research by Bongar and Harmatz (1989), this study indicates that training to work with suicidal clients should begin early in a master's student's training and be integrated throughout courses. Specifically, a course that presents training based in a theoretical training program that uses multiple types of training methods, including role-plays, discussion, case studies, lecture, and other experiential activities. Further, there is a greater need for multicultural issues to be integrated throughout training. Formal training in a specific assessment model or workshop would benefit future training programs.

Counseling practice could benefit from more insight into current agency protocols relating to suicide prevention and assessment. Generally, participants desired more in-depth training, and there did not seem to be consistent training across work settings. Counselors should not only be seeking out additional trainings that are evidenced based, but should also be advocating to their agencies to provide consistent, recurring training.

Limitations of Study

Sampling for this study was limited to solicitation of participants through online communication methods. It is possible that those who replied to the call for participants felt more comfortable with the topic of suicide and suicidal clients, which could have an effect on the overall essence of participant experience. Although member checking was

used to increase rigor, responses were limited. Further, not all major race/ethnicity groups were represented in the sample.

Future Research Directions

Future research should focus on further exploration of counselor suicide prevention and assessment preparation in training settings across education levels. Development of an instrument that measures current counselor competency and knowledge in suicide prevention and assessment would be an important, better understanding the current state of counselor competency. Multicultural training was seen as a weak spot by participants in their knowledge of suicide risk. Assessing cultural competence in relation to suicide prevention and assessment could be an important next step in assessing current state of counselor preparation.

Further, assessment and intervention and components of preparedness have future research implications. Specifically, counselor assessment and intervention strategies that warrant future research could be investigating the connection between minimizing risk/wrong or no intervention and the level of safety planning used with a client and frequency of assessment. Finally, degree of adequacy of training and preference for assessments could lead to a better understanding of if increased specificity leads to more consistent assessment use.

use.

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APPENDIX

Appendix A

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OLD DOMINION UNIVERSITY
I D E A FUSION

DARDEN COLLEGE OF EDUCATION
Human Subject Committee
Norfolk, Virginia 23529-0156
Phone: (757) 683-6695
Fax: (757) 683-5756

May 20, 2014   Approved Application Number: 201401128

Dr. Danica Hays
Department of Counseling and Human Services

Dear Dr. Hays:

Your Application for Exempt Research with Heather Dahl entitled "Counselor's Perceived Degree of Preparedness when Working with Suicidal Clients" has been found to be EXEMPT under Category 6.2 from IRB review by the Human Subjects Review Committee of the Darden College of Education.

The determination that this study is EXEMPT from IRB review is for an indefinite period of time provided no significant changes are made to your study. If any significant changes occur, notify me or the chair of this committee at that time and provide complete information regarding such changes. In the future, if this research project is funded externally, you must submit an application to the University IRB for approval to continue the study.

Best wishes in completing your study.

Sincerely,

Theodore P. Remley, Jr., J.D., Ph.D.
Professor and Batten Endowed Chair in Counseling
Department of Counseling and Human Services
ED 110
Norfolk, VA 23529
tremley@odu.edu

Chair
Darden College of Education Human Subjects Review Committee
Old Dominion University

Appendix B

Demographic Sheet

Age: _____   **Gender:** Female   Male   Transgender

Race/Ethnicity:

African American   Asian American   Hispanic   Native American   White/European

American Biracial/Multiracial   Other not specified: _____

Sexual Orientation: Bisexual   Gay/Lesbian   Heterosexual   Questioning

Other not specified: _____

Relationship Status: Single/Not in Relationship   Partnered   Divorced   Widowed

Religious/Spiritual Orientation:

Buddhist   Christian   Hindu   Jewish   Muslim   Other not specified:

_____

Are you: Non-Practicing   Somewhat Practicing   Practicing

Highest Degree Completed:

Bachelors   Masters   Educational Specialist   Doctorate

Current Educational Status:

Bachelors   Masters   Educational Specialist   Doctorate

       N/A

Approximate total number of clients seen per week (currently): _____

Credentials (Certifications/Licenses): _____

Geographical Location: _____

Current Work Setting

(including practicum/internship):   Private Practice   Community Mental Health

School   Hospital   University/College   Vocational Rehab

      Residential Setting

Other not specified: _____

Clinical Interests:

_____

Appendix C

INFORMED CONSENT DOCUMENT
OLD DOMINION UNIVERSITY

<u>**PROJECT TITLE:**</u> Counseling perceived degree of preparedness when working with suicidal clients.

<u>INTRODUCTION</u>
The purposes of this form are to give you information that may affect your decision whether to say YES or NO to participation in this research, and to record the consent of those who say YES. This qualitative study's purpose is to gain knowledge on master's students' perceived degree of preparedness when working with suicidal clients.

<u>RESEARCHERS</u>
Doctoral student in Counseling that is in charge of and conducting research:
> Heather Dahl, MS
> Phone: (509) 307-3556
> E-mail: hdahl@odu.edu

<u>DESCRIPTION OF RESEARCH STUDY</u>
Several studies have been conducted looking into the subject of suicide prevention, but little research has been done in the area of student's feelings of competency after receiving suicide prevention training for counselors.

If you decide to participate, then you will join a study involving research of your feelings of competency when working with suicidal clients. If you say YES, then your participation will last for one individual interview sessions located at _____ and taking place over two semesters. Approximately 10 individuals will be participating in this study.

<u>EXCLUSIONARY CRITERIA</u>
You should currently be enrolled in or already completed a Counseling master's degree program. If you are enrolled currently in a graduate program, you must have completed suicide prevention education provided by your university and have completed or be enrolled in practicum in counseling. To the best of your knowledge, you should not have any conflict of interests that would keep you from participating in this study.

<u>RISKS AND BENEFITS</u>
RISKS: If you decide to participate in this study, then you may face a risk of discussing potentially uncomfortable topics. The researcher tried to reduce these risks by allowing the participant to choose not to answer any question that they do not feel comfortable answering. As with any research, there is some possibility that you may be subject to risks that have not yet been identified.

BENEFITS: The main benefit to you for participating in this study is that you are aiding in research that hopes to better prepare Counseling master's students to work with suicidal clients. Your participation in this research is a valued part of this process.

COSTS AND PAYMENTS
The researchers are unable to give you any payment for participating in this study.

NEW INFORMATION
If the researchers find new information during this study that would reasonably change your decision about participating, then they will give it to you.

CONFIDENTIALITY
The researchers will take reasonable steps to keep private information, such as identifying information confidential. The results of this study may be used in reports, presentations, and publications; but the researcher will not identify you. Of course, your records may be subpoenaed by court order or inspected by government bodies with oversight authority.

WITHDRAWAL PRIVILEGE It is OK for you to say NO. Even if you say YES now, you are free to say NO later, and walk away or withdraw from the study -- at any time. Your decision will not affect your relationship with Old Dominion University, or otherwise cause a loss of benefits to which you might otherwise be entitled. The researchers reserve the right to withdraw your participation in this study, at any time, if they observe potential problems with your continued participation.

COMPENSATION FOR ILLNESS AND INJURY
If you say YES, then your consent in this document does not waive any of your legal rights. However, in the event of harm arising from this study, neither Old Dominion University nor the researchers are able to give you any money, insurance coverage, free medical care, or any other compensation for such injury. In the event that you suffer injury as a result of participation in any research project, you may contact Heather Dahl at (509) 307-3556 or Dr. George Maihafer the current IRB chair at 757-683-4520 at Old Dominion University, who will be glad to review the matter with you.

VOLUNTARY CONSENT
By signing this form, you are saying several things. You are saying that you have read this form or have had it read to you, that you are satisfied that you understand this form, the research study, and its risks and benefits. The researchers should have answered any questions you may have had about the research. If you have any questions later on, then the researchers should be able to answer them:

Heather Dahl, MS
Phone: (509) 307-3556
E-mail: hdahl@odu.edu

If at any time you feel pressured to participate, or if you have any questions about your rights or this form, then you should call Dr. George Maihafer, the current IRB chair, at 757-683-4520, or the Old Dominion University Office of Research, at 757-683-3460.

And importantly, by signing below, you are telling the researcher YES, that you agree to participate in this study. The researcher should give you a copy of this form for your records.

Subject's Printed Name & Signature	**Date**
Witness' Printed Name & Signature (if Applicable)	**Date**

INVESTIGATOR'S STATEMENT

I certify that I have explained to this subject the nature and purpose of this research, including benefits, risks, costs, and any experimental procedures. I have described the rights and protections afforded to human subjects and have done nothing to pressure, coerce, or falsely entice this subject into participating. I am aware of my obligations under state and federal laws, and promise compliance. I have answered the subject's questions and have encouraged him/her to ask additional questions at any time during the course of this study. I have witnessed the above signature(s) on this consent form.

Investigator's Printed Name & Signature	**Date**

Appendix D

Final Codebook

Structural Codes	Textural Codes	Definition
Training Preparedness	Degree of Integration	The degree of preparation in suicide prevention and assessment from inadequacy to specificity.
	Degree of Adequacy	The degree of adequacy of training in suicide prevention and assessment.
	Source of Integration	The location, depth, and breadth of suicide prevention and assessment training.
Components of Preparedness	Ethical Considerations	The responsibility or duty to protect clients and be educated in the area of suicide prevention and assessment
	Counselor Dispositions	The degree in which counselor intuition, fear/anxiety and personal experience affected suicide prevention and assessment.
	External Support	Professional support as a component of preparedness for counselors working with suicidal clients.
Assessment and Intervention Knowledge	Preference of Assessment	The preference of use of suicidal assessments, if any, while working with clients.
	Frequency of Assessment	The frequency in which clients were assessed for suicide risk.
	Safety Planning	The degree in which safety planning was used with clients who presented with suicide risk.

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	Minimizing Risk/Wrong or No Intervention	The minimization of suicide risk that could lead to the wrong or no intervention by counselor.
	Therapeutic Relationship	The role of the therapeutic relationship in assessing and intervening with suicidal clients.
Training Recommendations	Formal Assessment and Intervention	The recommendation for increased formal assessment and intervention training in counseling master's programs.
	Multicultural Training	The recommendation for increased multicultural training in counseling master's programs.
	Legal/Ethical Training	The recommendation for increased legal/ethical training in counseling master's programs.

Appendix E
Within-Case Display Example

Participant Characteristics	Perception of Training Experience in Suicide Prevention/Assessment	Conceptualization of Preparedness	Suicidal Client Experiences and Feelings	Recommendations
Age: **29** Gender: **Female** Race/Ethnicity: **Hispanic** Sexual Orientation: **Bisexual** Relationship Status: **Divorced** Religious/Spiritual Orientation: **Atheist** ACES Region: **Southern** Highest Degree Completed: **Masters** Current Educational Status: **Doctorate** Approx. Number of Clients seen per week: **10** Credentials: **LMHC, NCC, DCC** Current Work Setting:	**Master's Program Training** → None (28) **Pre-Masters** → None **Post-Masters training** → Self-Sought/Study → On the job training (34-38) → 20-30 hours → Psychiatric Hospital Experience (42)	**Conceptualizations of Preparedness** → Understanding assessment and intervention (406-407) → Desire to transfer client at risk to others (62-63) → Legal issues in state of work (413-414) → Self-guided study (419-421) → Understanding Gaps in knowledge (59-61)	**Feelings toward Suicide/Suicidal Clients** → Minimization of client risk, client marginalization (119-121, 128-130), Ethically grey (47-49) → Displacement of responsibility (60-63) → Unsubstantiated Confidence in competence_ Client Story (146-156) → Grey Area (291-297, 95-96)	**Increasing Competency/ Recommendations** → More formal training (418-421) → One day of a class, discussion of formal assessments, safety contracts (431-434) **Participant in Interview** → Uncomfortable (40) → Vagueness throughout → Harsh

University/College; Private Practice Clinical Interests: **Religious/belief system change, distance counseling, multicultural issues** (Inpatient Experience)		→ Anxiety (70) → Experience increases competence (111-115, 362-363) → Lack of Outside Support (134-136) **Conceptualization of suicide risk** → Assessment: → Formal Assessment tool knowledge: Rejection of (6-8, 19-20, 188, 224-227, 260-264); Long pause related to (230, 236-237) → Assessment Frequency_E very Session if overt suicide risk	→ Detachment (104-105) → Inevitability (93-96) → Ethical Boundaries Client Story (146-156, 174-176) → Not responding to high risk of client (181-183, 192-199) → Habituation to client risk (373-376)	Tones when discussing clients who had multiple attempts

		(227), only when suspected (299-300) → Intent-Plan-Means (19-22) **Conceptualization of Intervention** → Safety Contract (149-151) → Reliance on Safety Contract (160-163, 205-207, 209-210) → Contradiction -Rejection of safety contract (455-459) **Conceptualization of Counselor Intuition** → Having a feeling (296-297) → Anxiety (70)		

VITA

Heather Danielle Dahl earned a Bachelor of Arts in Psychology in 2010 from
Central Washington University. Immediately following, she continued her education and
received a Master's of Science in Mental Health Counseling in 2012, also from Central
Washington University. She is a member of the American Counseling Association, the
Association for Counselor Education and Supervision, the Association for Assessment
and Research in Counseling, the Southern Association for Counselor Education and
Supervision, and the Western Association for Counselor Education and Supervision. She
is a National Certified Counselor (NCC) and has presented at local, regional, and national
conferences.