THE PROCESS OF COUNSELOR SUPERVISION 
FOR COUNSELOR TRAINEES WHO 
WORK WITH SUICIDAL CLIENTS

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The purpose of the current study was to generate an emergent theory of the process of counselor supervision for counselor trainees who work with suicidal clients. The intent of the study was to explore the perspectives of five counselor supervisors who occupied the role of director of a counselor education counseling clinic/practicum training lab. An assumption was that counselor supervisors’ views about the process of counselor supervision with counselor trainees for suicidal clients may include such things as securing client safety, facilitating client growth, and promoting counselor trainee (i.e., pre-licensed counselor) maturation. The question that guided the current study was: How do five counselor supervisors express the process of supervision with counselor trainees for suicidal clients (i.e., clients with suicidal ideation, suicidal ideation with plan for suicide, or clients who attempt suicide)?

The inclusion criteria for participants were: Director of a Counselor Education Counseling Clinic housed in a counselor education department or program at a CACREP-accredited university, earned doctoral degree in counselor education, licensed as a professional counselor, received formal training as a counselor supervisor, provided direct supervision to practicum students, and provided supervision to a supervisee who worked with a suicidal client within the past two years. Numerous procedures (e.g., process notes, member checking, peer review) helped establish trustworthiness and
credibility of the data analysis. All participants engaged in three semi-structured, individual telephone interviews lasting approximately 45 minutes and completed a 30-minute member check telephone interview. Data were analyzed according to constant comparison procedures.

The emergent theory, *Supervision for Suicidal Clients as an Immediate, Versatile Collaboration Between Counselor Trainees and Counselor Supervisors*, explained the experience of counselor supervision for counselor trainees who work with suicidal clients as a complex and evolving process characterized by the needs of the counselor trainee and the suicidal client. Contributions of the findings to existing literature are presented, implications, limitations and delimitations are explored, and suggestions for future research are provided.
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CHAPTER I

INTRODUCTION TO THE STUDY AND REVIEW OF THE LITERATURE

In 2004, suicide was the 11th leading cause of death in the United States, accounting for more than 32,000 fatalities (Centers for Disease Control [CDC], 2007). Each year, more Americans die from suicide than homicides (American Association of Suicidology [AAS], 2007). Data on attempted suicide is not systematically collected, thus it is difficult to assess the frequency of attempts that do not end in death (AAS, 2007; McBee-Strayer & Rogers, 2002). However, current estimates suggest that approximately 8 to 25 attempted suicides occur for every completed suicide (Moscicki, 2001). A general population survey of U.S. citizens between the ages of 15 and 54 found that nearly 5% of respondents had made at least one suicide attempt and nearly 14% had reported feelings of suicidal ideation (Kessler, Borges, & Walters, 1999). Results suggested that the lifetime probability of transitioning from suicidal ideation to a suicidal plan was 34%, and the lifetime probability of transitioning from a suicidal plan to a suicide attempt was 72% (Kessler et al.).

Likelihood of Working With Suicidal Clients

Current counselor preparation programs may consistently prepare students for the realities of working with suicidal clients in mental health practice. Research estimates are that approximately 800,000 people attempt suicide each year (AAS, 2007). Approximately 37% to 52% of adolescents and adults who were hospitalized for a suicide attempt had received outpatient mental health services in the month prior to their attempt.
(Barnes, Ikeda, & Kresnow, 2001; Suominen, Isometsä, Marttunen, Ostamo, & Lönnqvist, 2004) and approximately 26% of adults reported visiting a mental health professional for services during periods of active suicidal ideation (Brook, Klap, Liao, & Wells, 2006).

Attempted suicide is one of the most significant predictors of completed suicide (Brown, Beck, Steer, & Grisham, 2000; Brown et al., 2005; Nordstrom, Asberg, Asberg-Wistedt, & Nordin, 1995). Given the prevalence of suicidal behaviors (i.e., suicidal ideation, attempted suicide, and completed suicide), counselors can expect that they will at some point in their careers be required to provide services to clients who are actively suicidal. In a study of 285 psychologists, Pope and Tabachnick (1993) found that over 25% of participants reported experiencing at least one client suicide during their professional career. In a survey of 241 counselors, Rogers, Gueulette, Abbey-Hines, Carney, and Werth (2001) found that 71% of participants had worked with a client who attempted suicide. Because persons contemplating suicide frequently engage in help-seeking behaviors, counselor supervisees should be prepared to work with suicidal clients as part of their practicum experiences.

Precursors to Suicide

Van Herringen (2001b) suggested that suicidal behaviors result from the interaction between stressor-induced state-dependent characteristics. For example, an individual who is experiencing a financial-related crisis (stressor) may display dispositional characteristics of anxiety, agitation, and depression (state-dependent characteristics). This view of the etiology of suicide suggests that suicidality arises from
an interaction of environmental circumstances (e.g., high stress occupations, living in poverty) and factors within the individuals (e.g., irritability, anxiety). Similarly, suicide can also be conceptualized as the result of being unable to deal with or refusing to accept the terms of some human condition, such as chronic depression (Maris, 1981).

Attempted suicides may be cathartic and may produce a short-term elevation of affect (Maris, 1981). Michel, Dey, Stadler, and Valach (2004) conducted interviews with 18 individuals admitted to the hospital for a suicide attempt. A protocol was developed by the researchers to assess the nature of participants’ suicidality. This protocol consisted of brief (less than 30 minutes) video recorded interviews in which participants were asked to explain what led them to attempt suicide. After completing this interview, each participant then watched the recorded interview with the researcher. The videotape interview was paused every 2-4 minutes and the researcher asked participants to record any thoughts, feelings, and sensations they had at the time of the interview. The video interview review portion of the research lasted between 45-120 minutes for each participant. Participants reported the following reasons for their suicide attempt: (a) problems with self-esteem, (b) difficulties in coping with separation (e.g., from loved ones or confidents), (c) experiences of rejection, and (d) feeling restrained and dependent in relationships (Michel et al.). This study suggests that suicidality is a complex condition, one that may develop from a number of various precipitants. Counselor supervisors, because of their responsibility for ensuring both client safety and helping their supervisees develop counseling skills, must be aware of the numerous potential
precipitants (e.g., low self-esteem, recent loss, recent rejection) involved in the
development of suicidal ideation.

Feelings of hopelessness and perceived burdensomeness predicted suicidal
behavior in a study of adults receiving outpatient counseling (Van Orden, Lynam, Hollar,
& Joiner, 2006). In a study of the self-reported needs of 245 individuals who had
contemplated suicide or who had attempted suicide, approximately 60% of participants
reported one or more therapeutic needs (e.g., counseling, medication, skills training) was
unmet by mental health professionals (Pirkis, Burgess, Meadows, & Dunt, 2001).

Suicidal ideation may have a pervasive course. In a study of adolescent suicide
attempters, Spirito, Valeri, Boergers, and Donaldson (2003) found that 12% of
participants who were treated for a suicide attempt reported re-attempting suicide within
a three-month period following treatment. As previously mentioned, attempted suicide is
one of the most significant predictors for completed suicide (Brown et al., 2000). A study
of 153 individuals, ages 13 to 34, who had recently used near-lethal means to attempt
suicide, found that 63% of participants had consulted someone (friend, family, or
professional) prior to the attempt (Barnes et al., 2001). This finding suggests the
importance of counselors meeting with family members and other persons in the client’s
life when working with a potentially suicidal client. Counselor supervisors may need to
ensure that counselor supervisees are utilizing these informants when working with
potentially suicidal clients.

In a study of 180 adults who presented to the emergency room for a suicide
attempt, 52% did so by over-dosing with a coma-producing substance (Brown,
Henriques, Sosdjan, & Beck, 2004). Thus, it can be assumed that clients who intend to end their lives do so by using fairly lethal means. Impulsivity has also been identified as a factor related to suicide attempts. Simon et al. (2001) found that approximately 24% of survivors of a nearly lethal suicide attempt had spent less than five minutes between the decision to attempt suicide and the actual attempt, which suggests that, at least a portion of suicide attempts are made impulsively. Thus, assessing a client’s history of impulsivity may be a beneficial component of a thorough suicide evaluation.

Concerns related to actual client death by suicide or attempted suicide may be the most difficult for beginning counselors to effectively deal with (Kirchberg, Neimeyer, & James, 1998). Given the inherent complexity of client suicidal ideation, it seems that effective and appropriate counseling supervision may be critical for counselor supervisees who work with suicidal clients. Additionally, counselor education programs must prepare students for the reality of encountering suicidal clients (Foster & McAdams, 1999). A study of psychology interns found that 1 out of 4 interns had worked with a patient who had made a suicide attempt (Kleespies, Penk, & Forsyth, 1993). It is reasonable to assume that counselor supervisees may also come into contact with clients who have attempted suicide at similar rates. Rodolfa, Kraft, and Reilley (1988) found that attempted suicide by a client was ranked by mental health supervisees as the second most stressful professional event, and was ranked only behind being physically assaulted by the client. Compared to suicidal ideation, suicide attempts have a significantly greater impact on supervisees, and thus may warrant greater support and possible intervention from appropriate supervisory sources (Kleespies et al., 1993).
College students have been shown to demonstrate high levels of suicidal ideation (Granello & Granello, 2007). In a study of over 1,400 college students at several Midwestern universities, Furr, Westefeld, McConnell, and Jenkins (2001) found that 53% of participants reported experiencing significant depression and 9% of participants reported that they had considered committing suicide since beginning college. Granello and Granello (2007) suggested that college students may experience unique risk factors for suicide: (a) perfectionism, (b) victimization, (c) interpersonal relationships, (d) risk-taking behaviors, and (e) cognitive vulnerability.

Counselor supervisees who complete practicum training hours in a university counseling center/clinic may encounter suicidal clients. College students who seek counseling services frequently have complex problems that include both the expected college student problems (e.g., difficulties in interpersonal, academic concerns), as well as more severe problems (e.g., depression, suicidal ideation; Benton, Robertson, Tseng, Newton, & Benton, 2003).

Some research has suggested that college students have been presenting for counseling services at an increased rate. Benton et al. (2003) examined the number of college students who presented for university counseling center services during a 12-year period (1989—2001) to determine if the complexity of college students’ mental health concerns were increasing. Results suggested that the number of students seen each year with depression doubled over the time period, whereas the number of suicidal students tripled. In light of the increased severity of college student mental health concerns, some college campuses have begun developing multifaceted interventions (e.g., staff trainings,
campus-wide initiatives, and psychoeducation) to help college counseling centers meet
the needs of complex clients (Nolan, Ford, Kress, Anderson, & Novak, 2005).

**Importance of Supervision**

The role of the supervisor is pivotal following a client’s suicide attempt or
completed suicide (Kleespies, Smith, & Becker, 1990). Knox, Burkard, Jackson,
Schaack, and Hess (2006) examined the experiences of 13 pre-licensed doctoral
supervisees. Participants were solicited through various mental health profession listservs
(i.e., American Counseling Association, American Association of Suicidology, American
Psychological Association of Graduate Students, Association of Psychology Postdoctoral
and Internships Centers, and Division 17 of the American Psychological Association). In
order to qualify for the study, participants had to have experienced a client’s completed
suicide while they were in prelicensure training. Through consensual qualitative research
methods, Knox et al. identified three primary supervisor responses that supervisees
reported were helpful to them following a client completed suicide: providing a safe
environment, supervisor disclosure of his or her similar experiences with client suicide,
and normalizing supervisees’ reactions to the suicide. Supervisees also identified
potentially *unhelpful* supervisor responses to client suicide: supervisees forced to process
emotional content quickly and publicly (e.g., during a treatment team meeting);
supervisors providing callous, or unresponsive reactions to client suicide; supervisors
attending less to the needs of the supervisee than to potential legal ramifications of the
suicide; and supervisors informing supervisees of the client suicide without providing
ample opportunity for the supervisee to process his or her emotional reaction. The results
of this study suggest that supervisees value a strong supervisory presence, as evidenced by the participants’ need to have contact with supervisors in the aftermath of client suicide.

Preparing counselors to work with complex client presentations (e.g., suicidal, crisis situations) is a formidable task (Grant, 2006). Mental health supervisees may be more vulnerable to the stress experienced with a client’s completed suicide or attempted suicide compared to licensed and seasoned professionals (Kleespies et al., 1990). Knox et al. (2006) found that doctoral level counseling and psychology interns received little formal training in assessing, interviewing, or responding to client suicidal behaviors as part of their graduate program. Thus, a disparity exists: It is common for counselor supervisees to practice in agencies that service actively suicidal clients; however, they may be practicing without the proper training or education in suicide assessment or intervention. The counselor supervisee’s assigned supervisor may therefore be the one to train and educate the counselor supervisee to develop the necessary skills to work with suicidal clients.

Purpose of the Study

The purpose of the current study was to examine the experiences of counselor supervisors who provided supervision to at least one supervisee who had worked with a suicidal client. No published research has focused specifically on the experiences of counselor supervisors who work with counselor supervisees regarding suicidal clients. Research estimates on the prevalence of suicidal ideation and attempts underscore the frequency of events such as client suicide ideation and client suicidal attempts.
Supervisors must be able to help counselor supervisees provide effective counseling services to suicidal clients.

The present study focused exclusively on licensed professional counselors with a supervisory designation and not other mental health professionals (e.g., psychologists, social workers, psychiatrists). More specifically, counseling centers/clinics housed in a Council for Accreditation of Counseling and Related Educational Programs (CACREP) accredited counselor preparation program were chosen as the practicum site of interest and clinic directors who supervise practicum students represented the sample population. University clinics typically treat clients with diverse disorders, including suicidal behaviors (Foster & McAdams, 1999). For counselor supervisees, counselor education counseling clinics may represent the first time they will provide counseling services to a client.

The researcher was interested in understanding perspectives on the supervisory process from counselor supervisors who supervise practicum students who had counseled suicidal clients. The researcher was especially interested in learning about how the supervisor balanced the dual role of ensuring client safety and helping the counselor supervisee learn from the experience.

Overview of Procedures

Participants in this study were five counselor supervisors who served as counseling center/clinic directors in CACREP-accredited counseling programs each of whom supervised a counselor supervisee who worked with a suicidal client within the past two years. The study followed a grounded theory design to help the researcher
understand and represent the meaning of human experience under investigation (Rennie, 1994). A purposeful sampling technique was utilized to ensure that participants had experienced the event under investigation (i.e., supervision of client suicidal behavior). Grounded theory was considered an appropriate methodology for the present study because it allowed the researcher to gain an understanding of the experience under investigation through the use of multiple, in-depth interviews with participants.

Research Question

The question that guided the current investigation was: What are counselor supervisors’ perspectives on the process of supervision with suicidal clients? The intent of this question was to elicit the perspectives of supervisors regarding their role both in helping the supervisee deal with his or her feelings, thoughts, and behaviors associated with the client’s suicidality and their responsibility to ensure client care.

Definitions of Terms

Attempted suicide. Attempted suicide involves an actual life-threatening behavior with the intent of jeopardizing one’s own life, but one that does not result in death (Kleespies et al., 1993). Valente (2006) identified the outcome of the suicidal action as being the key component between attempted and completed suicide where attempters are those who survive a potentially fatal attempt. Completers, on the other hand, are those whose attempts end in death. For purposes of the current study, attempted suicide was used to describe volitional acts of self-harm performed with the intent to cause death.

Counselor supervisee. The term counselor supervisee is used to refer to an individual who is enrolled in a master’s degree granting, CACREP accredited counseling
program, who has completed the core counseling curriculum required for the practicum experience.

*Counselor supervisor.* The term *supervisor* refers to a seasoned practitioner who directs less experienced colleagues and pre-service supervisees (Bradley & Kottler, 2001). For the purpose of the present study, a supervisor is defined as an independently licensed mental health counselor who holds a supervising counselor designation (if applicable) and who is the counseling center/clinic director at a counselor education program.

*Suicidal behavior.* All behaviors (e.g., talking about suicidal ideation, reporting hopelessness for the future) that represent a person’s possible intent to commit suicide.

*Suicidal client.* A suicidal client is a client who reports experiencing suicidal ideation (e.g., reporting “I have no reason to live”), who demonstrates behaviors suggestive of suicidal ideation (e.g., self-injurious cutting), or who has attempted suicide (e.g., intentionally overdosing on a medication).

*Suicidal ideation.* Suicidal ideation refers to current thoughts of death (Miller, Rathus, & Linehan, 2007). Suicidal ideation can further be divided into *passive* or *active* suicidal ideation. In passive suicidal ideation, individuals may wish they were dead, but they have no intent or plan to kill themselves. Actively suicidal individuals have intent, or in some case a plan, to commit suicide (Miller et al.).

*Suicidal process.* The suicidal process refers to the development and progression of suicidality within the individual and in interaction with his or her environment (van Herringen, 2001b). The suicidal process may start with fleeting thoughts about suicide, or
the wish to end some sort of pain or suffering and may progress to an actual suicide attempt (van Herringen, 2001b). It is important to note that the suicidal process may not become evident to others until the individual engages in some sort of communication (e.g., writing a letter) or a behavioral action (e.g., taking an overdose of medication; van Herringen, 2001b).

**Suicidality.** In the present study, the term suicidality refers to the cognitive and behavioral characteristics that may become evident as suicidal ideation or attempted suicide (van Herringen, 2001a).

**Suicide plan.** A client with a suicide plan has moved past the stage of thinking about suicide and has begun to consider the steps he or she would need to take to commit suicide. Suicide plans can be either vague (e.g., client has considered how he or she would commit suicide but does not have a specific step-by-step plan of action) or specific (e.g., individuals have a detailed plan related to the time, place, and method of suicide).

**Supervision.** Supervision is an intervention that has the dual purposes of enhancing the professional functioning of the supervisee and monitoring the services offered by the supervisee to his or her client (Bernard & Goodyear, 2004). As a point of distinction, the term supervision is used to refer to *clinical* supervision activities rather than administrative supervision duties. Clinical supervision refers to supportive and educative activities designed to improve the application of counseling theory and technique directly to clients (Association for Counselor Education and Supervision [ACES], 1993). Supervision can take place individually, in triads, or in groups. For
purposes of the present study, the term supervision was used to indicate an individual face-to-face meeting that takes place between a supervisor and supervisee.

Supervisory relationship. For purposes of the present study, the term supervisory relationship is used to describe work towards mutually agreed upon goals for both the supervisee and supervisor and the emotional bond (i.e., mutual trust) between supervisee and supervisor (Bordin, 1983).

Review of Literature

Supervisor Development

The practice of supervision requires specific training and preparation (Bernard & Goodyear, 2004). CACREP (2009) requires that all accredited doctoral programs provide training in counselor supervision. Supervisor training may be a complex process. The transition from counselor to counselor supervisor may be confusing for some counselors, and even those who have extensive clinical experience may have difficulty assuming the role of supervisor (Borders, 1992). K. W. Nelson, Oliver, and Capps (2006) used a series of multiple interviews to examine the experience of eight doctoral student supervisors-in-training. Results of this grounded theory investigation suggested that doctoral student supervisors-in-training were concerned about both their supervisee’s well-being, as well as their own ability to be an effective supervisor. Specifically, novice supervisors-in-training reported anxiety about their ability to provide adequate supervision to counselor trainees. Supervisor anxiety has been identified by other researchers (e.g., Shohet & Wilmot, 1991), and seems to be most prevalent in beginning supervisors (Hess, 1986). In
general, supervisors tend to feel more confident in their abilities over time (Baker, Exum, & Tyler, 2002; Watkins, 1993).

Borders (1992) suggested that counselor supervisors must shift focus from client to counselor. Borders identified two potential pitfalls for novice supervisors: (a) focusing exclusively on client care, and (b) treating supervisees as if they were clients. In the first instance, supervisors adopt an educative stance and basically tell the supervisee what he or she should do with the client. As a result of this overreaching guidance, supervisees may fail to develop their own professional autonomy. A second potential pitfall of novice supervisors can occur when the supervisor places too much emphasis on elements of the supervisee’s personal life. In this case, the supervisor may inadvertently assume the role of a counselor with his or her supervisee. Borders suggested that supervisors who focus exclusively on personal dynamics of the supervisee may fail to consider other areas of potential concern (e.g., level of supervisee skill, supervisee knowledge base with certain client concerns). Supervisor preparation and relative level of comfort with the supervisor role may therefore have implications for the present study. It seems likely that beginning supervisors, when compared to more seasoned supervisors, may have greater anxiety regarding their ability to supervise counselor trainees who are working with suicidal clients.

Supervisors may go through a developmental learning process similar to the developmental process of a counselor supervisee. Watkins (1993) suggested four stages in the development of counselor supervisors: (a) role shock, (b) role recovery and transition, (c) role consolidation, and (d) role mastery. In the first stage, role shock,
supervisors struggle for clarity about roles, boundaries, and definitions. Supervisors may feel anxiety regarding the structure of supervision. Overall, this first stage is characterized by ambiguity and the supervisor’s insecurity in his or her own supervisory abilities. Supervisors in this first stage may feel overwhelmed in situations where a supervisee’s client is suicidal. When confronted with the attempted suicide of a supervisee’s client, supervisors in the role shock stage may display reactive behaviors that focus exclusively on potential liability (e.g., ensuring proper documentation, developing a no-suicide contract for the client), to the exclusion of supervisee-related concerns (e.g., processing the event, attending to supervisee’s professional needs).

Watkins (1993) identified the second stage, role recovery and transition, as a period when supervisors gain more realistic views of their supervisory abilities. During this time, supervisors may have positive experiences that enable them to gain more self-confidence. In this stage, supervisors are more tolerant of ambiguity and experience less tension. Watkins also suggested that supervisors will begin to identify with the role of supervisor more readily in this stage. Supervisors in this stage may feel more competent in their general practice of supervision, but will likely continue to experience ambiguity and tension when dealing with supervisory situations involving suicidal clients.

Role consolidation, the third stage of supervisor development, is characterized by the supervisor’s broadening perspective of the supervision process (Watkins, 1993). Supervisors continue to display increased self-confidence, and they have greater understanding of their supervisor identity, and subsequently, the process of supervision. In this stage, supervisors generally feel qualified for their role as supervisor, yet they may
display inconsistent supervisory performance based on the supervision circumstances. Counselor supervisors in this third stage may continue to demonstrate confidence when working with most supervisees and clients, but may feel some concern when confronted with supervisory issues related to a suicidal client. For example, supervisors may focus on ensuring client safety, yet may minimize the importance of helping supervisees process the experience.

In the fourth stage, role mastery, supervisors experience a sense of competence with regard to their role and performance of supervisor-related behaviors. Supervisors display behaviors in supervision sessions that are consistent with advanced-level supervisors, such as devoting attention to both client welfare and supervisee issues (e.g., professional development, wellness). In this stage, counselor supervisors will feel competent in their work with supervisees, regardless of the specific situation. Thus, in situations where a supervisee is providing services for a suicidal client, the supervisor will demonstrate competence in ensuring client safety and advancing the growth of the supervisee. This might include taking extra time for processing the experience and following-up with the supervisee on several occasions.

Counselor supervisors must receive appropriate training to ensure that they are qualified to provide supervision to counselor supervisees. Getz (1999) developed a model to train, and subsequently assess, the development of supervisors-in-training. This approach employed a group instructional format that combined didactic and experiential instruction. In this model, the instructor provides an overview of supervision-related readings, lectures, and videotapes primarily during the beginning of training, with the
intent of providing supervisors-in-training an overview of supervision practice. After supervisors-in-training have basic conceptual knowledge of counselor supervision, they provide supervision services to supervisees under observation of the course instructor. Supervisors-in-training also receive feedback from their peer supervisors in training during supervision class sessions.

Goals of Supervision

Counseling supervision is central to both counselor education and the ongoing professional development of counselors (Ward & House, 1998). Bernard and Goodyear (2004) suggested that supervision is an intervention, the functions of which include promoting the supervisee’s professional development and ensuring client welfare. Similarly, Blocher (1983) suggested that the purpose of supervision is to educate and prepare competent, ethical, and responsible professionals.

Evaluation is viewed as the nucleus of clinical supervision and supervisors must monitor those entering the profession (Bernard & Goodyear, 2004). Supervision, by definition, is a relationship that combines evaluative and therapeutic components (Bernard, 1979; Holloway, 1995). Thus, even though supervisors may endeavor to achieve a productive supervisory relationship with their supervisees, the evaluative component of supervision may have implications for the development of a strong supervisory alliance. According to Holloway, the goal of supervision is establishing an ongoing relationship in which the supervisor designs learning tasks related to supervisees’ development.
The process of supervision is intended to facilitate the growth of the counselor supervisee (Blocher, 1983). Supervision can be conceptualized as a continuous and generative conversation in which supervisees can work with their supervisors to develop self-efficacy (Anderson & Swim, 1995). In contrast to developmental models of supervision that suggest that supervision needs to be highly structured to reduce the beginning supervisee’s anxiety, research has suggested that supervisees prefer flexibility and reciprocity in their interactions with supervisors (Gazzola & Theriault, 2007). Rodolfa et al. (1988) suggested that mental health interns rated their supervisory experiences as more stressful than mental health practicum students. Interns may thus place more importance on the supervisory process, or may value different aspects of their relationship with supervisors compared to practicum students.

Counselor Supervisee Development

Several researchers (e.g., Blocher, 1983; Borders, 1989; Stoltenberg, McNeill, & Delworth, 1998) have suggested that counselor supervisees may complete discrete stages of development. The Integrated Developmental Model (IDM; Stoltenberg et al., 1998) conceptualizes the development of supervisees by the acquisition of three marker events: self and other awareness, motivation, and autonomy. Self and other awareness is a cognitive and affective component that identifies the supervisee’s level of self-preoccupation, awareness of the client’s world, and enlightened self-awareness. Considering Stoltenberg et al.’s description of self and other awareness, it is likely that supervisees at an early stage of development who encounter suicidal clients may become
preoccupied with their own personal needs and consequently less responsive to the needs of the client.

*Motivation* refers to the supervisee’s interest, investment, and the amount of effort expended in clinical training. Supervisees who display motivation will likely be interested in learning more about clinical practice areas. Supervisees at a more advanced stage of development who encounter a suicidal client may be motivated, for example, to seek additional training, or complete additional readings related to the topic of suicide if supervision helps them see their learning opportunities.

*Autonomy* is defined as the degree of independence demonstrated by supervisees over a period of time. Learning to handle difficult situations may increase self-efficacy and facilitate autonomy. Supervisees who attain a higher level of autonomy may feel more confident in their abilities to effectively work through complicated client situations, such as suicide. Supervisees who have achieved a higher level of autonomy may feel more confident in their abilities; however, it is likely that they will continue to benefit from supervision.

Stoltenberg et al. (1998) proposed that eight domains of counselor supervisee functioning are evident (or expressed) in each of the three IDM marker events. The eight domains guide counseling practice and encompass the following forms of clinical activity: (a) *intervention skills*, (b) *assessment techniques*, (c) *interpersonal assessment*, (d) *client conceptualization*, (e) *individual differences*, (f) *theoretical orientation*, (g) *treatment plans and goals*, and (h) *professional ethics.*
Stoltenberg et al. (1998) suggested that all eight domains represent a relevant contribution to understanding counselor supervisee development. The domains of *intervention skills competence* and *assessment techniques* may be particularly relevant to the present discussion of counselor supervisees who work with suicidal clients.

*Intervention skills competence* speaks to the counselor supervisee’s ability to implement therapeutic interventions. For example, a counselor supervisee working with a potentially suicidal client may feel unprepared to implement an intervention (e.g., a crisis plan) and may therefore need his or her supervisor to accompany him or her in the counseling session or practice introducing a crisis plan to a client or both. The domain of *assessment techniques* relates to the counselor supervisee’s ability to conduct mental health assessments. Thus, a counselor supervisee working with a potentially suicidal client must demonstrate the ability to administer standardized measures (e.g., Beck Scale for Suicidal Ideation; Beck & Steer, 1991) and informal assessments (e.g., SIMPLE STEPS; McGlothlin, 2008) designed to assess the person’s likelihood of following through with a suicidal act.

Although *intervention skills competence* and *assessment techniques* may be most relevant to counselor supervisees’ work with suicidal clients, the skills of *interpersonal assessment, professional ethics, client conceptualization, individual differences, theoretical orientation, and treatment plans and goals* have applicably to this work as well. *Interpersonal assessment* refers to incorporating the use of self (i.e., the counselor’s own thoughts and beliefs) in conceptualizing a client’s interpersonal dynamics. Mental health professionals who work with suicidal clients must clarify their own values in
regard to the issue of suicide before attempting to treat the client (Granello & Granello, 2007). Counselor supervisees must be aware of how their own belief systems may potentially impact their work with suicidal clients. Similarly, counselors must display an ability to act ethically with all suicidal clients. Professional ethics dictate practice in the counseling profession.

*Client conceptualization* is the ability of counselors to consider how the client’s current presenting problems are influenced by his or her personality characteristics (e.g., depression, anger, sadness) and life circumstances (e.g., poverty, friendships, family support). With suicidal clients, the conceptualization may include numerous broad and complex presenting concerns, typically encompassing a mix of environmental circumstances (Haley, 2004).

*Theoretical orientation* refers to the selection of theory based on the counselor’s ability to work from the counseling theory that best explains the needs of the client. Counselors must be cognizant of the needs of suicidal clients, as some theories may be better suited to the needs of client presentation. Similarly, counselors must be able to effectively develop plans for client treatment. The ability of the counselor to organize his or her efforts into a cohesive plan for counseling is reflected in the treatment plan and goals. When working with suicidal clients, the treatment plan is much more than a demonstration of the counselor’s abilities; it is a document that delineates a plan for survival (McGlothlin, 2008). For example, with suicidal clients the goals of the treatment plan would be to address immediate needs (i.e., self-destructive behaviors) first.
Learning to be a Counselor

Learning to be an effective counselor may be a complex and ambiguous developmental process (Blocher, 1983). Howard, Inman, and Altman (2006) examined the experiences of nine pre-practicum counselor supervisees to determine what they perceived as critical to their professional growth. Results suggested that the beginning supervisees typically had little or no exposure to the realities of counseling, such as practical responsibilities (e.g., scheduling client appointments) and clinical responsibilities (e.g., assessing suicide risk). If counselor supervisees are unprepared for some elements of counseling practice, they may experience difficulties when presented with complex counseling situations. Thus, it is important that counselor supervisees receive proper training and education during their core counseling courses. It might be particularly helpful to share information regarding the types of experiences that counselor supervisees may encounter during their clinical training (Howard et al.). In a grounded theory investigation of counselor-in-training identity formation, Auxier, Hughes, and Kline (2003) found that students initially preferred conceptual learning during their early educational process, although later in the process they preferred more experience-based activities.

Counselor training often requires students to demonstrate a high level of cognitive functioning, specifically the ability to consider a dilemma or challenge from multiple perspectives in order to demonstrate empathic understanding with a diverse client population (Blocher, 1983). Supervisees progress through sequential stages as they acquire more advanced counseling skills and become more aware of their own personal
beliefs, specifically as they impact the counseling process (Borders, 1989). Howard et al. (2006) reported that limited professional experience, especially with regard to a variety of clinical issues, may result in counselor supervisees feeling overwhelmed by ambiguous situations and may indicate that supervisees have an inadequate cognitive framework for understanding their experiences. In a phenomenological study of the experiences of pre-practicum counselor supervisees, Woodside, Oberman, Cole, and Carruth (2007) found that feelings of self-doubt were common in participant narratives. Specifically, all eight participants indicated concern about their lack of skills and lack of training.

Supervisors must be cognizant of how threatening the practicum experience may be for some students, as practicum often serves as the student’s first exposure to the behavioral requirements of the counseling profession (e.g., ensuring client safety, effectively documenting services; Ronnestad & Skovholt, 1993). Academic preparation in counseling may not be adequate for all possible situations counselor supervisees will experience in practicum settings. It is important for supervisors to be able to help counselor supervisees who feel unprepared to deal with client suicidality. Supervisors can promote self-assessment in supervisees by encouraging identification of goals regarding client issues and the counseling process (Ward & House, 1998). This may be especially important for counselor supervisees who work with suicidal clients, as goals for future counseling sessions may need to be clearly identified.
Supervisory Responsibilities

**Ethical and Legal Issues**

Counselor supervisors have several obligations to supervisees. Supervisors are responsible for the supervisee’s learning and professional identity (Getz, 1999). Counselor supervisors also have obligations to the supervisee’s client. The American Counseling Association’s (2005) *ACA Code of Ethics* and the Association for Counselor Education and Supervision’s (ACES, 1993) *Ethical Guidelines for Counseling Supervisors* specify the expectations of those counselors who provide supervision to supervisees, and that the primary goal of counselor supervision is to ensure client welfare. Thus, it appears that the primary obligation of counselor supervisors is to monitor the counseling services provided by counselor supervisees. To fulfill these obligations, supervisors meet regularly with supervisees to review case notes, videotaped clinical work, or live observations (ACA Code of Ethics, Section F.1.a; ACES Section 2.07). In addition, counselor supervisors must be competent to provide supervision services. Specifically, counselors must have training in supervision methods and techniques (ACA Code of Ethics Section F.2.a; ACES Section 2.01). Counselor supervisors must also regularly engage in continuing education activities on topics related to both counseling and counselor supervision (F.2.a; ACES Section 2.01). Lastly, counselor supervisors document and provide supervisees with ongoing performance appraisal and feedback (ACA Code of Ethics, Section F.5.a; ACES Section 2.08).
Supervisor Liability

Counselor supervisors have a responsibility to maintain the ethical and legal standards of the counseling profession (Bernard & Goodyear, 2004). Supervisors are held accountable for the interventions and clinical decisions performed by their supervisees (Falvey & Cohen, 2003). Clients who consent to receive counseling services conducted by a counselor supervisee do so after they have been informed that they will be treated by a supervisee. Although consent is given, the client is not consenting to receive substandard counseling care simply because they are being treated by a counselor supervisee (Harrar, VandeCreek, & Knapp, 1990). Thus, it is the responsibility of the supervisee’s supervisor to ensure the supervisee is providing appropriate services given the client’s presenting concerns. Counselor supervisors may be held liable for failing to provide an appropriate level of supervision; however, counseling supervision has rarely been the focus of judicial inquiry (Stone, 1994).

The supervisor’s legal liability to the client can be direct or vicarious (Harrar et al., 1990). Direct liability may occur when a supervisor fails to provide appropriate supervision to the counselor supervisee and as a result, the client is injured (Harrar et al.). For example, direct liability could occur if the supervisor assigned a client to a supervisee who was not prepared to work with the particular client’s needs or presenting problems (Harrar et al.). Given the concept and examples of direct liability, it is reasonable to assume that supervisors may be held liable for placing a knowingly suicidal client with a counselor supervisee who has limited experience in suicide assessment and intervention.
The term *vicarious liability* refers to the possibility of supervisors being held liable for the actions of their supervisees even in cases where they were not aware of these actions taking place (Bernard & Goodyear, 2004). The concept of vicarious liability is based on the rationale that supervisors have the option of deciding who they wish to supervise (Harrar et al., 1990). Vicarious liability is a noteworthy concept for counselor supervisors who supervise counselor supervisees working with suicidal clients. In order for the supervisor to be held vicariously liable, the supervisee must have acted within the scope of tasks permitted by the supervisor and the supervisor must have had the power to control and direct the supervisee (Harrar et al.). In order to avoid the potential for vicarious liability, counselor supervisors must be able to effectively balance the responsibilities of helping the counselor supervisee develop therapeutic skills, while ensuring the continuous safety of the client.

The concepts of direct and vicarious liability have been well-documented in the literature. However, supervisors being held liable to supervisees for their actions have received comparatively less attention. Guest and Dooley (1999) stated that malpractice claims brought by the supervisee against the supervisor require that the following elements are present within the professional relationship: (a) legal duty of care (i.e., the supervisor had a professional relationship with the supervisee in which he or she formally agreed to provide supervision services), (b) standard of care (i.e., the supervisor failed to provide an appropriate level of supervision as measured by the standards of the counseling profession), (c) harm (e.g., the supervisee experienced some sort of psychological harm), and (d) proximate cause of harm (e.g., negligent supervision was
the direct cause of the harm). Legal duty of care is especially relevant when supervising counselor supervisees working with suicidal clients. Guest and Dooley maintained that when the supervisee is assigned to a supervisor, a legal duty is established by implied contract, which resembles the legal duty present in the counselor-client relationship. Counselor supervisors must be aware of the inherent power differential in their role as a supervisor and must demonstrate an ability to appropriately help supervisees work effectively with complex client cases.

*Supervisee Evaluation*

Bernard and Goodyear (2004) described supervision as inherently evaluative and stated that supervisors act as *gatekeepers* for those who are to enter the counseling profession. Bradley and Kottler (2001) identified the three main purposes of counselor supervision as facilitating the supervisee’s professional and personal development, promoting supervisee competence, and promoting accountability in counseling services. The *ACA Code of Ethics* (2005) states that counselor supervisors must be fair, accurate, and honest in their assessments of counselors-in-training (Section F). Bernard and Goodyear (2004) noted the important professional socialization function of supervision and stressed the importance of supervising members of the same profession. For example, a supervisor can provide a model of professional behavior for the supervisee to follow, and can also help illuminate possibilities within the profession, such as attending and presenting at professional conferences.
Counselor Supervision and Suicide

It is important that mental health professionals have the necessary conceptual knowledge to work with potentially suicidal clients (Ellis, Dickey, & Jones, 1998; Pieters, De Gucht, Joos, & De Heyn, 2003; Remley, 2004). Jobes and Maltsberger (1995) underscored the prevalence of suicidality in practice and the associated challenges of assessment, intervention, and standards of care. Information on the frequency and impact of client suicide and models of support for managing the stress of the experience may be useful during training and supervision (Foster & McAdams, 1999). Put simply, counselor supervisees need to be aware of the possibility that they will encounter suicidal clients. Perhaps this would be best accomplished through an orientation provided by the counselor supervisor to the supervisee in the first supervision session.

Several researchers (e.g., Jobes & Maltsberger, 1995; Juhnke, 1994; Kleespies, 1993) have recommended that suicide education become a routine part of counselor preparation. Kleespies described a pedagogical activity designed to encourage reflection and discussion among supervisees regarding the potential impact of a client suicide. In this activity, supervisees assume the role of therapist in an actual case of a client who completed suicide. Kleespies suggested that this activity may help supervisees engage in discussion about their feelings regarding working with a suicidal client. A similar activity may include asking counselor supervisees to assume the role of a counselor working with a client who recently attempted suicide. This training exercise, although somewhat different from Kleespies’s activity, may generate classroom discussion and reflection related to the emotions evoked by working with a suicidal client. The intent of such
discussion might include helping normalize supervisee reactions to suicide and providing diverse perspectives on the treating suicidal clients.

Counselors should be properly trained in suicide prevention and intervention before they are faced with these issues, rather than being trained “on-the-job” as a consequence of experiencing a client suicide or attempted suicide (Carney & Hazler, 1998; Thomas & Leitner, 2005). One such intervention proposed by Juhnke (1994) is for master’s level counselor supervisees to receive videotaped instruction on suicide risk assessment. The suicide assessment training he described consisted of a structured, 55-minute, self-instructional videotape that supplemented classroom lectures. The videotaped instruction addressed components of a thorough suicide assessment, including performing a face-to-face clinical intervention, empirical evaluation, and consultation. Participants who received this instruction were significantly more able to identify immediate suicide risk and propose appropriate clinical interventions compared to counselor supervisees who did not receive such instruction (Juhnke). Similarly, Bongar and Harmatz (1989) suggested that didactic and clinical training related to suicide should be routinely incorporated into graduate curriculum in psychology-related disciplines. Thus, it appears that counselor supervisees should be exposed to pedagogical activities aimed at increasing their ability to work effectively with suicidal clients. If such training is absent in graduate preparation, counselor supervisors will need to find ways to supplement their education post graduation (e.g., continuing education). Counselor supervisors who do not receive suicide-related training in graduate preparation, and who
do not supplement their own post-graduate education with training in suicide, may be unprepared to assist supervisees with suicidal clients.

Limited training in suicide assessment and prevention may be a concern across all counselor preparation program areas or counselor specialty areas. In a study of 186 high school counselors, King, Price, Telljohann, and Wahl (1999) found that 87% of school counselors believed that it was their responsibility to identify students at risk for suicide. However, only 38% of participants stated that they would be able to accurately recognize a student at risk for attempted suicide due to limited graduate training in suicide assessment. Thus, it appears that school counselors understand the importance of accurately identifying students with potential suicidal ideation, but most school counselors do not believe they are competent to identify students at risk.

Overall, it seems that suicide training needs to be more fully integrated into core counseling curriculum. Jobes and Maltsberger (1995) suggested that the lack of suicide prevention training may reflect an unconscious discomfort that mental health professionals have about suicide. Counselor supervisors model appropriate professional behavior for their supervisees and so they have an opportunity during supervision sessions to help counselor supervisees explore ways to discuss potentially sensitive client information, such as suicidal ideation. For example, it may be necessary for counselor supervisors to discuss with supervisees the possibility of working with a suicidal client during their practicum experience. Ideally, this conversation would take place proactively (i.e., before the supervisee encounters a suicidal client), rather than reactively (i.e., after the supervisee has encountered a suicidal client).
Foster and McAdams (1999) suggested that counselor educators consider the following areas when developing counseling departmental suicide intervention policies for practicum training labs: (a) level of faculty clinical and supervisory expertise, (b) level of clinical and supervisory expertise of off-site supervisors, (c) current policy and procedures regarding clinical emergencies, (d) CACREP and other relevant standards for clinical training and supervision, and (e) ethical considerations of client welfare and counselor competence. Additionally, Foster and McAdams suggested that on-campus clinical facilities used as practica and internship sites should be periodically evaluated to determine adherence to ethical and legal standards of practice, and to assess the severity of the client population.

Berman et al. (2004), in concert with the American Association of Suicidology (AAS), developed a set of 24 core competencies for mental health professionals who work with suicidal clients. Although all 24 competencies have a bearing on the present study, the following competencies seem particularly relevant to the training needs of counselor supervisors: (a) mental health professionals must manage their own reaction to suicide through awareness of emotional reactions and beliefs about suicide, (b) mental health professionals maintain a collaborative, non-adversarial stance with clients through the use of empathy, (c) mental health professionals demonstrate an understanding of the phenomenon of suicide, and demonstrate an ability to identify potential risk factors. Counselor supervisors must be cognizant of their own thoughts and feelings regarding suicide. Specifically, counselor supervisors must be aware of their own emotions related
to suicide, which may be impacted by previous personal (e.g., the suicide death of a loved one) and professional (e.g., the suicide death of a client) experiences.

**Supervisory Relationship**

The supervisory relationship serves as a fundamental component of the student’s professional development (Henderson, Cawyer, & Watkins, 1999; Ronnestad & Skovholt, 1993). The supervisory relationship, the bond between supervisor and supervisee, includes a number of tasks to be completed during supervision: (a) mastery of counseling skills, (b) increased understanding of client issues, (c) expanding supervisee awareness of process issues, (d) increasing awareness of self, (e) overcoming personal obstacles, (f) increasing understanding regarding counseling theories, (g) providing an impetus to research, and (h) maintaining appropriate standards of care for clients (Bordin, 1983). The supervisory relationship may be especially important during crisis situations. In times of crisis it is important that the supervisor maintain clear communication with the supervisee and provide appropriate assistance, such as helping make decisions about appropriate level of care (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999).

Supervision requires a strong working alliance to handle any ruptures in the relationship that may arise (M. L. Nelson & Friedlander, 2001). Despite the importance of supervisory relationship to clinical training, supervisees often have little formal preparation in their role as supervisee (Vespa, Heckman-Stone, & Delworth, 2002). Supervisees may feel somewhat unprepared to formally assume the role of supervisee, or may be confused as to what the role of supervisee actually entails. In light of this confusion, supervisors must be prepared to deal with a supervisee’s reticence to embrace...
the potentially ambiguous role of supervisee. Supervisors should openly address potential supervisee concerns, with the intention of focusing supervision on the needs of the supervisee and minimizing the potential for a supervisory misalliance (S. S. Rubin, 1989). Supervisors should aim to create an atmosphere of safety, while also challenging the supervisee to go beyond his or her comfort level (Gazzola & Theriault, 2007).

Counselor supervisees may begin the supervisory process with poorly defined expectations regarding the goals of supervision, and the roles of supervisor and supervisee (Bahrick, Russell, & Salmi, 1991). Bahrick et al. used a role induction procedure in which beginning supervisees listened to a 10-minute audiotape that described Bernard’s (1979) model of supervision (e.g., roles and responsibilities of supervisor and supervisee). Results suggested that the process of role induction (i.e., educating the counselor supervisee about the expectations of supervisor and supervisee) may result in improved efficacy of supervision.

Role preparation is a concept similar to that of role induction. Role preparation is described as the process of providing information about what will be expected of clients in therapy and preparing the client to participate in the treatment process (Orlinsky, Grawe, & Parks, 1994). When applied to a supervision context, supervisees are given information about what is expected of them in the supervisory relationship. A written supervision contract is a potential mechanism to help supervisees understand the expectations associated with supervision. Osborn and Davis (1996) suggested that counselor supervisors and supervisees develop a written contract for supervision. The intent of this contract is to clearly establish the roles and responsibilities of both the
counselor supervisor and the counselor supervisee, with the intent of avoiding possible ethical pitfalls. The beginning counselor supervisee’s vulnerability and anxiety make it important for the supervisor to create a relationship characterized by support and understanding (Ronnestad & Skovholt, 1993). It also may be helpful for novice supervisees to have a supervisory relationship that has clear expectations and boundaries, and the written supervision contract may help establish these parameters.

Just as the therapeutic relationship is central to the development of a strong counseling alliance, a supervisory relationship is important to the development of a productive working environment. The conditions of good counseling such as empathy, respect, and a trusting and respectful attitude also play a role in good supervision (Ronnestad & Skovholt, 1993). The supervisory relationship is informed by the uniqueness of two individuals—supervisor and supervisee—and is modified by the demands of the various contexts within which supervision occurs (Bernard & Goodyear, 2004). Ideally, the supervision relationship should be characterized by trust, respect, and concern (Blocher, 1983). A supportive supervision relationship may help motivate the supervisee and provide optimism regarding clinical skills. However, it may also prevent the supervisee from full awareness of skill deficits and possible areas of weakness (Foster, Lichtenberg, & Peyton, 2007). Specifically, if a counselor supervisor avoids discussion of a supervisee’s limitations, the supervisee’s growth may be inadvertently stifled. The counselor supervisor must be appropriately supportive of the supervisee, and yet must also help supervisees develop confidence and competence as a future counselor. It may be important for supervisors to take into account the developmental stage of the
supervisee and the content of the supervision meeting when deciding how much structure to provide during supervision sessions (Tracey, Ellickson, & Sherry, 1989). Supervisors also need to promote the development of a counselor supervisee’s self-confidence because a potential concern in supervision is counselor supervisee disempowerment (Morrisette, 2001).

Counselor supervisees tend to report positive and negative supervisory experiences with nearly equal frequency (Howard et al., 2006). Worthen and McNeill (1996) conducted a phenomenological investigation with eight intermediate to advanced-level supervisees to determine what constituted good supervision from the supervisees’ experience. According to Worthen and McNeill, the most pivotal and crucial component of good supervision experiences was the quality of the supervision relationship. More specifically, favorably-rated supervisors manifested empathy, adopted a non-judgmental stance toward the supervisee, and actively provided support and affirmation. Additionally, self-disclosure by the supervisor played a significant role in helping supervisees (especially those with less experience) to reduce negative perceptions of their behavior (Worthen & McNeill). Supervisors who do not communicate openness to theories and methods proposed by the counselor supervisee may subsequently limit the development of counselor supervisees (Ronnestad & Skovholt, 1993). Counselor supervisees may leave supervision sessions feeling defeated and insecure about their skills and ability to help clients, and for some students, clinical supervision does not represent a time of support and encouragement (Morrisette, 2001). Supervisees working with suicidal clients may be especially prone to feelings of discouragement and insecurity.
due to the potential for inaccuracy in predicting whether a client will commit suicide. Thus, counselor supervisors must provide educative feedback to counselor supervisees in order to support and encourage professional development.

The supervision relationship may be central to the development of effective supervision. Holloway (1995) developed a systems approach to supervision that focuses on the nature of the supervisory relationship. In this relational model of supervision, the relationship is viewed as the process by which supervisees acquire knowledge and skills. The relationship is the primary context for facilitating the involvement of the supervisee and for reaching goals in supervision and designing specific learning tasks and teaching strategies related to supervisees’ development as a professional (Holloway, 1997). Holloway (1995) suggested that a learning alliance emerges in the supervisory relationship. In Holloway’s systems approach to supervision, there are three phases of the supervisory relationship: developing, mature, and termination. The developing phase is characterized by clarifying and establishing the roles and responsibilities of supervisor and supervisee. For example, the written supervision contract would be developed and reviewed during the developing phase. The developing phase is also characterized by the supervisor offering support for the supervisee’s training and development. Supervisees who work with a suicidal client during the developing phase might be offered structure and increased support from the supervisor.

The mature phase is less role-bound. In this stage, supervisees may begin to feel more comfortable with their role because the goals and boundaries established in the first stage enabled the supervisee to have clear expectations about the supervision process.
Supervisees in this stage may display increased confidence as a result of the support and firm boundaries they received. Supervisors may notice increased participation during supervision sessions from supervisees as they gain maturity in their role. Supervisees in this phase who work with a suicidal client may still experience anxiety related to working with a suicidal client; however, they will generally feel ready to work with the client after receiving some direction and support from the supervisor.

In the final phase, terminating, the supervisee displays a decreased need for direction. In this stage, supervisees may feel confident with their abilities and may begin to demonstrate an understanding of the connections between counseling theory and practice. This does not mean the supervisee has outgrown the need for supervision, but rather, feels able to more fully contribute to the supervisory sessions. Similarly, supervisees in this phase may feel some anxiety about their responsibilities for providing services to a suicidal client, yet they may continue to seek feedback and assistance from their supervisors.

Numerous researchers have supported the importance of the supervisory relationship. M. L. Nelson and Friedlander (2001) examined the perspectives of counselor supervisees in determining their experiences in a conflictual supervisory relationship. They conducted 35-to-90-minute semi-structured individual interviews with 13 master’s and doctoral-level supervisees to develop a description of conflictual supervisory relationships that had a negative impact on the supervisees’ training experience. Discourse analysis was utilized to analyze participant responses, and results underscored the importance of the supervisory relationship. Specifically, participants
noted difficulties related to the misuse of supervisor power (e.g., supervisor being overly prescriptive with regard to theoretical approach, supervisor violating supervisee’s confidentiality). Nelson and Friedlander concluded that the quality of the supervisory relationship is essential to positive outcomes in supervision. The presence of a strong supervisory relationship seems to be especially important when the supervisor is expected to provide supervision to a supervisee who is in a stressful situation, such as working with a suicidal client.

*Supervision in Crisis Situations*

Counselor supervisees who experience stressful events may need increased support from their supervisor (Blocher, 1983). Even in non-crisis situations, beginning supervisees may tend to rely on supervisors to tell them the “right” thing to do (Borders, 1989). Tracey et al. (1989) examined the preferences of 78 beginning and advanced level counselor supervisees for structure in supervision by exposing participants to two of four audiotaped supervision sessions. The audiotaped supervision sessions varied on (a) amount of supervisor structure; with participants receiving either the high structure condition (i.e., the supervisor provided clear direction regarding what was discussed in supervision, how the client was conceptualized, and what needed to be done by the supervisor), or the low structure condition (i.e., most decisions regarding what was to be discussed, how to conceptualize the client, or what needed to be done in session, were left to the counselor’s dissection), and (b) content of supervision session (i.e., either a suicidal client or a client with relationship issues). Participants completed four survey instruments designed to assess their reactance potential, their evaluation of supervision, their
evaluation of the supervisor’s effectiveness, and their subjective level of development as a counselor. A three-way MANOVA was conducted to analyze participant’s responses to the suicide content supervision tapes. Results suggested that counselor supervisees, regardless of experience level, preferred structured supervision when working with suicidal clients. Supervision may certainly be helpful for counselor supervisees who work with suicidal clients, but supervision alone cannot compensate for inadequate foundational knowledge regarding how to treat and care for suicidal clients (Lomax, 1986; Ramberg & Wasserman, 2003).

Although counselor supervisors have numerous responsibilities, ultimately, they are charged with making every effort to monitor both the professional actions, and failures to take action, of their supervisees (ACES, 1993). When inexperienced clinicians undertake the treatment of suicidal clients, regular supervision is a necessity (Jobes & Maltsberger, 1995). At the start of the supervisory relationship, supervisees should discuss their feelings regarding working with suicidal clients, specifically their level of competence, comfort, and knowledge of working with suicidal clients (McGlothlin, 2008).

In the aftermath of a client attempted suicide, there may be numerous supervisee needs to address in subsequent supervision sessions. Although limited research has addressed supervisee needs in the aftermath of a client’s attempted suicide, Ellis and Dickey (1998) underscored the importance of meeting the emotional needs of supervisees after the experience of a client completed suicide. Similarly, in situations where the supervisee experiences a client’s attempted suicide, it may be necessary for supervisors to
meet the needs of supervisees through case conceptualizations and discussions. Supervisors may also need to spend time processing the emotional reactions of their supervisees. However, supervisors at times may be reluctant to provide emotional support or advice to counselor supervisees regarding a client’s suicidal behavior because they are concerned that the content of supervision sessions may be subpoenaed in any subsequent legal proceedings, although according to Ellis and Dickey, no legal precedent exists for such a practice. Recently, Dvoskin (2006) outlined the potential legal ramifications, specifically Internet consultation, related to mental health professionals offering casual consultation on counseling cases.

In addition to providing emotional support, Ellis and Dickey (1998) suggested that the supervisor assess whether adjustments are needed in the training or supervisory process of the supervisee. Specifically, the supervisor may need to consider adopting a more directive stance in supervision. Also, counselor supervisors may need to prescribe to the supervisee specific educational experiences (e.g., reading a text on suicide, attending a suicide survivor’s support group, and writing a reaction paper).

The supervision responsibilities related to suicidal clients can be conceptualized as two-fold. First, when working with a client at risk for suicide, it is important to thoroughly evaluate the client and document that an evaluation of the client was completed (Kleespies, Deleppo, Gallagher, & Niles, 1999). Supervisors must be aware of what interventions, assessments, and precautions had been provided during the therapeutic session. Supervisees tend to withhold information from their supervisors, such as clinical mistakes and general client observations (e.g., client presenting problems;
According to Ladany et al., supervisees may be more likely to withhold information when they experience negative reactions toward their supervisors. Thus, it may be beneficial for supervisors to engage in live supervision or to provide co-therapy when there are concerns regarding the client’s risk for self-harm.

Second, supervisors have an obligation to process with the supervisee feelings that may arise as a result of working with a suicidal client (Knox et al., 2006). Counselor supervisees, most of whom have had little experience working with suicidal clients, may feel overwhelmed at the possibility of working with a suicidal client. Considering that supervisees may have had only minimal training in suicide, supervision is likely the primary resource for supervisees to normalize and process reactions to suicidality (Knox et al., 2006; McGlothlin, Rainey, & Kindsvatter, 2005).

A supervisor’s theoretical orientation and model of supervision are elements that affect how a supervisee manages a crisis intervention process (Charlés, Ticheli-Kallikas, Tyner, & Barber-Stephens, 2005). McGlothlin et al. (2005) developed a model of supervision, the Cube Model of Supervision and Suicide, to address the supervisory needs of counselor supervisees who work with potentially suicidal clients. This model incorporates various models of suicide assessment with the three levels of the Integrated Development Model (IDM; Stoltenberg et al., 1998) and elements of the Discrimination Model of counselor supervision (Bernard, 1979) to guide assessment of suicide lethality, supervisee developmental level, and supervisor role. The model is visually conceptualized as a 3x3x3 cube that considers client suicide lethality (low, moderate,
Supervisors must demonstrate an ability to suggest appropriate therapeutic interventions when counselor supervisees are called upon to provide therapeutic services to potentially suicidal clients. Supervision using, at minimum, weekly direct observation or videotape review should accompany the provision of counseling services to seriously ill or at risk clients to decrease the risk of inadequate assessment or treatment (Foster & McAdams, 1999). It is important for supervisors to know what their supervisees are doing during the course of their counseling sessions. Moreover, supervisors must be able to suggest appropriate interventions for potentially suicidal clients.

Client Suicidal Behavior and Mental Health Treatment

Maltsberger (2006) recommended that counselors who treat potentially suicidal clients must first establish a therapeutic alliance, with the focus of such an alliance the mutual intent to increase reasons for living. Empathically connecting with a client focused on dying may be difficult and may pose significant barriers to effective treatment (Jobes & Maltsberger, 1995). When attempting to establish a therapeutic alliance with a potentially suicidal client, Shneidman (1996) suggested that the most important questions are “Where do you hurt?” and “How can I help you?” (p. 6). Similarly, Paulson and Worth (2002) utilized concept mapping to examine helpful elements of counseling as reported by 35 clients who had recently experienced suicidal ideation or who had made a suicide attempt. Concept mapping is a methodological approach that involves three basic operations: (a) participants generate ideas, thoughts, or experiences through an
unstructured card sort; (b) participants group together the ideas, thoughts, or experiences through an unstructured card sort; and (c) card sort data are statically analyzed. Overall, participants indicated that the most helpful aspect of counseling was acknowledging and overcoming feelings of helplessness and despair.

Suicidal behavior may elicit negative reactions from clinicians (Bongar, 1992). When a client experiences a disconnection from his or her counselor it may reinforce his or her perceptions of isolation and despair (Paulson & Worth, 2002). Moreover, unless suicide is a current issue, many therapists do not explore the possibility that the client may have been suicidal in the past (Rogers & Soyka, 2004). Avoiding the topic of suicide may, in turn, perpetuate the notion that suicide is a taboo subject and may not allow the client the opportunity to integrate his or her suicidal behavior into the treatment process in a way that will help the client move forward (Rogers & Soyka, 2004). Similarly, if supervisors avoid the topic of suicide in supervision sessions, they may inadvertently reinforce the notion that suicide as a topic should be avoided in discussions between client and counselor.

In a study of therapists who had experienced a client’s completed suicide, Hendin, Haas, Maltsberger, Koestner, and Szanto (2006) found six recurrent problem areas related to the provision of psychotherapy services: (a) lack of communication with other treatment providers, (b) permitting clients or client relatives to control therapy, (c) avoidance of issues related to sexuality, (d) ineffective actions resulting from the therapist’s anxiety, (e) not recognizing the meanings in client communications, and (f) under-treatment of client symptoms. Perhaps most noteworthy to the present discussion is
the relationship of therapist anxiety and ineffective actions. Hendin et al. found that therapists’ anxiety regarding the possibility of suicide interfered with their ability to treat clients properly. Although the current study did not examine situations involving completed suicide, Hendin et al.’s results may be applicable for supervisory issues involving client suicidal behavior (i.e., suicidal ideation, suicidal gestures, and attempted suicide). Specifically, it might be possible for supervisor anxiety about potential client suicide to interfere with the supervisor effectively providing supervision.

**Impact of Client Suicidality**

There is limited research on the impact of client suicidality on counselor supervisors and counselor trainees. However, some research has examined the impact of completed suicide on mental health professionals. In the aftermath of a client’s completed suicide, therapists often experience a myriad of emotions such as anger and helplessness, and in turn, they may demonstrate hyper vigilance in future interactions with clients (Knox et al., 2006). Interestingly, in a study of 54 psychology interns Kleespies et al. (1990) found that working with a client who attempted suicide produced levels of distress similar to those experienced when a client commits suicide. Thus, whether a client has survived or died from a suicide attempt, the levels of distress for therapists may be quite similar. This is likely due to the many factors related to the aftermath of the action. For example, in a completed suicide, counselors may experience shock, disbelief, grief, distress, or anxiety about possible litigation (Kleespies et al., 1993; McAdams & Foster, 2000). In the aftermath of a suicide attempt, counselors may experience self-blame for failing to prevent the attempt, concern about continued work with client, and doubt in
their ability to help clients (Knox et al., 2006). Although counselor supervisors may experience similar emotions in the aftermath of a client suicide or attempted suicide, they may also experience additional feelings related to their role as supervisor (e.g., anxiety regarding liability concerns, concern related to professional competence as a supervisor). No published research has examined the impact of client suicidality on counselor supervisors.

A client suicide attempt can induce a strong emotional reaction (e.g., anxiety, fear), or even a professional crisis, when experienced by a supervisee (Kleespies, 1993). Supervisees may be more vulnerable to the stresses experienced with a client’s completed suicide or suicide attempt than are more established clinicians (Kleespies et al., 1990). Thus, counselor supervisors will likely be pivotal in helping supervisees after a client attempts suicide because, in general, client situations concerning death trigger heightened subjective distress for counselor supervisees (Kirchberg et al., 1998). It is important for counselor supervisors to provide support and assistance to help counselor supervisees effectively work with issues pertaining to suicidal behavior in clients. A strong therapeutic working alliance may be especially important in these situations.

Counselor supervisees may experience many emotions after learning of a client’s suicide attempt. Interns who experienced a client’s suicide attempt described their reactions to the attempt as shock, anger, sadness, loss of self-confidence, fear, discouragement, sorrow for the client, and relief that the client was still alive (Kleespies et al., 1990). Birtchnell (1983) suggested that counselors may interpret a client’s suicide attempt as a form of rejection of the counselor and that the counselor may feel that he or
she has failed as a clinician. However, the working alliance between a client who recently attempted suicide and his or her counselor can be improved when the counselor acknowledges his or her emotions and the relevance of understanding those emotions to understanding the client’s suicidality (Michel et al., 2004). It may be important then, for counselor supervisors to help counselor supervisees verbally express their feelings related to the client’s suicidality. Counselor supervisors also have a responsibility to assist counselor supervisees in their continued work with a suicidal client. They also have a responsibility to assess the competency of the counselor supervisee and determine if the client’s needs may be best served through a referral to another counseling professional.

A client’s attempted suicide may suggest to the counselor supervisee that a completed suicide will eventually occur (Kleespies et al., 1993). Supervisees who work with clients who attempted suicide may require greater support and intervention from their supervisors (Kleespies et al.). In the aftermath of a client’s completed suicide, it may be helpful for the supervisee to process with the clinical supervisor feelings such as grief, responsibility, and other emotions associated with the incident (Lafayette & Stern, 2004). Similarly, after a client has attempted suicide, it may be beneficial for the supervisee to develop with the supervisor a plan for future counseling sessions with the client.

Counselor supervisees enrolled in a practicum experience in a university counseling center will most likely be providing some proportion of their counseling services to college students. Providing effective counseling to suicidal students in a college counseling setting is an intensive process, and it may require working with the student’s family, residence hall staff, academic department, psychiatrists and health
Counselor supervisees may need assistance from their supervisors to help navigate the additional adjunct services available to clients. Due to the complexity of college students’ mental health concerns, supervisors have found a greater need to be available outside of scheduled supervision hours to consult with interns on more complex and severe cases (Benton et al., 2003).

Summary

The purpose of the current study was to generate an emergent theory of the process of counselor supervision for counselor trainees who work with suicidal clients. Previous research (e.g., Kleespies et al., 1990; Knox et al., 2006; McAdams & Foster, 2000) suggests that supervisees may experience concern about continued work with a client and may have doubts regarding their ability to help a client. Whether the client’s suicidal behavior took place immediately preceding the formation of the counseling relationship, or during counseling, it is reasonable to assume that the counselor supervisee may struggle working therapeutically with the client and controlling his or her own desire to protect the client from harm. Although no previous research has specifically examined the impact of client attempted suicide on counselor supervisors, it seems that supervisors may experience issues similar to counselors after a client suicide attempt (e.g., anxiety, fear, and self-doubt).

A suicide attempt is a strong predictor of a subsequent completed suicide (Brown et al., 2000); therefore, counselor supervisors must demonstrate an ability to help counselor supervisees assess for any potential indicators of continued suicidal ideation. In
addition to the continued monitoring of the client’s well-being, supervisors must also help facilitate the supervisee’s growth and professional development. In sum, although the experience of client suicidality may be one of the most stressful professional events experienced by counselors, it may be all the more intense for counselor supervisors due to their responsibility to both the supervisee and the supervisee’s client.

Chapter I introduced the study and reviewed relevant literature. Chapter II describes grounded theory as a method of qualitative inquiry appropriate for the study of counselor supervisors’ perspectives of providing supervision to counselor supervisees who worked with suicidal clients. The procedures used for participant selection, data collection, establishing trustworthiness, and data analysis are explored.
CHAPTER II
METHODOLOGY

Research on supervisory issues with suicidal clients has focused on the limited graduate training on suicide for counselor supervisees (Foster & McAdams, 1999), supervisee perspectives regarding working with suicidal clients (Knox et al., 2006; Tracey et al., 1989), the emotional reactions of supervisees in the aftermath of a completed suicide (Ellis & Dickey, 1998), and supervising psychologists’ responsibilities after a client’s completed suicide (Kleespies et al., 1999). No current published research has examined the process of counselor supervision for counselor trainees who work with suicidal clients. The current study was designed to generate an emergent theory of the process of counselor supervision for counselor trainees who work with suicidal clients.

Purpose of the Study

An assumption was that counselor supervisors’ views about the process of counselor supervision for counselor trainees who work with suicidal clients may include such things as securing client safety, facilitating client growth, and promoting counselor trainee (i.e., pre-licensed counselor) maturation. Given the responsibility and intensity of the supervisory relationship, supervisors are well positioned to help supervisees understand and learn from client suicidal behavior (Knox et al., 2006). Thus, it seems worthwhile to investigate the perspectives of counselor supervisors regarding the process of supervision for counselor trainees who work with suicidal clients. The question that guided the current study was: How do five counselor supervisors express the process of
supervision for counselor trainees who work with suicidal clients (i.e., clients with suicidal ideation, suicidal ideation with plan for suicide, or clients who attempt suicide)?

Qualitative Inquiry

Qualitative research is an interpretive, naturalistic approach to investigating the world (Denzin & Lincoln, 2005) which allows the researcher to understand the meanings people assign to their experiences (Creswell, 2007; Polkinghorne, 1991). Qualitative methods typically produce a wealth of detailed information about a defined group of people with the goal of increasing the depth of understanding of a particular event, situation, experience, or process (Patton, 2002). According to Creswell (2007), qualitative research is appropriate for providing a complex, detailed understanding of an issue.

Perhaps most relevant to the current study, qualitative research is useful in developing ideas or theories when partial or inadequate theories exist for certain populations (Creswell, 2007). As previously mentioned, no current published research has examined the process of counselor supervision for counselor trainees who work with suicidal clients. Qualitative research was intentionally chosen for the current study because it enabled the participants to describe their processes of supervision for suicidal clients.

Grounded Theory as Qualitative Inquiry

Grounded theory, a method of qualitative inquiry, was selected for the current study. Merriam (2002) suggested that qualitative research is based on the idea that meaning is socially constructed. Qualitative research assumes that reality is constructed
within a particular context, and as such, there is no objective reflection of reality (i.e., no one perspective; Burck, 2005); rather, there are multiple constructions and interpretations of reality (Merriam, 2002). Other qualitative research modalities that may have been appropriate for the present investigation were phenomenology and case study methods. Phenomenological research describes the meaning of experience for a group of individuals, and case study research investigates a bounded system (i.e., case) over a period of time through the collection of multiple sources of information (e.g., observations, interviews, and documents; Creswell, 2007). Ultimately, grounded theory was selected as the most appropriate methodological approach because of the researcher’s wish to generate a theory of a process (Strauss & Corbin, 1998), the process of supervision for counselor trainees with suicidal clients.

Grounded theory research employs systematic guidelines for collecting and analyzing qualitative data with the intent of constructing theories grounded in data (Charmaz, 2006). Glaser and Strauss (1967) developed grounded theory as a research method to construct theoretical explanations of social processes. The term grounded implies that theories are generated from the data collected throughout the research process (Glaser & Strauss, 1967; Strauss & Corbin, 1998). Although grounded theory has many advantages as a qualitative method, perhaps the greatest strength of grounded theory is its ability to generate theories about processes (Burck, 2005).

Grounded theory is generally considered a good fit for a research project when an existing theory is not available to explain a process (Creswell, 2007). In grounded theory, data collection and analysis are not separate phases of research, but rather represent a
continuous iterative process (Glaser & Strauss, 1967). Creswell (2007) likened the research process to a zigzag, one in which the researcher is “out to the field to gather information, into the office to analyze the data, back to the field to gather more information, into the office, and so forth” (p. 64).

Recent researchers have recommended revisions to the grounded theory model developed by Glaser and Strauss (1967). Charmaz (2006) suggested that grounded theory is a way to learn about the worlds (e.g., supervisory processes) studied and is a method for developing theories to understand them. However, Charmaz maintained that grounded theories are not discovered, but rather constructed through the researcher’s involvement with participants, perspectives, and research practices. Thus, this updated model of grounded theory advocates for a social constructionist perspective that includes diverse views and actions (Creswell, 2007).

The task of grounded theory methodology is to assist the researcher in understanding the meaning of human experiences and behaviors (Rennie, 1994). The major difference between grounded theory and other methods of qualitative inquiry is the emphasis on theory development (Strauss & Corbin, 1998). The grounded theory approach provides a set of inductive steps that lead the researcher from studying constructed realities to rendering a conceptual understanding (i.e., theory) of them (Charmaz, 2002). The data form the foundation of the generated theory and, in turn, the analysis of the data generates the concepts constructed (Charmaz, 2006).

Current supervision research has benefited from both qualitative and quantitative methods of inquiry. Ultimately, the goals of the research project dictate the selection of
the most appropriate methodological approach. A grounded theory approach enabled the current researcher, with assistance from participants, to co-construct the process of supervision for counselor trainees who work with suicidal clients.

Procedures

*Purposive Sampling*

Purposive research sampling is a technique used to ensure that all participants have experienced the same situation or condition (Berg, 2001). For the purposes of the current study, it was important that participants had provided supervision to a practicum student who had worked with a suicidal client. The purposive sampling technique fits with Polkinghorne’s (2005) recommendation that participants in a qualitative study “are not selected because they fulfill the representative requirements of statistical inference but because they can provide substantial contributions to filling out the structure and character of the experience under investigation” (p. 139).

Inclusion criteria were developed to select participants who had provided supervision to a counselor supervisee who worked with a suicidal client. The researcher was interested in ensuring that all participants had experienced the situation under investigation (i.e., supervision of a counselor trainee working with a suicidal client) within the past two years. The researcher limited the length of time to within the past two years to ensure that participants were able to recall a detailed description of their experience. The intent of the current study was to contribute to the counselor supervision literature. Thus, the researcher included only participants who identified as a professional counselor, so those who identified as a psychologist, social worker, or a member of
another helping profession were not considered for inclusion in the current study. The researcher intentionally selected participants from diverse geographic regions as rates of suicide attempts vary across the United States. Finally, in order to promote diversity in responses, the researcher selected two female and three male participants for the current study.

Approval was obtained from the Kent State University Human Subjects Review Board (HSRB) prior to making contact with research participants (see Appendix A for HSRB Approval Form). In order to identify participants, the researcher first consulted the CACREP (n.d.) *Directory of Accredited Programs* and then visited program websites to determine which programs housed a counseling clinic. The researcher developed a list of all CACREP-accredited counseling programs with counseling clinics. Potential participants were first contacted via email (see Appendix B for a copy of the recruitment email sent to potential participants). Those who expressed interest were screened via a brief email correspondence to ensure they met full criteria for the study: (a) held a doctoral degree in counselor education; (b) held, at the time supervision was provided, a license as a professional counselor; and (c) provided clinical supervision as a clinic director in a counseling clinic/practicum training lab, within the past two years, to a supervisee (i.e., practicum student) who worked with a suicidal client. Appendix C provides the inclusion criteria for the participants and a detailed step-by-step account of the process used to recruit participants.

Five potential participants who met the three criteria were invited to participate in the study. All participants were informed of the duration of data collection and
preliminary data analysis (approximately 4 months) and were told that they would be asked to participate in three rounds of individual interviews and one individual member check interview. Because all five of the participants initially contacted agreed to participate in the study, there was no need to develop a waitlist of potential participants.

Written informed consent was obtained from all participants prior to the first interview. Two copies of the informed consent document (see Appendix D) were mailed to all participants for their review. Participants were asked to sign and return one copy of the consent form. After receiving the signed informed consent forms, the researcher contacted each participant to schedule the initial individual interview that occurred via telephone. Telephone interviews were scheduled within two weeks of receiving all participants’ signed informed consent document. First interviews with participants did not commence until all five written consent forms were received and all five participants had scheduled interviews.

Participant Characteristics

Participants included five counselor supervisors from separate institutions across the United States. Each participant occupied the role of director of a counselor education counseling clinic/practicum training lab in a CACREP-accredited counselor preparation program. Participants included only those who had earned doctoral degrees in counselor education (e.g., completed a required course in counselor supervision as part of their doctoral studies).
Counselor Licensure

Counselor licensure laws vary according to the laws set forth in each state. In the current study, counselor supervisors had obtained the independent counselor license in their state and had received formal supervisory training.

Practicum Supervisory Duties

All participants provided direct, individual, face-to-face supervision to master’s-level counseling students enrolled in a counseling practicum course. The practicum experience took place on-site, in the counselor education counseling clinic/practicum training lab each participant directed.

Length of Time

In order to ensure participants were able to provide a detailed perspective of their experience, participants were only chosen if they had experienced the process under investigation within the past two years. This length of time was intentionally selected to ensure that participants’ experiences were recent enough to discuss in sufficient detail. Thus, all participants had provided supervision to a supervisee (i.e., practicum student) within the past two years who had at least one client with suicidal ideation.

Client Suicidal Behavior

All participants had provided supervision to a supervisee who provided counseling to a suicidal client. For purposes of the current study, a suicidal client is a client who reported thoughts of suicide, a plan for suicide, or who had engaged in a suicide attempt (e.g., overdosing on a medication). Supervisors who worked with a client
who committed suicide (i.e., a suicide attempt that ended in death) were not included in the current study.

Diversity

To promote diverse responses, three participants were males and two were females. Participants represented three of the five Association for Counselor Education and Supervision (ACES) regions.

The following pseudonyms were selected by the researcher to protect the identities of participants: Michael, Angela, Andrew, Ryan, and Meredith. All five participants were employed in a doctoral-degree granting program. All five participants maintained involvement throughout the four-month duration of data collection. All participants worked in counselor education training clinics that used a combination of live observation and videotaped review for practicum supervision. None of the participants reported utilizing bug-in-the-eye or bug-in-the-ear technology in their training clinics. All participants worked in a counselor training lab/clinic that provided services to both university students and community clients.

Researcher Qualifications and Involvement

In qualitative research, it is important to clarify potential researcher bias at the outset of the research, including any past experiences, prejudices, and orientations that may shape the interpretation and approach to the study (Creswell, 2007). Awareness of possible biases is paramount because the credibility of qualitative research depends on the skill, competence, and rigor of the researcher (Patton, 2002). In the present study, the researcher conducted all interviews. The researcher is a Caucasian female who is
currently a doctoral candidate in the CACREP-accredited Counselor Education and Supervision doctoral degree program at Kent State University, a public university located in Northeast Ohio. She is a licensed Professional Clinical Counselor in Ohio and a Nationally Certified Counselor. She has worked as a licensed professional counselor in community mental health for approximately four years. She is an ACES student member, is single, heterosexual, middle class, and does not have any children.

The researcher’s primary interest in the topic arose from working with child and adolescent clients in an inpatient mental health unit during her master’s counseling internship. Many of the clients had either attempted suicide prior to the inpatient admission, or had a plan to commit suicide. The researcher found her internship site supervisor to be invaluable in helping her conceptualize client cases, determine appropriate treatments, and process feelings of anxiety that arose from working with a high-risk population.

Additionally, during her time as a doctoral student supervisor, the researcher supervised a practicum student in a master’s degree counseling program who worked with a client with active suicidal ideation. The researcher experienced some difficulty in balancing the immediate needs of the client, with the needs of the supervisee. Specifically, the researcher felt that she struggled to ensure that the supervisee had sufficient time in which to process the experience of working with her first suicidal client. Thus, the researcher was interested in understanding how counselor supervisors view the process of supervision for suicidal clients.
Data Collection Protocol

Appendix E contains a flow chart describing the procedures utilized in the present study. First round individual interviews were semi-structured and lasted approximately 45 minutes. The interviews took place via telephone due to the geographical locations of participants. The initial interview (i.e., Round I) focused on supervision processes in general and also participants’ views of suicidal clients. Follow-up interviews (i.e., Round II and Round III) were developed based on data analyzed from the first two interviews.

An electronic digital recording device recorded all interviews (i.e., interview Rounds I, II, III, and the member check conversation). An electronic folder on the researcher’s personal desktop computer was designated to hold all interview data. The personal computer was password protected and accessible only to the researcher. Additionally, the electronic folder was also password protected. In order to ensure the safety of the data, the electronic file was routinely backed up on an external hard drive and a jump drive. To maintain the security of the data, both the external hard drive and the jump drive were password protected.

During each interview, the researcher wrote process notes. The aim of the process note (described later in this chapter) is to help the researcher bracket (i.e., separate her personal beliefs and biases from the research process) assumptions and expectations (Rennie, 1994). Within seven days of the completion of each interview, the researcher transcribed the audio recording. The researcher also created a memo within two days of transcribing the interview. The intent of the memo was to link the data coding to the writing of the analysis (Charmaz, 2002). The member check interview was conducted
individually with all participants one month after all three rounds of interviews were completed and preliminary data analysis conducted.

_Semi-Structured Interview Format_

The participant interview process in grounded theory differs from other types of qualitative interviewing in that the researcher narrows the range of interview topics with each successive interview to gather specific data for her theoretical framework (Charmaz, 2002). In grounded theory, the interview questions focus on understanding how individuals experience the process under investigation (Creswell, 2007). A grounded theory interview is open-ended but it is framed and focused on the experience under investigation (Charmaz, 2002) and the in-depth nature of the interview elicits participants’ interpretation of their experience (Charmaz, 2006). Following the structure suggested by Charmaz (2006), the first interview (i.e., Round I) was somewhat flexible (e.g., “Please tell me about a time when you supervised a counselor trainee who worked with a suicidal client”), whereas subsequent interviews (i.e., Round II and Round III) were slightly more structured, and focused on identifying and elaborating on theoretical assumptions (e.g., “Can you tell me a little bit more about the debriefing process that you mentioned in our last interview?”).

After initially exploring the process under investigation, and conducting preliminary data analysis, the researcher returned to the participants, in Round II and Round II interviews, to ask more detailed questions that helped shape the coding process. Charmaz (2002) suggested that this multiple interview format allows each participant’s story to gain depth and detail, and the continual process of data collection and analysis
allows the researcher to follow up on earlier leads, to strengthen the emerging analysis, and to move closer to an understanding of the process itself. In sum, the data collection process is a recursive and iterative process in which feedback informs and shapes further inquiry (Burck, 2005).

*Interview Questions*

The researcher developed a semi-structured protocol for each round of interviews. Semi-structured individual interviews are the most common method of data collection in grounded theory (Fassinger, 2005). Although a semi-structured protocol was used, the researcher followed Charmaz’s (2006) recommendations for developing questions that were broad and open-ended. Specifically, Charmaz (2002) noted that questions must be sufficiently general to cover a wide range of experiences but must be narrow enough to explore each participant’s personal experience (Charmaz, 2002).

*Round I Interview Protocol*

Prior to beginning the interview, the researcher reiterated the purpose of study and informed each participant that the study had received Kent State University HSRB Approval (See Appendix A). Additionally, each participant was reminded that strict confidentiality standards would be maintained throughout the data collection and analysis process. Finally, participants were informed that all potentially identifying information (e.g., supervisor and supervisee names, institutional affiliation) would be masked to protect their anonymity.

The following prompt was used to help participants describe their experience of supervising a trainee who worked with a suicidal client: “Think back to the last time that
you supervised a counselor trainee who worked with a suicidal client. Describe for me, if you would, what happened.”

Additional (i.e., follow-up) questions were developed based on the participants’ responses. Examples of follow-up questions were:

1. “How long ago was that?”
2. “What makes this case stand out?”
3. “What did you learn from the process?”
4. “Was this supervisory experience different than your customary supervisor practice? If so, how was it different?”
5. “How did you respond?”
6. “Did you experience any concerns relating to the supervisee in your ongoing relationship with him or her?”

Round II Interview Protocol

Round II questions were formulated based on data analysis from Round I (e.g., “You mentioned that you worked with your supervisee to help develop her confidence. Can you tell me more about what exactly you did to help your supervisee develop confidence?”). Questions were formulated for each individual interview, and therefore all participants were not asked the exact same questions. The following questions represent the types of questions asked of participants:

1. “How does your personal model of supervision fit a trainee who has a suicidal client? Do you have to adapt it in any way?”
2. “What is your biggest concern when your trainee has a suicidal client?”
3. “Please describe your process of debriefing.”

4. “What are your concerns with regard to supervisor liability?”

5. “You mentioned in our first interview that most supervisees seek out support from you immediately when there is a suicidal client. I wonder if you ever had a time when that did not happen. For example, have you ever had a supervisee who did not come to you for assistance when working with a suicidal client?”

6. “Tell me a little bit more about supervisee empowerment. What does it look like and how do you know if your supervisee is empowered?”

7. “As clinic director, you work with trainees over a period of time; however, you also are responsible for providing immediate supervision in situations with a suicidal client. Which do you find more challenging: continued work with a supervisee or one-shot supervision sessions with a trainee who consults? Why?”

8. “You mentioned that you assess supervisee competence to determine if supervisees are capable of working with suicidal clients. How do you assess competence? How do you know if trainees are competent?”

9. “From a counselor education standpoint, do you believe that working with a suicidal client is a good learning experience for trainees? Why or why not?”

10. “Do you have anything else you would like to add to this interview?”
Round III Interview Protocol

Consistent with the tenets of grounded theory, Round III questions were formulated based on data analysis from Round I and Round II. The following questions were asked of all five participants during the Round III interviews:

1. “What changes, if any, are needed in the preparation of counselor trainees for working with suicidal clients?”
2. “What do you believe is a key ingredient of a successful supervisory relationship with trainees who have anxiety about working with a suicidal client?”
3. “In the aftermath of working with a suicidal client, what have you found to be the most frequent trainee reaction?”
4. “Can you tell me a little bit about your own emotional reaction to a supervisee working with a suicidal client?”
5. “How do you process your own emotions in the aftermath of dealing with the suicidal behavior of a trainee’s client?”
6. “In what ways did your own experience as a counselor or a counselor trainee working with suicidal clients impact your practice as a supervisor?”
7. “I am going to read you a statement from one of the participants in this study. This statement was made in regard to the supervisor’s emotional response to having a trainee work with a suicidal client. It goes as follows: ‘I think sometimes supervisors can be very stressed out and afraid themselves and be a
little too critical and judgmental and come down on the trainee.’ Can you please tell me your thoughts on this statement?”

8. “Do you have anything else you would like to add to this interview?”

Trustworthiness Procedures

Researchers need to be aware of the assumptions and perspectives they might import into interview questions (Charmaz, 2002). Qualitative researchers must find ways to maintain self-reflexivity (i.e., to own their ideas and to bracket them in analyzing the data); otherwise, the potential exists of analyzing the data to support what they hoped to find (Burck, 2005). Fassinger (2005) and other grounded theory researchers stipulated that the procedures for researcher reflexivity be made apparent. Creswell (2007) recommended that qualitative researchers engage in at least two trustworthiness procedures. The current study used four procedures (i.e., process notes, memos, peer review, and member check) to help the researcher establish self-reflexivity and, as a result, establish the trustworthiness of the study.

Process Notes

Process notes were used to help the researcher bracket her assumptions and expectations (Rennie, 1994). Process notes can help the researcher identify speculations, feelings, problems, hunches impressions, and prejudices (Bogdan & Biklen, 2006). The researcher wrote process notes during and immediately following the interviews (i.e., within 30 minutes) to ensure that she was able to capture her immediate reactions to the interviews. Writing process notes was similar to the process of journaling and made the
researcher’s reflexivity more apparent by capturing the ideas, observations, assumptions, biases, insights, and choices of the researcher (Fassinger, 2005).

The researcher noted the following in each of her process notes: her thoughts (e.g., ―I agreed with most of what he said, he seemed to blend a great deal of clinical experience with scholarly research‖), her impressions (e.g., ―He is a seasoned supervisor and seems like he could handle even the most difficult situation‖), her feelings (e.g., ―I felt like she had a strong sense of her role as a supervisor‖), her observations (e.g., ―I did a lot of prompting in this interview‖), and any potential questions to clarify in subsequent interviews (e.g., ―I wonder if she has ever had a situation where a supervisee did not consult with her when working with a suicidal client, but instead, attempted to work independently.‖).

Memo Writing

Memo writing links the data coding to the initial phase of data analysis (Charmaz, 2002) and records the researcher’s ideas about developing categories and their interconnectedness (Montgomery & Bailey, 2007). Memo writing, a pivotal intermediate step between data collection and analysis (Charmaz, 2006), occurs continually throughout the research process (Fassinger, 2005). In grounded theory, memos help to elaborate on processes used while defining codes (Charmaz, 2002). Charmaz (2002) stated that the use of the memo is to help the researcher explore her own ideas and write down questions for future reference. Writing memos during each phase of the study is intended to strengthen the ongoing data analysis process in terms of clarity and theoretical relevance (Charmaz, 2002).
Memo writing provides a record of conceptual, procedural, and analytic questions and decisions (Fassinger, 2005). In the present study, memo writing consisted of ongoing notes kept by the researcher that detailed the decisions made in the process of collecting, analyzing, and interrogating the data. Charmaz (2006) suggested that no one single mechanical procedure defines a useful memo. However, the following procedures are generally useful in the composition of an effective memo: (a) study the emerging data; (b) title each memo as specifically as possible; (c) record, from the researcher’s perspective, what is happening with the data (e.g., “It appears that debriefing is an important component in the aftermath of a trainee working with a suicidal client.”); and (d) identify the beliefs and assumptions that support codes (e.g., “projecting calm and confidence appears to be an important component of the role of the supervisor”). In sum, “memo writing forms a space and place for explanation and discovery” (Charmaz, 2006, p. 82).

The memo writing format utilized in the current study incorporated the following components: (a) data unit, (b) meaning unit, and (c) subcategory (if applicable). Appendix F provides the basic format of the memo. In order to reference the source of the data, a capital letter (i.e., A, B, C, D, and E) was used to identify each participant, a Roman numeral was used to identify the interview (i.e., I = Interview Round 1, II = Interview Round 2, III = Round 3, and IV = Member Check), and the page and line number from which the original data unit was associated were also recorded. Thus, a data unit from page 6, line 23 of the transcript from the Round II interview conducted with Participant C would be labeled as: C, II, 6, 23.
After transcribing Round I interviews with each participant, the researcher began organizing the transcript into data units; these data units (i.e., single pieces of interpretable information) were then organized and coded in the memo. Once all data units were identified, the researcher returned to the memo and assigned a meaning unit (i.e., a descriptive label) to each data unit. For example, in Round II the following data unit: “I think the biggest thing for me that’s not helpful is to just really come down on the trainee and to focus most or all on just the negative—what the person didn’t do . . . to be very judgmental and critical” (Michael, II, 6, 247), was interpreted by the researcher as Michael describing the potential for the experience of working with suicidal clients to be somewhat disempowering for the trainee. Thus, the meaning unit assigned was “potential disempowerment.” Upon further levels of data analysis, it appeared that the idea of potential trainee disempowerment fit within the subcategory Potential Pitfalls of Working With the Suicidal Client, which was encompassed by the key category Working With Suicidal Clients as a Formative Learning Experience. This process was followed throughout the data analysis process for all three rounds of interviews.

Peer Review

Creswell (2007) recommended the use of a peer reviewer for consultation and feedback. Burck (2002) described the peer reviewer’s role as that of helping the researcher identify prior assumptions and ideas. The peer reviewer embodies an external perspective and, in that capacity, provides a check of the research process. The benefit of utilizing a peer reviewer is to maintain researcher objectivity (Lincoln & Guba, 1985).
Lincoln and Guba stated that the peer reviewer keeps the researcher honest by asking questions about methods, meanings, and interpretations.

In the current study, the peer reviewer had expertise in grounded theory but was not affiliated with the research project. The peer reviewer was an independently licensed professional clinical counselor who also had a state-issued counselor supervisor endorsement. The peer reviewer holds a Ph.D. in counselor education and supervision and she had conducted research on the topic of counselor supervision. At the time of the study, the peer reviewer was employed as a professional counselor specializing in clients with severe and persistent mental illness at a large community counseling agency. The researcher provided the peer reviewer with a copy of the purpose of the current study, statement of the problem, research question, and memo format prior to the commencement of data collection. The peer reviewer was not given any identifying information about the participants.

The peer reviewer monitors the overall process and product of the study (Fassinger, 2005). In the current study, the peer reviewer was consulted on four occasions throughout data collection and analysis (See Appendix G for the Peer Review Format). The peer reviewer was consulted immediately following the transcription of Round I interviews. The peer reviewer was provided with the interview guide, the resulting interview transcription, and all Round I memos. The peer reviewer reviewed the material and then provided suggestions and comments to the researcher. For example, the peer reviewer noted that trainee self-doubt seemed to be an emerging theme, and she
encouraged the researcher to ask follow-up questions to elicit more information on this idea.

The researcher considered all of the peer reviewer’s feedback when developing interview questions for Round II and Round III interviews. Beginning with Round II interviews, the peer reviewer was provided with a summary of the emerging categories from the data analysis. The peer reviewer was helpful in assisting the researcher to identify lines of inquiry with which to follow-up in Round II and Round III interviews. For example, after reviewing Round II transcriptions and memos, the peer reviewer noted that Michael was the only participant who had discussed the potential for supervisors to respond critically to trainees during crisis situations. The peer reviewer believed that other participants may have thoughts on the potential to respond critically to trainees and she recommended that the researcher follow up with all five participants in Round III on this area. Thus, in Round III, all participants were read Michael’s quote and asked to respond with their thoughts on the statement.

The peer reviewer was also provided with the member check transcription. The peer reviewer was asked for her feedback on the member check process and the peer reviewer’s feedback was included in the final interpretation of the data. Additionally, the peer reviewer’s suggestions and comments were utilized in the data analysis process throughout all three rounds of interviews. For example, while reviewing the Round II data, the peer reviewer suggested that one of the emerging categories, Supervisor Reaction, seemed to fit within the key category of the Role of the Supervisor. The
researcher agreed with the peer reviewer’s recommendations and *Supervisor Reaction* was moved to a subcategory of the *Role of the Supervisor.*

**Member Checking**

In member checking, the researcher was interested in soliciting participant views of the emergent theory (Lincoln & Guba, 1985). Lincoln and Guba indicated that member checking is “the most critical technique for establishing credibility” (p. 314). Creswell (2007) cautioned against simply asking participants to review transcripts or raw data, but rather participants should be encouraged to reflect on researcher-identified themes and to comment on what may be missing from the analysis. In the current study, participants were emailed a copy of the written analysis of data (i.e., the interpretation of all three rounds of interviews in text form; see Appendix H for the member check instructions). After participants reviewed the analysis, the researcher conducted a 30-minute individual and semi-structured telephone interview to obtain their feedback on the analysis. Each member check interview was scheduled approximately two weeks after participants received the materials to review and within one month of the last interview (i.e., Round III). The researcher asked each participant the following questions to solicit feedback about the emerging theory:

1. “What has the interview process been like for you?”
2. “How does the preliminary organization of the data represent your process of supervision for suicidal clients? In what ways does the preliminary organization of the data not represent your process of supervision for suicidal clients?”
3. “What areas need to be clarified so as to accurately reflect your process of supervision for suicidal clients?”

4. “Throughout the interview process, participants stated that it was difficult to conceptualize the actual events that constitute their process of supervision. How has your conceptualization of the process of supervision for suicidal clients been formalized through the interview process, if at all?”

5. “Is there anything else you would like to add about the interview process, the emerging themes, or the transcriptions?”

Data Analysis

In grounded theory, a constant comparison method of data analysis is employed using open, axial, and selective coding (Fassinger, 2005). The emergent theory is constantly being verified and modified through continued interaction with participants (i.e., in the individual interviews) until theoretical saturation is reached (i.e., no new categories emerge from the gathering of further data) and a grounded theory is articulated (Fassinger). The eventual or emergent theory is intended to represent the voices of participants, the reflexivity of the researcher, and a description and interpretation of the process (Creswell, 2007).

Grounded theory aims to move beyond a general description of an experience and generate a theory (i.e., an abstract schema of a process; Creswell, 2007). Coding, the categorization of data, is the pivotal link between collecting data and developing an emergent theory to explain the data (Charmaz, 2006). Coding is generally a two-step process: (a) open and axial (i.e., initial) coding allows the researcher to begin making
decisions about the data, and (b) selective (i.e., focused) coding involves using the most frequently appearing initial codes to sort, synthesize, and conceptualize the data (Charmaz, 2002). Although open, axial, and selective coding are often discussed as a sequential processes, these coding procedures actually occur recursively according to the method of *constant comparison* (i.e., each new piece of data is compared to existing data to generate coherent categories of meaning; Fassinger, 2005).

**Open Coding**

Open coding is the first level of coding (See Appendix I for an example of a coded transcript). In open coding, transcribed data are broken into units of meaning (i.e., concepts), labeled, and interrogated for alternative interpretations (Fassinger, 2005). This process represents the initial close, line-by-line or word-by-word examination of the data for the purpose of developing preliminary categories (Draucker, Martsolf, Ross, & Rusk, 2007). During open coding, the researcher remains open to exploring the theoretical possibilities in the data (Charmaz, 2006). In open coding, the researcher groups together information by using the participants’ words about the experience being studied (Creswell, 2007; Montgomery & Bailey, 2007). Within each grouping of data, the researcher identifies several subcategories (i.e., data units with shared properties), and looks for data to add dimension to the property (Creswell, 2007). The researcher examines the data (i.e., transcribed interviews) for salient groups of information and attempts to *saturate* the groups of information until new information obtained from participant interviews does not further provide insight into the grouping (Creswell). During initial coding the researcher asks the following questions: (a) What are these data
a study of? (Glaser & Strauss, 1967) and (b) What theoretical grouping does this specific datum indicate and from whose point view? (Glaser, 1978)

In order to provide an example of the process of identifying emergent codes, it is helpful to illustrate the steps of the method. First, one unit of meaning is assigned (e.g., “supervisory reaction is important during situations involving suicidal clients”), then a concept label (i.e., reviewer-assigned description) is assigned (e.g., “the supervisor has a responsibility to model appropriate counseling responses”), and lastly, a second concept label is assigned (e.g., “the supervisor needs to help supervisees debrief after situations involving suicidal clients”). In successive coding, these three example statements are grouped and labeled “Supervisory Roles.” This example demonstrates how each level of categorization encompasses more of the level before it.

**Axial Coding**

Axial coding, the second level of the constant comparison method of coding, is specifically focused on an emerging category (Draucker et al., 2007). In axial coding, the relationships among categories (i.e., first-level open codes) are organized and further explicated by putting fractured data (i.e., words, sentences) back together in the form of categories (Fassinger, 2005; Montgomery & Bailey, 2007). Whereas initial coding fractures data into separate pieces and distinct codes, axial coding brings data back together as a coherent whole (Charmaz, 2006). Strauss (1987) identified axial coding as building “a dense texture of relations around the axis of a category” (p. 64). In axial coding, the researcher identifies a central phenomenon (e.g., Working With Suicidal Clients as a Formative Learning Experience), explores causal conditions (e.g., Training
Considerations), specifies strategies (e.g., Proactive Training), identifies the context and 
intervening conditions (e.g., Discuss Suicide Openly), and delineates the outcomes (e.g., 
Greater Attention to Addressing Reactions and Feelings; Creswell, 2007).

Axial codes are provisional, comparative, and grounded in the data (Charmaz, 
2006). In the current study, the researcher followed the format provided by axial coding 
by grouping the interrelated subcategories into more encompassing key categories (i.e., 
subcategories with shared properties; Fassinger, 2005; Glaser & Strauss, 1967).

**Selective Coding**

Selective coding, the final stage of data analysis, is focused on examining the data 
with the intent of constructing a key category and achieving the integration of the 
theoretical framework (Draucker et al., 2007). Selective coding involves creating a 
substantive theory (i.e., theory related to the process under investigation and one that is 
developed from the data; Fassinger, 2005) through the integration of theoretical labels to 
represent the links between key categories (Montgomery & Bailey, 2007). Similar to 
previous stages of analyses, an emerging theory is developed as meaning units are 
constantly compared to emerging concepts (i.e., data units and categories) until no new 
shared properties are identified (Fassinger, 2005; Glaser & Strauss, 1967). The emergent 
theory represents the shared properties among all of the key categories (Strauss & Corbin, 
1990).

**Member Checking**

The researcher transcribed the digitally recorded member check interview after 
completing the interview with each participant. The primary intent of the member check
interview process was to solicit participants’ views on the interview process and the emerging key categories and themes. A secondary goal of the member check process was to solicit greater detail from participants regarding the emerging themes. Participant responses to the member check questions supported the emerging themes. It also allowed the participants the opportunity to comment on the interview process. With regard to the interview process, Andrew stated: “It’s actually been pretty enlightening. What I really enjoyed going back through was the review of the transcriptions. I thought that it was a neat experience for me to reflect” (Andrew, IV, 1, 21). Andrew also noted some changes he had made in his work as a supervisor, as a result of his participation in the interview process:

   Based on some of the transcripts that I was reading . . . not only Role of the Supervisor, but also Supervision Differs [in Suicidal Situations] . . . I thought that bringing different people in would be advantageous to the practicum students . . . so, I now have a suicide prevention group coming into my practicum class.

   (Andrew, IV, 1, 28)

Most participants expressed that the supervisory relationship was an important component of successfully working with counselor trainees who have suicidal clients. However, Meredith identified the supervisory relationship as an area of her supervisory practice related to suicidal clients that she would like to adjust:

   One thing that stood out for me is that I didn’t focus a lot on the relationship with the supervisee when it comes to suicidal clients. I do very much in my classes and regular supervision but, on this topic, I wasn’t thinking very much about the
relationship with the supervisee . . . And so, as we were talking more about that, [it] made me step back and think a little bit more about why I do, or don’t, focus on relationships at given times and how I can possibly pull that aspect in more while still doing the safety and control aspect of things. (Meredith, IV, 3, 100)

Participants reported that the key categories, and sub-categories, accurately represented their process of supervision for suicidal clients. Michael stated: “I think it’s very accurate. You represented what I said and it feels right to me” (Michael, IV, 2, 52). Similarly, Ryan stated: “I think it represented it very well. When I read through [the transcripts and data analysis] I didn’t really disagree with anything” (Ryan, IV, 2, 67).

Meredith identified two of the four key categories as encompassing her own process of supervision for suicidal clients:

In particular, the item Supervision Differs When a Client is Suicidal and Working With Suicidal Clients as a Formative Learning Experience, I think those two probably capture it most for me. As I looked through our themes, it was neat to see some of the repetition—the things that I had been experiencing and then clearly other people were experiencing them too. (Meredith, IV, 1, 40)

Angela explained that the interview process helped her to refine her own process of supervision for suicidal clients: “I am more aware now of the multiple levels that are going on at the moment with supervision of any kind” (Angela, IV, 3, 100). Ryan agreed, adding:

It’s been reaffirming for me. I think sometimes: Am I doing this right? Am I doing everything that I can? I think even reading through some of the statements
that I made; it’s been kind of reaffirming knowing that I’m doing kind of what I believe. (Ryan, IV, 1, 19)

Chapter Summary

Chapter II presented an overview of a qualitative approach to research, grounded theory, as an appropriate method for studying the perspectives of supervisors who provided supervision to counselor supervisees who worked with suicidal clients. Participants were five counselor supervisors who occupied the position of university clinic director in a counselor education program. In sum, the inclusion criteria for participants were: Director of a Counselor Education Counseling Clinic housed in a counselor education department or program at a CACREP-accredited university, earned doctoral degree in counselor education, licensed as a professional counselor, received formal training as a counselor supervisor, provided direct supervision to practicum students, and provided supervision to a supervisee who worked with a suicidal client within the past two years. Numerous procedures (e.g., process notes, member checking, peer review) helped establish trustworthiness and credibility of the data analysis. All participants engaged in three semi-structured, individual telephone interviews lasting approximately 45 minutes and completed a 30-minute member check telephone interview. Data were analyzed according to constant comparison procedures.

Chapter III presents the findings of the current study. The findings are intended to illumine the process of supervision with a suicidal client through the anticipated emergence of a theory of supervision. This theory may help inform additional research
studies related to the interwoven roles of supervisor and supervisee in the provision of services for suicidal clients.
CHAPTER III

RESULTS

Chapter III presents the results of the analysis of interview data that addressed the primary research question: How do five counselor supervisors express the process of supervision for counselor trainees who work with suicidal clients (i.e., clients with suicidal ideation, suicidal ideation with plan for suicide, or clients who attempt suicide)? Results include the emergent theory and its properties, as well as the contributions of the peer reviewer.

Emergent Theory

The emergent theory (i.e., the theory grounded in the interview data as interpreted by the researcher) was titled: Supervision for Suicidal Clients as an Immediate, Versatile Collaboration Between Counselor Trainees and Counselor Supervisors. Throughout the three individual interviews and one member check interview, all five participants noted that the process of supervision differed from traditional supervision when counselor trainees had a client who presented with suicidal ideation. Participants noted that the role of the supervisor was complex and multi-layered, and it often required that the supervisor be flexible enough to meet the needs of both the trainee and the client. Participants identified positive (e.g., learning experience) and negative (e.g., potential for disempowerment) aspects of the trainee’s work with suicidal clients. Additionally, each participant underscored the role of the supervisor in helping trainees learn from their experiences with suicidal clients.
Becoming a counselor supervisor is a developmental process and participants noted that their own development as a supervisor was influenced by experiencing crisis situations as a counselor, specifically client suicidal behavior. As a result of their own learning experiences as a counselor trainee, counselor, and counselor supervisor, each participant reported that he or she automatically assumed a more directive supervisory role with trainees in situations involving potentially suicidal clients. Although participants conceptualized their role as more directive, they also identified that they generally assumed a more supportive stance in situations involving suicidal clients. In other words, participants believed that working with suicidal clients could be an overwhelming experience for counselor trainees, and thus, they valued a more supportive stance in their supervisory interactions.

Four key categories illustrate aspects of the process of supervision for suicidal clients as dynamic and complex, and largely influenced by the needs of the supervisee and the client. The four key categories contribute to an understanding of the process of supervision for suicidal clients by illustrating: (a) the behaviors and actions of the supervisor (Role of the Supervisor); (b) the learning experiences for both supervisor and supervisee (Working With Suicidal Clients as a Formative Learning Experience); (c) the potential impact, both positive and negative, of client suicidal behavior on the supervisory relationship (Client Suicidal Behavior Affects the Supervisory Relationship); and (d) the necessary adjustments and accommodations to the supervisory relationship when a trainee encounters a suicidal client (Supervision Differs When a Client is Suicidal).
The researcher followed the guidelines of the constant comparison method throughout the process of data collection and analysis. The emergent theory developed through the researcher’s coding of the transcribed data into memos and subsequently, data units with corresponding meaning units. As previously mentioned, the peer reviewer was instrumental in both the development of the interview protocols for each round of interviews, and in refining the emergent theory. Additionally, the member check interviews served to further refine the emergent theory because participants were able to directly comment on the meaning units assigned by the researcher. Figure 1 provides a visual representation of the emergent theory, and the 4 categories and 10 subcategories that encompass it.

Role of the Supervisor

Participants identified several ways in which their role as supervisor is affected when their trainee begins working with a suicidal client. Participants suggested that client suicidal behavior often leads to an increased level of involvement from the supervisor (e.g., increased observation, increased attention to documentation, increased time to debrief). Participants noted the importance of attending to risk management concerns (e.g., vicarious liability); however, all participants also underscored the role of the supervisor in attending to the needs of the trainee (e.g., helping the supervisee process his or her emotional response). Michael commented on the potential for supervisees to feel overwhelmed, especially if it is their first experience with a suicidal client. Michael noted that, in those situations, the supervisor has a responsibility to help the trainee by modeling appropriate reactions to crisis situations. He stated: “I’ve learned that it’s
Supervision for Suicidal Clients as an Immediate, Versatile Collaboration between Counselor Trainees and Counselor Supervisors

Role of the Supervisor

Working with Suicidal Clients as a Formative Learning Experience

Client Suicidal Behavior Affects the Supervisory Relationship

Supervision Differs when a Client is Suicidal

Supervisor Reaction

Supervisor’s Developmental Trajectory

Supervisee Considerations

Rupture

Components of the Relationship

Supervisee Needs After Working with a Suicidal Client

Training Considerations

Collaboration

Supervision for Suicidal Clients vs. Traditional Supervision

Dimensions of the Supervisor’s Role

Supervision for Suicidal Clients as an Immediate, Versatile Collaboration between Counselor Trainees and Counselor Supervisors

Figure 1. Emergent theory with key categories and subcategories
important to look at the situation objectively and step outside, and model how to be
thoughtful, and calm, and centered for students” (Michael, I, 2, 87). Andrew also
identified the importance of providing a calm presence for trainees: “Presenting that
professional manner, just calm, empathic, spend a lot of time reassuring confidence in our
supervisees [on] their ability to help their clients during crisis situations” (Andrew, II, 7,
306).

Although participants identified the importance of modeling calm reactions for
trainees, participants also reported that they experienced emotional responses to
supervising situations involving suicidal clients. Michael expressed his reaction as
follows: “Sometimes the first reaction is ‘Uh-oh.’ It’s hard to describe what the feeling is,
but it’s one of, maybe the adrenaline starts pumping a little more and you become on
heightened alert” (Michael, III, 2, 72). Andrew expressed a similar reaction: “I have
anxiety, fear, whatever you want to call it, to make myself more vigilant, to make sure we
service the client the best we can and to make sure I service my supervisee the best I can”
(Andrew, III, 4, 162).

Participants identified stress, concern, and anxiety as their most frequent
emotional responses to supervising trainees in situations involving suicidal clients.
Participants explained that providing supervision to a counselor trainee working with a
suicidal client was generally a stressful experience. Participants indicated the importance
of making sure that they were meeting the needs of both the client and the counselor
trainee. Participants reported concern for the trainee’s well-being and they reported
helping him or her manage his or her reactions to client suicidal behavior. Anxiety was
most often related to risk-management concerns and balancing other liability-related responsibilities as clinic director.

Angela, however, was the only participant who noted that her own emotional reaction to supervising a counselor trainee with a suicidal client was not something that she frequently spent much time thinking about:

I don’t usually think about what I’m feeling when I’m working with a student [trainee] . . . certainly concern, but I’m not anxious . . . I’ve never thought about that, I’m concerned for the student [trainee] and the client—I’ve just never focused on what I’m feeling. (Angela, III, 5, 181)

All participants in the present study served as clinic director and supervisor of practicum experiences. Several participants discussed the potential for liability. Angela noted that, given her role as both a counselor supervisor and counselor education training clinic director, she was often concerned about issues related to risk management and liability when her trainees encounter a suicidal client in their practicum experience. She stated: “As a supervisor, even when I’m talking them [the counselor trainee] through it, I’m hoping we’ve covered all the bases with the client, and we’ve done the right thing and treated the situation with the seriousness it deserved” (Angela, I, 5, 222).

It is worthwhile to note Angela’s use of “I” and “We.” When talking about her supervisory role, Angela used the first person singular (i.e., “I”); however, when she began to discuss more global liability issues (i.e., “covered all the bases,” “done the right thing”), she moved to speaking in the first person plural (i.e., “We”). This grammatical shift may underscore Angela’s thoughts about her responsibility for the practicum clinic.
Thus, in addition to her role as counselor supervisor, Angela appeared cognizant of her responsibilities as clinic director and her comments reflect a consideration of the potential ramifications of her clinical decisions for the practicum clinic. This interpretation of Angela’s use of “I” and “We” appears consistent with Angela’s comments throughout the interview process regarding her responsibility to the client, counselor trainee, and the clinic she directs.

Similar to Angela, Ryan suggested that he also frequently considered potential issues of supervisor liability when he has a counselor trainee who is assigned a suicidal client. He stated:

It’s a balance between administrative and clinical . . . and I think there’s a huge clinical responsibility of keeping this person alive. In the back of my mind as Director, I also think about liability. And it weighs pretty heavily on me, not in a negative way, but I carry that around all the time. (Ryan, I, 6, 252 & 255)

Three subcategories, Supervisor Reaction, Dimensions of the Supervisor’s Role, and Supervisor’s Developmental Trajectory, are encompassed in the key category Role of the Supervisor. Each subcategory contributes a greater understanding of the complex and often diverse role of the counselor supervisor in situations involving suicidal clients.

Supervisor Reaction

Participants described various emotions they experience when dealing with the high-risk situations of client suicidal behavior. The three main reactions supervisors reported experiencing were stress, concern, and anxiety.
Michael identified that stress has the potential to affect the supervisory relationship. He explained that supervisors are not immune to experiencing the stressors that might accompany working with a suicidal client:

I think that sometimes, being that these are very stressful situations for most everyone . . . supervisors can be very stressed out and afraid themselves and be a little too critical and judgmental and come down on the trainee— and I think trainees might not learn from that and they might shut down and it also might rupture the relationship with the supervisor. (Michael, II, 6, 251)

Ryan noted that he is cognizant of the potential for liability, and with that knowledge, he often has some concern regarding his role as clinic director. He explained: “If something goes wrong and if someone gets sued, regardless, my name is going to be on it—whether I’m the practicum instructor, the supervisor, or just the director who makes up the rules and procedures manual” (Ryan, III, 4, 269).

Andrew also expressed his concerns regarding the potential for supervisor liability, and he indicated that he ensures that his trainees are aware of their roles and responsibilities when a client may be suicidal:

The number one thing that all of my supervisees know [about is] supervisory liability. [Trainees] can’t handle all this stuff on their own. [They] need to let us know so that ethically and legally we’re covered from a liability standpoint. (Andrew, I, 6, 236)

Meredith reported that she sometimes experiences anxiety during situations involving suicide:
I think about it [client suicidal ideation] a lot and I want to make sure that we’ve done everything that we could do and that we have solid documentation . . . It’s very much on my mind . . . I want the client to get quality service, regardless of the potential for liability. (Meredith, III, 4, 170)

Andrew indicated that he too feels anxiety, although he indicated that the anxiety may be an inevitable response to working with suicidal clients. Additionally, Andrew appeared to view anxiety as a quality assurance mechanism, or a way of ensuring that he was treating the situation with the seriousness that it deserved:

I do feel some anxiety, I think if you didn’t feel some anxiety . . . then I’m missing something because anytime someone says they’re suicidal . . . If there isn’t a heightened sense of anxiety, then I’m probably not going to do everything that I should do. (Andrew, III, 3, 127)

Participants identified the importance of modeling for trainees calm reactions to crisis situations, including modeling clinical decision-making and case conceptualization skills with regard to suicidal clients. According to Michael:

[It is important to] model, through dialogue the thoughtful decision-making process . . . how to review ethics and laws and how to think through an effective process for dealing with this situation and documenting it as well. And, that’s another important thing to model, how to document the process that you went through and what outcome you chose. (Michael, I, 3, 107)

Participants also noted the importance of modeling the ability to decompress after working with suicidal clients. Ryan explained:
I try to model just basically telling people that you can’t carry this [the stress of working with a suicidal client] around with you and even arguing the point, “You’re worrying about this for the rest of the day, what benefit does that do? How does that serve the rest of the clients that you’re going to be seeing today?” So, I try to model that and teach it as well, because I don’t think it’s healthy for the counselor [trainee] to carry it around. (Ryan, III, 6, 239)

Participants expressed that, whether or not they had a strong emotional reaction to the crisis situation, they felt that it was important for them to debrief after the event. Angela explained her own process for debriefing: “I’m talking to my colleagues. I believe very strongly in verbal debriefing . . . it’s very important for me to do that, plus, I learn for myself ways that they might have handled it or ideas” (Angela, III, 2, 219).

Andrew supported the importance of utilizing colleagues for debriefing purposes: “I’m always in consultation with my colleagues . . . I will spend some time processing and going through—if there were certain emotions that I didn’t expect, if something appears kind of amiss” (Andrew, III, 4, 168).

*Dimensions of the Supervisor’s Role*

Participants identified that working with suicidal clients is a complex process that requires the supervisor to maintain versatility. Participants indicated that, as counselor supervisors, they were often required to adopt an educative stance that included identifying resources that the trainee could consult to learn more about suicide, and helping the trainee develop skills and competence to work with suicidal clients. Michael noted the importance of helping trainees develop more competence in their work with
suicidal clients: “I do think it’s important to give constructive feedback and to be collaborative and learn what was done positively and what could have been done differently” (Michael, II, 6, 249).

Andrew had similar thoughts about the role of education during these high stress situations: “I look at it from the stand point that I’m an educator, because I’m educating them, especially in this process—I’m educating them on the process of what’s going on” (Andrew, I, 7, 285).

Angela also noted the importance of providing corrective feedback with the intent of helping trainees develop counseling skills to use with suicidal clients:

They [counselor trainees] are already so self-critical all the time—if you aren’t sort of sandwiching somehow between what they did right, and even if what they did right was to come and get you, the supervisor, it’s like, “That’s excellent, that’s good judgment.” And then you can move into what they might have done differently. (Angela, II, 8, 339)

Ryan reported that he valued the educative aspect of supervision, and that he was cognizant of the importance of helping trainees learn from their experiences with clients, even during situations involving suicide. However, he also explained the need to be cognizant of his role as an administrator, which included attending to issues of liability:

I think my role is really to take a little bit of time to educate when it’s applicable . . . [In situations involving suicidal clients] I would say it’s probably 10% educational, 45% clinical [directed toward client’s needs], and 45% administrative . . . administrative being the liability portion. (Ryan, I, 6, 236)
Attending to the needs of the counselor trainee while they are in the midst of attending to a suicidal client may be especially important. Participants identified specific debriefing strategies that they used to help support counselor trainees in their work with suicidal clients. Ryan discussed the potential for supervisees to experience anxiety and nervousness when they realize that their client may have thoughts of suicide. Ryan explained that trainees may feel overwhelmed and may not be able to concentrate on directives from their supervisor. He stated that he generally attempts to help the counselor trainee gain control over his or her emotions, before he offers any sort of feedback on the clinical needs of the client:

Get them to slow down, stop and focus on what I’m saying . . . If they come in and their mind is racing and they’re not able to focus on what I’m saying then they’re going to go back in there and not remember what I just told them. (Ryan, I, 8, 350)

Michael agreed with the importance of providing supportive assistance to the counselor trainee while working with a suicidal client. He stated: “Part of it is me helping [the trainee] feel safe and comfortable through the rest of the process and part of it is helping [the trainee] feel more confident should that situation occur again in the future” (Michael, I, 4, 156).

The role of the supervisor may largely depend on the immediate needs of the counselor trainee and the client. In general, participants noted that they believed they often took an active and directive role in situations involving suicidal clients; however, certain factors did dictate the level of involvement of the supervisor. Ryan explained his
approach as follows: “It’s tailored to what [the trainee] needs . . . there are some students who are really needy, some students who just wear their heart on their sleeve . . . So it’s finding that way of communicating with the student” (Ryan, I, 8, 330).

Acting as a gatekeeper to the counseling profession was identified as another aspect of the counselor supervisor role in situations involving suicidal clients. Specifically, participants noted that they often assessed the competence level of their trainees when a suicidal client was involved. All participants mentioned the importance of utilizing live observation and videotape review to ensure counselor trainees are able to detect and assess suicidality. Meredith described the following situation: “As I’m watching this on the screen [during live observation], I’m really feeling that it’s screaming the need for a suicide assessment, and the counselor trainee did not assess for suicide . . . So I became quite directive with [the trainee]” (Meredith, I, 7, 303).

Although participants noted the importance of identifying potential deficits in the counselor trainee’s skill level, Andrew underscored the importance of assessing the counselor trainee’s developmental level: “I really go back to a developmental model, and really share with them that they are a beginning counselor-in-training. There are things that are not expected of them at this point” (Andrew, I, 6, 231). Ryan added: “In terms of knowing whether [a trainee is] competent . . . it’s the people who kind of just brush things off . . . the people who never ask questions...who scare me the most” (Ryan, II, 3, 107 & 129).

As previously discussed, working with suicidal clients is often multifaceted and challenging. The relationship between supervisor and supervisee adds another layer to
this already complex process. Meredith had completed numerous trainings on suicide assessment, and she had conducted several research studies on the topic of suicide and suicide assessment. As a seasoned counseling professional she noted that her biggest challenge when her trainee has a suicidal client is: “To not take over [the session] completely” (Meredith, I, 7, 332).

Similarly, Angela explained that, as a supervisor, it is often difficult to avoid inadvertently disempowering the counselor trainee:

Challenging for me as a supervisor is to go in and do an intervention myself without discouraging the student trainee . . . Usually, when I have that sense . . . it’s really seriously dangerous . . . In that case I have the concern: Am I doing the right thing? Am I assessing properly, am I making the right decisions? As a supervisor I’m concerned that the student is picking up on this and not feeling good [about the supervisory process] and feeing that they are being usurped . . . I’m concerned for the client first, but then there’s also the counselor educator side. (Angela, II, 1, 21)

Being overly critical of the trainee was a concern among participants. Previous experiences with trainees (i.e., experiences outside of the practicum classroom) can affect the supervisor’s views of the trainee’s competence to work with a suicidal client. Meredith explained an experience she had with a trainee who she felt had received adequate curricular instruction in suicide assessment:

I know [the counselor trainee] was with me for six hours of suicide assessment, [the trainee] also did a 14-hour workshop that I helped to conduct and did well in
those . . . So, I know that [the trainee has] had 20 hours of training including practice and [the trainee] gets into this crisis situation with a client, and doesn’t want to go into the room with the client. [The trainee] actually says, “I’m not going to go back in there.” My response was anger, “How, after all of this preparation, how could you think that you can’t go back in?” (Meredith, III, 4, 136)

*Supervisor’s Developmental Trajectory*

All five participants described the influence of their own past experiences working with suicidal clients, either as a counselor trainee, a professional counselor, or a counselor supervisor. Participants noted that working with suicidal clients as a counselor informed their ideas about how to be effective in supervisory crisis situations. Past experiences also helped to remind participants of some of the emotions that trainees might experience. Ryan recounted that he often reflects on his own experiences when he was a beginning counselor:

I remember just being scared to death about what to do, what to say, being recorded—what happens if this person goes and kills themselves? And I reflect on that every time, maybe not absolutely crystal clear but I carry that with me so whenever I’m talking with [counselor trainees] I know where they are. (Ryan, III, 3, 117)

Similar to Ryan, Meredith noted that she found that her past experiences working with suicidal clients led her to consider how to build her skills in this particular area. Meredith explained that she had worked with several suicidal clients during her own
counseling practicum experiences, and she felt that her counselor supervisors were not able to articulate the steps that she should take with suicidal clients: “Those early experiences that I had really were a driving experience for me, so as a supervisor, I try to tap into how frustrated I was when nobody seemed to know what to do” (Meredith, III, 2, 73). Meredith elaborated on the emotional component of her experience as a trainee, and indicated how she uses those experiences as a supervisor:

It was really highs and lows where I would think, “Okay, I can handle this, I’m confident” and then “I can’t believe this happening” . . . I try to remember my experiences, and very often I’ll use my own experiences to remind me how important it is for repetition and to convey the sense that “We are going to get through this together . . . You’re not going to be alone.” (Meredith, III, 2, 75)

Michael identified that his past counseling experiences working with suicidal clients had served to help him “desensitize” from the shock of having a suicidal client:

It becomes a reality, your experiences help desensitize you emotionally and cognitively and I’ve felt that, as a clinician—I found that I very quickly desensitized to the surprise and the shock and the disconcerting part of the whole thing and [was] easily… able to just be there and be present and centered and grounded, and then I could do what I needed to do professionally because I wasn’t thrown off emotionally. But I think that happens with the more experience that someone gains. (Michael, III, 4, 151)

Angela credited her own supervisors with the development of her skills in working with suicidal clients. More specifically, she noted that, as a trainee, her
supervisors were instrumental in helping her to identify her professional responsibilities and boundaries. Angela noted that she learned that although counselors have a responsibility to protect clients, ultimately, they cannot control whether a client commits suicide:

When I was being supervised, it was very valuable in helping see where that line was drawn, and it’s hard to describe easily, it’s a set of skills . . . it’s nonverbal, as well as verbal, as well as the history of the client, and my work as a counselor has been valuable. When I work with students, I try to help them understand the same level that I was taught. (Angela, III, 3, 124)

Andrew, who reported that he had seen a dramatic increase in the number of suicidal clients seeking services at his clinic, noticed that he had amended his practice as a supervisor to be more proactive with regard to the potential for client suicidality. He explained that he now finds himself “watching any signs that would alert me if someone might become suicidal, trying to pick those clients out on characteristics and experiences that I’ve had - before the supervisees kind of get there with them” (Andrew, III, 3, 98).

Summary

The key category, Role of the Supervisor, encompassed three subcategories: Supervisor Reaction, Dimensions of the Supervisor’s Role, and Supervisor’s Developmental Trajectory. This key category reflected participants’ conceptualization of their multidimensional supervisory role in situations involving suicidal clients. Participants noted that they often experienced stress, concern, and anxiety, yet they maintained that they were able to put aside their own emotional reaction and focus on
issues related to client welfare and counselor trainee needs. Participants also reported that their past experiences working with suicidal clients, both as a supervisor, counselor, and counselor trainee, impacted their supervisory practice with suicidal clients. Additionally, supervisors reported that their process of supervision for trainees working with suicidal clients was constantly being adjusted and adapted to meet the unique needs of counselor trainees and clients.

**Working With Suicidal Clients as a Formative Learning Experience**

The idea that client suicidal behavior could be a powerful learning experience emerged as a key category. Participants identified that working with suicidal clients could be a beneficial educational experience for both the supervisor and the counselor trainee; however, participants also noted potential pitfalls (e.g., potential for disempowerment, vicarious trauma) that could inhibit the educational experience.

Participants identified numerous factors that could be affected through the trainees’ work with suicidal clients, such as increased self-reflection, self-efficacy building, and counselor proficiency and skills-building. Participants also noted that their supervisory experiences with suicidal clients had led them to examine counselor preparation curriculum, and to consider ways to help educate and prepare counselor trainees to work with suicidal clients. For example, Meredith noted that she felt some of her supervisees were well prepared to work with suicidal clients; however, she reported: “I don’t think we’re nearly as systematic as we need to be about this issue as a profession” (Meredith, III, 5, 218). Meredith further explained:

I identify strongly as a professional counselor—I believe in the powers of human
development, wellness . . . in all of those things . . . I think sometimes, I don’t know if we [the counseling profession] hide behind it, or, maybe the realities of our clinical worlds have changed, but I think sometimes we ignore some really important aspects of training because, “Oh, well, that’s for people who are sick and counselors work with people who are mostly well.” (Meredith, III, 5, 225)

Developing competency in working with suicidal clients is an important goal of counselor training. Ryan explained that working with suicidal clients can help trainees develop the skills necessary to be an effective counselor by benefiting from the expertise of their supervisor. According to Ryan, the opportunity to work with suicidal clients as a practicum student does have benefits:

I wish that every one of our trainees had a suicidal client. I wish they had two or three actually because they’re receiving more supervision now than they ever will in the rest of their career. They literally have someone who can step in the door the second something goes wrong, or if it’s going badly, there are people to answer questions. So, I think it’s very, very beneficial for them. (Ryan, II, 5, 191)

Similar to Ryan, Andrew expressed thoughts about the benefits to trainees of working with suicidal clients: “Certainly my philosophy is that any time you can log hours in doing this [working with suicidal clients], that’s the only way we get better” (Andrew, II, 6, 253).

Angela also noted the importance of the counselor trainee having the opportunity to work with suicidal clients:
When you’re dealing with someone who is suicidal . . . I think that’s more frightening to counseling students just because of the consequences of their lack of experience . . . I think that the only way you could develop a sense of competence is really through the work . . . So having them actually carry through the entire process is very important to their training. (Angela, III, 3, 92)

Angela’s statement seems to suggest that she values the potential learning experience for counselor trainees who work with suicidal clients. Angela suggested that working through this experience can help trainees learn to develop confidence in their clinical skills. Supporting trainees as they develop skills and competence was mentioned by several participants as an important aspect of counselor supervision. Participants reported that it was important for trainees to have opportunities to develop confidence to work with various client presentations, including clients with suicidal ideations or behaviors. Michael described the process of working with a suicidal client as beneficial to the trainee’s growth and development as a professional counselor: “There is a cognitive and emotional part that I think is important for [trainees] to go through” (Michael, I, 4, 158).

These and other participant statements reflected participant beliefs that working with suicidal clients can be a learning experience for both counselor trainees and supervisors. Participants identified the importance of helping trainees learn about counseling interventions during their supervisory interactions. Participants also noted the importance of educating counselor trainees about working with suicidal clients, including information about completing lethality assessments. Participants also identified the
importance of critiquing their supervisory practice after providing supervision to a
counselor trainee who worked with a suicidal client. Two subcategories, *Supervisee
Considerations* and *Training Considerations*, helped explain the formative learning
process.

**Supervisee Considerations**

Participants noted that supervisees have the opportunity, through experiences with
suicidal clients, to build their self-efficacy skills as counselors. Working with suicidal
clients helps trainees begin to develop competency in working with high-risk populations,
and encourages the growth of counseling skills. Michael explained that suicidal clients
“trigger the trainee to want more concrete resources” (Michael, I, 5, 207). Michael
explained that “concrete resources” were materials like workshops, texts, readings, and
instructional videos related to suicide assessment and prevention.

It is important to note that trainees are not “blank slates,” and previously held
beliefs about life and death may impact their reaction to client suicidal behavior.
Meredith identified that past experiences may influence the manner in which trainees are
affected by client suicidal behavior:

> A lot of it has to do with their previous experiences and attitudes towards suicide.

> Some [supervisees] might have had suicidal thoughts in the past, or they may
have had a loved one have thoughts in the past, or who engaged in actions, so
sometimes that can bring those previous experiences up. Some people are very
closed off to the idea of even thinking about suicide . . . so it can challenge their
worldview. (Meredith, III, 2, 53)
Angela noted the potential for supervisees to experience various emotions when they encounter suicidal clients. She stated: “When you’re dealing with someone who is severely depressed and/or suicidal, I think that’s more frightening to counseling students just because of the consequences of their lack of experience [as a counselor] could be so severe” (Angela, III, 3, 92). Meredith provided a similar response:

I think for trainees, well, for anyone, but especially for someone who hasn’t been through this a couple times, the idea that they could have a suicidal client is very much overwhelming, and so, sometimes they’ll feel out of control just that the situation is out of control, or loss of security. (Meredith, III, 1, 29)

Although there is the potential for trainees to feel overwhelmed, there are also potential benefits to trainees of working with suicidal clients. Ryan indicated that he often notices a tangible difference in his trainees after they provide counseling to a suicidal client: “It matures them, within an hour, and they come out [of the counseling session] and they’re a completely different person” (Ryan, II, 5, 207). Ryan explained that he usually notices trainees have more insight into their own strengths and limitations as a counselor trainee after working with a suicidal client.

Michael also noted the importance of counselor trainees working with suicidal clients and he underscored the importance of the supervisor helping trainees to grow through the experience: “In terms of trainee growth . . . self-reflection, rapport, empathy, helping them understand what they’ve been through and how they have developed and what they might need also, whether it’s debriefing, or specific suggestions of advice to increase their self-efficacy” (Michael, I, 4, 152).
Angela identified the importance of trainees developing proficiency in working with suicidal clients. Specifically, she revealed the importance of trainees developing the ability to navigate difficult and complex situations, and to develop skillfulness in working with high-risk clients. Discussing her approach in response to learning that her trainee has a potentially suicidal client, Angela reported: “[I] insist that they carry through with the assessment, and with the reporting . . . certainly coaching them . . . urging them strongly to do it without having their supervisor do it” (Angela, III, 2, 82).

Andrew asserted the potential for a positive learning experience for trainees who work with suicidal clients: “It’s a great learning experience for them. Because it won’t be the only time they deal with a suicidal client. So, kind of how they’re processing things too, and taking things in, their perceptions of what’s going on” (Andrew, I, 7, 294). Ryan explained that he often notices that counselor trainees who work with suicidal clients in their practicum experience seem to develop counseling competencies faster compared to those who don’t work with a suicidal client. Ryan described the differences he noted in his supervisees who work with suicidal clients:

I’ve noticed a difference in almost all students who have a suicidal client in comparison to those who don’t. There is just something different about them later on in the semester, there’s just something, a little more . . . their eyes are open a little bit more. (Ryan, II, 5, 196)

Training Considerations

Participants discussed the importance of proactive training (e.g., curriculum that addresses suicide, opportunities to learn about suicide assessment) for counselor trainees,
preferably early in their training program. Specifically, participants identified the importance of role playing to help trainees develop some level of comfort in their interactions with suicidal clients. Angela underscored the importance of experience-based activities to help trainees gain a sense of competence in their work with suicidal clients: “Role-playing gives them a sense of how things might go in practice and in doing a suicide assessment and I think that’s the thing that generally feels uncomfortable to students” (Angela, III, 2, 55).

Similar to Angela, Meredith also noted the importance of preparation in suicide assessment for counselor trainees, but she also cautioned that training alone does not necessarily mean that counselor trainees will be effective with suicidal clients: “We can do all the classroom prep in the world, and then [trainees] get into a real-world situation and some people really shine through that, and some struggle” (Meredith, II, 2, 81).

Participants explained that the topic of suicide may not be adequately addressed in counselor education. Andrew emphasized the importance of incorporating suicide awareness into the counseling curriculum. He indicated that often, the topic of suicide is considered taboo and may not be discussed in the counseling curriculum: “It needs to be in the classroom as part of what we do as a profession. So, let’s talk about it, let’s learn about it, let’s continue research on it” (Andrew, III, 5, 228).

In addition to frank discussions about death and suicide, participants also identified the need as a profession to address suicide training through CACREP standards. According to Ryan, “I think we need more training in general . . . I think we need more training in the CACREP core areas. I’m not extremely, word-for-word
familiar with them, but I’m pretty sure they don’t have very much about suicide and training” (Ryan, III, 6, 252).

Meredith agreed with Ryan’s assessment about the importance of requisite training in suicide assessment and prevention. She noted:

I believe pretty strongly that we need to be attending to crisis in our core curriculum, and I think the new CACREP standards are going to help us do that more comprehensively . . . in an ideal world, attention to crisis intervention, with emphasis on suicide would be part of everyone’s core with lots of opportunities to practice. (Meredith, III, 6, 234)

Participants noted the importance of CACREP standards to ensure that counselor education programs are providing uniform instruction in suicide. Although the 2001 CACREP Standards did not require training in suicide or crisis counseling, the 2009 CACREP Standards include language that mandates counselor training in crisis intervention and suicide prevention strategies.

Additional training in suicide assessment and prevention may help some counselor trainees develop competency in working with suicidal clients. However, suicide training should not be considered a replacement for thorough counselor supervision. Although additional training in suicide was identified by participants as an area of potential improvement for counselor preparation, it appears important that counselor trainees have some experience working with clients before they complete curriculum related to suicide. Michael offered a note of caution:
I think [additional training in suicide] would be helpful. I think it would depend on where they’re at in their development. I certainly wouldn’t think that [in] someone’s first semester they should take a course in risk management because it might potentially scare them more than it would help and they wouldn’t have any basis for using it. I think it may be helpful as a pre-practicum, maybe like a prerequisite, for someone to have at least a one or two credit course on crisis assessment, risk management. (Michael, I, 8, 386)

Similarly, Andrew noted the risk of becoming too formalized in an instructional approach to suicide and he cautioned against being too form-driven when assessing suicidal clients. He noted that suicidal ideation, and suicidal behavior are complex, and thus, each client will present with unique factors and concerns: “There’s not a direct manual to deal with [suicide]—you can’t see it, you can’t dissect it” (Andrew, III, 5, 203).

Although participants generally agreed that client suicidal behavior could be a positive and powerful learning experience for counselor trainees, participants identified potential pitfalls for counselor trainees who work with suicidal clients. Angela identified that counselor trainees may feel self-conscious about their trainee status, and thus, they may feel ill-equipped to work with suicidal clients: “Students often feel if they were better at what they do, then they could handle things better” (Angela, III, 1, 29).

When discussing possible pitfalls of trainees working with suicidal clients, Andrew described the unique factors that he was experiencing at his counselor education training clinic. Andrew explained that, because a local mental health agency in his area
had closed, his training clinic had seen an increase in the number of clients in need of service, including those with suicidal ideation. Andrew noted that his practicum students were feeling stressed and were overwhelmed with the constant barrage of high-risk clients. He shared: “[The trainees] feel really overwhelmed [and] frightened . . . We’ve gotten to the point where, because we’ve had so many this semester, they’re just plain exhausted” (Andrew, II, 1, 27). Andrew further related that, because of the increased number of suicidal clients, some students had begun to experience effects similar to that of counselor vicarious traumatization:

We’ve had some [counselor trainees] who have talked with their supervisors, and this is probably the extreme, about quitting the program. We’ve had some who are just physically exhausted to the point where they’ve gotten ill, so they’re displaying physical symptoms . . . And they really point back to when they were dealing with a suicidal client as something that changed. (Andrew, II, 2, 48)

Similar to Andrew, Angela also described a difficult experience involving one of her counselor trainees who worked with a suicidal client. She explained that the trainee had a client who was experiencing intense suicidal ideation with a plan. The trainee consulted with Angela and made a decision to recommend that the client be assessed for hospitalization. Although the counselor trainee took all the necessary steps, including informing the client of the reason for the referral for hospitalization, the client became very upset and angry and, ultimately, did not return to the trainee for counseling services. Angela identified that the trainee felt frustrated at the hospital’s response (the client was
not admitted purportedly because of space limitations) and at the client’s reaction to the trainee’s legal responsibility to protect him or her from self-harm. Angela reported:

It’s almost as though [the trainee’s] reaction to this client and the way that it all sorted out at the hospital and everything, it’s almost as though [the trainee’s] reaction to the way things went was as though [the client] killed [herself or himself]. (Angela, II, 3, 133)

With regard to the incident, Angela noted that her process of working with the supervisee involved debriefing after the incident and ongoing support for her continued work with clients. Angela stated that the supervisee’s response to the situation (i.e., sadness, confusion, frustration, feeling helpless) suggested that the trainee would benefit from a supportive and directive supervision style, a style that characterized her ongoing interactions with the trainee.

Michael also discussed the possibility of trainees experiencing vicarious traumatization as a result of working with suicidal clients. Michael cautioned that some clients who present with lethal intent to harm themselves may be too overwhelming for beginning trainees: “Very, very acute high-risk situations [involving suicidal clients] can be vicariously traumatizing and so that’s a potential risk as well” [Michael, II, 5, 213]. Michael expanded on this idea by providing an example:

I think it depends on what experience trainees have under their belt, it depends on how acute the situation is, if it’s low or moderate lethality as a first, second, or third type of situation, that would be a lot more beneficial than if the first situation a trainee ever had to deal with is extremely high lethality because it could almost
put them over their threshold of tolerance emotionally or psychologically . . . It also depends mostly on how the trainee responds to it. If they respond in a way that they are extremely fearful and embarrassed and it’s a highly negative experience, it could actually paralyze them and make them more hesitant to work with suicidal clients. (Michael, II, 5, 187)

Although Angela, Andrew, Michael, and Meredith noted the potential for counselor trainees to experience vicarious trauma after working with suicidal clients, Ryan reported a somewhat different stance:

With vicarious trauma, I know it can exist . . . If you have a bad week as a counselor trainee and you see 5 or 6 clients in crisis, I can understand that being a rough week and maybe needing to talk to someone a little that week—but then you should be able to wash it off, let it go. If you meet with people in crisis and there isn’t really a learning curve [and] you constantly need to debrief or you’re constantly dealing with this trauma . . . not just a bad week or bad semester . . . then maybe you need counseling or you need to look at another profession. (Ryan, IV, 2, 77)

Ryan elaborated on his statement by providing the following analogy: “For me, it’s like being a physician and not being able to stand the sight of blood. If you can’t do that, then you need to find another profession” (Ryan, IV, 2, 86).

Summary

The subcategories Supervisee Considerations and Training Considerations helped shape the key category Working With Suicidal Clients as a Formative Learning
Experience by contributing to the description of the potential considerations for counselor supervisors and trainees. Participants reported that they encouraged trainees to reflect on their own emotions about working with suicidal clients and that the opportunity to work with suicidal clients helps trainees develop their skills for working with this population in the future. All participants reported that they felt it was important for trainees to have some experience working with suicide, especially with regard to assessing lethality and making clinical decisions about treatment. Participants explained their beliefs that working with suicidal clients is a reality of counseling practice, and thus trainees would likely benefit from early supervised exposure (i.e., during practicum or internship) to suicidal clients.

Although participants agreed that there can be educational benefits to trainees who work with suicidal clients, they also noted the potential for trainees to become overwhelmed if they do not have the proper supervisory support and guidance. Finally, demonstrating an awareness of the potential pitfalls (e.g., counselor trainee disempowerment, vicarious trauma) were important considerations for supervisors who provide supervision for counselor trainees working with suicidal clients.

*Client Suicidal Behavior Affects the Supervisory Relationship*

The potential impact of client suicidal behavior on the supervisory relationship was a concern of all five participants. Participants noted that, in general, they believed that the experience of working with a suicidal client helped strengthen the supervisory relationship. Meredith clarified:
In many cases, I feel that it almost brings us closer together especially if the student has experienced [client suicidal behavior] as something that’s very stressful and they would very often report to me that they appreciated me being calm, they appreciate the directness. They appreciated the opportunity to process . . . so usually, it’s a pretty positive thing. (Meredith, I, 6, 252)

Andrew discussed his view that supervision was a collaborative venture. He identified the potential for supervisors and supervisees to learn from each other: “I think supervision is a two-way street” (Andrew, III, 4, 166). Andrew noted that as a supervisor, he gained valuable experiences (e.g., learning what is helpful to trainees, adjusting clinic policies to ensure a detailed procedure for assessing suicidal risk) from his interactions with counselor trainees. He further explained that he tries to learn from each experience he has supervising a counselor trainee who is working with a suicidal client: “I guess what I try to do every time I have a situation like this is how can I better prepare myself to make sure that I am preparing my trainees” (Andrew, I, 9, 410).

Although the experience of working with a suicidal client generally served to improve the relationship between supervisor and supervisee, participants did identify several variables (e.g., trainee non-disclosures, overly critical supervisor reaction) that could lead to a rupture in the supervisory relationship. Meredith described some of these difficulties, such as assuming a greater role in the counseling session, especially if the client is actively suicidal. She stated this could affect her ongoing relationship with the trainee: “[It may be] harder to continue with the supervisee because there is more to balance” (Meredith, II, 2, 51).
Participants also noted several key ingredients that helped secure the relationship between the counselor trainee and counselor supervisor during times of crisis. They suggested it was important to avoid being too critical of the supervisee. Michael noted: “I think sometimes [supervisors] are so angry or fearful themselves and they’re so harsh with criticism, instead of constructive feedback—the [counselor trainee] may not learn intellectually and they just shut down emotionally” (Michael, II, 6, 264). Angela confirmed the idea that being overly critical of the supervisee could damage the relationship: “When it comes to supervision, it’s such a vulnerable position for the students and I’m acutely aware of that . . . It would be against all of my thinking to be negative with a student” (Angela, III, 5, 297).

The subcategories Rupture, Collaboration, and Components of the Relationship supported the key category, Client Suicidal Behavior Affects the Supervisory Relationship by illustrating the main ways in which the supervisory relationship can be affected by client suicidal behavior. Each subcategory is discussed in further detail.

Rupture

Although most participants reported that working with a suicidal client helped strengthen their relationship with trainees, several identified the potential for a rupture in the supervisory relationship. Michael indicated that although he had not perceived any rupture in his own relationship with supervisees, he did note the potential for such a rupture:

I think it’s a natural human response that when people are really pushed to the limit and stressed, that it often brings out the worst in people . . . If people are
reacting and they’re not conscious of what they’re feeling and countertransference
. . . it could potentially cause a whole new issue, it could cause a supervisee relationship issue. (Michael, I, 5, 191)

For those participants who reported experiencing some rupture in their relationship with trainees, the rupture appeared to be related to supervisee non-disclosures. Specifically, supervisees did not seek the assistance of their supervisor while working with a potentially suicidal client. Angela recounted an example of working with a trainee when she felt a small rupture had occurred. The trainee had worked with a potentially suicidal client but the student waited until after the client left the session and the counseling clinic before seeking assistance from Angela. According to Angela: “The student thought about [the client’s suicidal ideation] afterward . . . and she was worried so she came to me and I saw the tape, and it was like, “Yeah, you might have wanted to call me in there” (Angela, II, 5, 223).

Meredith provided a similar example:

I think the most common situation is that the supervisee doesn’t even realize some of the messages sent [by a suicidal client] during the session, so I remember doing tape review and seeing some very clear kind of invitations to assess for suicide that supervisees missed completely. (Meredith, II, 4, 158)

Collaboration

The idea of collaboration, which contributed to a strengthened relationship between supervisor and supervisee and guarded against supervisory rupture, was a theme underscored by all five participants. Ryan explained:
I don’t know that I’ve ever had someone with a suicidal client where it didn’t make my relationship with that student stronger . . . ’Cause we spend a little bit more time, they actually are able to ask me questions, they get to know that I am a resource rather than just the name on the door when you walk in, so it almost always makes it stronger... sometimes extremely strong, I mean, very surprisingly strong sometimes. (Ryan, I, 11, 469)

Michael indicated that the reason he feels a closer professional relationship with his trainees after working with a suicidal client may be due in part to their increased trust of him as a supervisor: “[It’s] more of a psychological thing, to know that if it happens again, they can trust and rely on their supervisor to be there . . . clinically for supervision purposes, but also to be there for them personally” (Michael, I, 5, 213).

Similarly, Angela identified that increased collaboration between the supervisor and supervisee may be influenced by the supervisor’s increased confidence in the trainee: “[Supervisors] have more confidence in [trainees] after going through something like that” (Angela, I, 8, 348).

Part of the collaboration may arise from the nature of the supervisor’s role in working with the counselor trainee to help the suicidal client. Meredith related that she often felt a greater sense of collaboration with her trainees after working through a suicidal crisis:

I sense a greater degree of trust . . . I think when one goes through a crisis, when I go through a crisis with a supervisee, my approach is generally that we’re in it together, we’re going to work it out together, we’re going to make it happen . . .
And I think that through the process, kind of as that happens, I feel closer to the supervisee . . . And I believe the supervisee also feels closer to me. (Meredith, I, 6, 269)

Meredith’s use of “We” (i.e., first person plural pronoun) appears to further underscore her assertion that she views her relationship with the supervisee as a collaborative endeavor.

Andrew discussed the importance of allowing the trainee the opportunity to work directly with a suicidal client while still being supervised. By this he seemed to mean that sometimes his first reaction when a client verbalizes his or her suicidal ideation is to immediately intervene and take over the session. However, Andrew stated that he avoids this initial impulse and instead prefers to closely monitor the session once a client verbalizes suicide: “I have the [trainee] in the room counseling the client because that’s what they’ve been trained to do . . . They are under my supervision and I have to give them every benefit of the doubt” (Andrew, III, 4, 151).

Components of the Relationship

Participants identified a number of key features of the supervisory relationship when a suicidal client is involved. As mentioned in the discussion of the Role of the Supervisor, participants noted that they felt it was important to project a sense of calm and confidence to their counselor trainees. They also noted that it was important to avoid being overly critical with trainees, and to attempt to create a collaborative relationship with the supervisee. According to Ryan:
I think one of the key ingredients for me is not being overly critical. Chances are they’ve made some mistake at some point. I think we all do. But not to be so overly critical that they’re just like, “Okay, all I know is what I did wrong.” (Ryan, III, 1, 21)

Michael underscored the importance of providing a supportive atmosphere to trainees, especially after they work with a suicidal client: “In order to keep the trainee-supervisor relationship strong, I do think it’s important to also even after the crisis is over to be supportive” (Michael, I, 4, 145).

In order to support counselor trainees and help develop the supervisory relationship, Meredith expressed her belief that it is important to provide the counselor trainee with a sense of support:

It’s the security of knowing I’m behind the screen, or the monitor . . . They’re a little bit relieved of some of that responsibility to know that somebody else is going to be checking up. So, they can alleviate some anxiety, and hopefully function better. (Meredith, II, 4, 147)

Ryan also identified the importance of helping trainees dealing with suicidal clients while at the same time finding an opportunity to lighten the seriousness of the situation. He stated:

I share a bit of myself and say, “Hey I was nervous for you” or “I could see where I could make that same mistake” and just relate to them on a personal level . . . Just to kind of normalize what they went through and let them know that I see them as a human being and let them know that they are fallible and that’s okay
. . . sharing somewhat of a human factor, I guess, a little bit of human connection
with me. (Ryan, III, 1, 23)

Summary

The subcategories Rupture, Collaboration, and Components of the Relationship
form the foundation of the key category, Client Suicidal Behavior Affects the Supervisor
Relationship in the current study. Participants’ reports of the effect of client suicidal
behavior on the supervisory relationship suggest that client suicidal behavior impacts the
supervisor’s relationship with his or her trainee. Participants noted that the effect of client
suicidal behavior on the supervisor-trainee relationship generally results in a strengthened
supervisory alliance, although the potential for rupture does exist. Participants identified
collaboration, encouraging trust, and being supportive of the trainee as protective factors
that guard against rupture.

Supervision Differs When a Client is Suicidal

Participants noted that supervision is an evolving process. All five participants
acknowledged that they interact differently when a trainee works with a suicidal client.
Specifically, participants suggested that a shift in focus occurs; that is they devote more
attention to the client’s needs when risk management issues are present. For example,
Meredith reported that although she generally spends a great deal of time focusing on her
trainee’s development, when a suicidal client presents for treatment, she shifts her
attention to ensuring adequate client care. She noted:

I think I go from really being focused on my supervisee’s development, and of
course, monitoring for client welfare, to really being focused on client welfare and
recognizing that the supervisee’s development will come later, or the focus on that and what that means will come later. So it’s really a perspective shift with me taking more responsibility for the client’s high risk situation. (Meredith, I, 5, 219)

Attending to a trainee’s needs in the aftermath of his or her work with suicidal clients was identified as a common concern among the counselor supervisors in this study. Specifically, participants identified debriefing as an important component of the supervisory process when a counselor trainee works with a suicidal client. Angela spoke in great detail about her own model of debriefing, noting that she generally works within Bernard’s Discrimination Model of Supervision (Bernard, 1979), and finds that she most often uses Bernard’s counselor role in her debriefing process with supervisees. Angela reported:

I’m much more [in the] counselor role when I’m debriefing because you’ve got to get to the personalization—whatever is in their past that’s coming through—in order to be able to help them work through it, in order for that to not be an issue in the future . . . when I’m debriefing a student it’s definitely the counselor [role].

(Angela, II, 8, 328)

Two subcategories, Supervision for Suicidal Clients vs. Traditional Supervision and Supervisee Needs After Working with a Suicidal Client helped explain the ways that supervision for counselor trainees who work with suicidal clients differed from traditional supervision.
Supervision With Suicidal Clients vs. Traditional Supervision

As previously mentioned, all participants indicated that they adjusted, changed, or amended their process of supervision when they provided supervision to a trainee working with a suicidal client. Michael noticed that he devoted increased attention to client-related issues when client suicide was a possibility. He stated:

The emphasis shifts to what is clinically and legally necessary for client care. Maybe if the focus of those two aspects in your average supervision session might be 50-50 or 60-40—I find that it shifts a little more toward 80-20, if you are in the midst of a potential emergency situation . . . meaning 80% focused on important clinical interventions, client care, follow through, documentation, that kind of thing. (Michael, I, 2, 123)

Participants noted that, at times, it was necessary to provide more empathy and support toward the trainee. Ryan outlined the process that he employs after the trainee has completed a session with a suicidal client:

I process whether they’re nervous, and the anxiety, and I think it’s probably—when we’re talking about the supervision afterward -- it’s probably about 50% of what I do, it’s just getting them to settle and letting them know that they didn’t screw everything up—so just processing their anxiety and relating to them. (Ryan, II, 7, 264)

Similarly, Andrew noted that he often finds that trainees value honesty and transparency with regard to knowing the processes and procedures of working with a suicidal client. Andrew indicated that he frequently updates trainees about the client’s
current status (e.g., the client was referred for a risk assessment at the local hospital, the client rescheduled an appointment for the counseling center) and he noted that this seems to help trainees feel supported by the supervisor. He stated: “I think just being forthright with them about all the information [related to the progress of the client] . . . really making sure that you support them” (Andrew, III, 1, 15).

Participants suggested that supervisors have an added layer of responsibility when a trainee works with a suicidal client. This level of responsibility, which includes the idea of vicarious liability, was often manifested in supervisors providing more direction to their trainee’s work with a suicidal client. Michael described his increased directedness as follows:

I may go into the mode of what I would do if I was working with the client myself and so I would naturally become more concrete and more active and that kind of thing, so as far as just being a supervisor, it just fits right in. I also find that it’s usually what students want, that they’re very relieved when someone with experience comes in and provides concrete direction, not in the form of being authoritarian about it, [but] being a little more concrete and active in the process.

(Michael, II, 2, 84)

Supervisee Needs After Working with a Suicidal Client

Participants identified a number of important considerations to address with a supervisee after working with a suicidal client. They noted the importance of completing some method of supervisee debriefing (i.e., processing emotional responses to work with
a suicidal client) after the counseling session. Meredith described her “ideal situation” after a counselor trainee’s work with a suicidal client:

We [supervisor and supervisee] would take a look at the tapes [of the counseling session], and take a look at just exactly what transpired, or have a report of what transpired if we didn’t have a tape available. Then I would focus initial attention to that emotional response . . . [We attend to] the cognitive response [first], [then the] emotional response. (Meredith, I, 5, 196)

Michael noted his style of debriefing considered the importance of helping the counselor trainee continue to work with the suicidal client. He reported that he values the debriefing process for helping trainees to learn and process their experiences and emotions:

[I] work with them to learn what worked, what could have been done differently, and just provide your opinion and have them share their opinion and have them debrief and vent and do the things that are necessary for them to be okay emotionally and to learn intellectually. (Michael, II, 6, 261)

Angela cautioned that supervisors can sometimes overlook the importance of debriefing, especially if the counselor trainee appeared to handle the experience of working with a suicidal client well. Angel explained her process of debriefing:

After these sessions [with a suicidal client], we [counseling clinic faculty] debrief our students and I ensure that that occurs . . . because even if they’ve handled it incredibly well . . . they still have anxiety, of course, and part of the debriefing . . .
is being clear about where the student’s responsibility ends and the client’s responsibility begins. (Angela, I, 5, 201)

Andrew also spoke of the importance of debriefing counselor trainees after their work with a suicidal client. However, he cautioned against simply normalizing client suicidal behavior as a reality of counseling practice. As an example, he noted that his practicum training lab provides the majority of counseling services for students at his university. He noted that it might be difficult for counselor trainees to understand that college students similar to themselves experience depression and suicidal ideation. Andrew stated: “The [counselor trainees] are seeing [university] students . . . [The counselor trainees] are still students at the graduate level [and] they’re seeing their peers have these suicidal issues, and it doesn’t seem normal to them” (Andrew, II, 2, 67).

Ryan noted that he often has to temper his constructive comments with more positive, supportive comments. He noted the potential for disempowerment as a result of being too harsh with criticism of the trainee: “[The trainee] could be very disempowered if it’s their first time [working with a suicidal client] and it’s all scary and if I just come in and tell them that they’re all wrong, then it’s not good” (Ryan, I, 8, 323). Ryan also expressed his view of the importance of providing strong support for counselor trainees:

I think as long as they [counselor trainees] feel supported, they are in good shape . . . We’ll talk about what they’re feeling anxious about and then we'll talk about boundaries, and we’ll talk about responsibilities, and really just talking them through it . . . not comforting them necessarily, but helping them understand
where they did really, really well and things they might do in the future that might be more effective. (Ryan, I, 10, 444)

Summary

The key category *Supervision Differs When a Client is Suicidal* encompassed two subcategories, *Supervision for Suicidal Clients vs. Traditional Supervision* and *Supervisee Needs after Working with a Suicidal Client*. Participants illustrated the differences between traditional supervision and supervision with a counselor trainee for a suicidal client. They mentioned that they generally adopted a more directive stance when their trainee encountered a suicidal client. Participants also identified that they experienced a shift in perspective, and they became more focused on the needs of the client so as to ensure the client’s lethality was properly assessed. Participants were cognizant of providing support after trainees worked with suicidal clients. Even if they have had prior training in suicide assessment and intervention, counselor trainees may not display the emotional readiness or maturity to work with high-risk suicidal clients. As a result, participants reported the importance of providing emotional debriefing for the trainee after working with a suicidal client. This debriefing generally took place during the supervision session and typically consisted of allowing the trainee ample opportunity to explore and process his or her emotional reactions to working with a suicidal client.

Chapter Summary

Participants noted that their process of supervision for suicidal clients was an evolving, complex process. Participants valued the collaborative relationship of supervision and they underscored the importance of reflexivity throughout the process of
supervision. Participants expressed that their supervisory process was informed by their previous experiences as a counselor trainee, a counselor, and a counselor supervisor. Participants also indicated that their past counseling experiences with suicide helped form the foundation for their response to a client presenting with suicidal ideation or intent.

Participants’ conceptualization of the current counselor training process revealed that they believed more training was needed to help counselor trainees develop competency working with suicidal clients. Participants reported client suicidal behavior is not an infrequent occurrence, but rather something that trainees should expect to experience in their counseling practice. Participants stressed the importance of infusing suicide prevention and assessment throughout the counselor education curriculum.

From this grounded theory study, four key categories were identified that contribute to the process of counselor supervision for suicidal clients. These key categories, Role of the Supervisor, Working With Suicidal Clients as a Formative Learning Experience, Client Suicidal Behavior Affects the Supervisory Relationship, and Supervision Differs when a Client is Suicidal, represent participants’ conceptualization of the process of counselor supervision with counselor trainees for suicidal clients. Further discussion of the results, including potential methodological considerations and areas of future inquiry, are presented in Chapter IV.
CHAPTER IV
DISCUSSION, LIMITATIONS, AND RECOMMENDATIONS

The purpose of the current study was to generate an emergent theory of the process of counselor supervision for counselor trainees who work with suicidal clients grounded in the experiences of five counselor supervisors. The question that guided the current research was: How do five counselor supervisors express the process of supervision with counselor trainees for suicidal clients?

In this chapter, the results of the present study are discussed and the contributions of the findings to the existing literature on counselor supervision are presented. Methodological considerations and delimitations are reviewed and suggestions for future studies are presented.

Methodological Considerations

The current study was purposefully limited by the following criteria: (a) participants occupied the role of director of a counselor education counseling clinic/practicum training lab, had obtained a Ph.D. in counselor education, and held professional counselor licensure; (b) participants were selected to represent three of the five geographic regions of ACES; (c) two of the five participants were female; and (d) participants had provided supervision for a counselor trainee working with a suicidal client within the past two years. Although the intent of the current study was to examine the experiences of individuals who met the specific criteria outlined above, results must be interpreted in light of further considerations related to the methodology.
As with any self-report study, it is possible that participants’ responses were affected by the desire to present themselves favorably. Accordingly, it is possible that participants avoided providing responses that presented themselves in a less than positive way. Although there is no evidence that participants were dishonest at any point in the study, it is possible that they answered questions according to the counseling profession’s standards of practice for a supervisor, rather than their actual day-to-day practice as a counselor supervisor.

The effectiveness of counselor supervision may rest on a supervisee’s willingness to disclose his or her concerns to his or her supervisor (Ladany et al., 1996). In the current study, participants were asked to recount their own experiences, and these experiences may have been affected by trainees’ non-disclosures. In other words, it may be that some trainees felt anxious or unhappy with the process of supervision after their counseling session with a suicidal client, and therefore opted not to disclose that information to their supervisor.

As mentioned earlier, each supervisor in the current study appeared to be operating from Watkins’ (1993) role mastery stage of supervisor development. Thus, participants in the current study appeared to be comfortable with their supervisory role and seemed to adjust well to various supervisory situations. Results may have differed had the present research examined individuals at other levels of supervisor development.

Participants were asked to discuss only experiences involving first-semester practicum students who worked with suicidal clients. It is likely that more advanced counselor trainees (i.e., second-semester practicum, internship, or doctoral trainees) may
require a different approach to supervision and thus, the supervisory style may need to be adjusted based on those needs.

Only counselor supervisors who occupied, at the time of the study, the role of counselor education/practicum lab director were considered for inclusion in this study. Additionally, only participants who had earned a Ph.D. in counselor education were considered for participation in the study. The intent of the selection process was to ensure that participants had similar education and training backgrounds. However, this may have limited the data collection process and participants with more varied backgrounds (e.g., master’s-level counselor supervisors, counselor supervisors who work in community mental health agencies) may have provided different perspectives.

Each round of interviews was conducted via telephone due to the geographic locations of participants. Interviewing participants via telephone may have posed some challenges with regard to data collection. Telephone interviewing may limit rapport-building and participants may want to start the interview quickly, especially if the interview takes place during a workday (H. J. Rubin & Rubin, 2005). In the current study, the researcher communicated with participants via email (e.g., scheduling appointment times, obtaining addresses for informed consent) on several occasions before Round I interviews began. Additionally, participants were asked to block out at least two hours of their schedule for each interview, which allowed sufficient time for the researcher to incorporate rapport-building conversation. The researcher’s interactions with participants suggested that she had been successful in developing rapport with them during the interview process. Participants’ responses to interview questions suggested that they had
spent time outside of interviews thinking about the current study. For example, Andrew appreciated the opportunity to reflect on his own process of counselor supervision:

I thought that was kind of a neat experience for me to try to reflect during the semester when so many things are going on, and we have so many students and clients in the clinic. Usually, I don’t take a lot of time to reflect on this process [of supervision]. (Andrew, IV, 1, 23)

Another potential concern regarding telephone interviews is the absence of visual feedback from participants. This is especially important with regard to talking about sensitive topics because visual cues provide feedback regarding a participant’s comfort with a certain line of questioning (Rubin & Rubin, 2005). In the current study, the researcher followed Rubin and Rubin’s recommendations for telephone interviewing and informed participants at the outset of the interview process: “Please let me know if I ask you something that you don’t feel comfortable answering so that we can move on to another topic.” The researcher also used process notes to help bracket her assumptions and her expectations with regard to the interview process.

A final consideration is in regard to participants’ personal experiences with suicide. The researcher did not ask questions directly related to any personal experiences with suicide (e.g., the suicide of a loved one), and it is possible that participants may have had personal experiences with suicide that impacted their professional counseling and supervisory practice. There are 4.6 million survivors of suicide (i.e., family members and friends of a person who died by suicide) in the United States (AAS, 2007); thus, it appears likely that counselor supervisors may be impacted by the suicide of a loved one.
Discussion of Emergent Theory: Supervision for Suicidal Clients as an Immediate, Versatile Collaboration Between Counselor Trainees and Counselor Supervisors

Grounded theory methods allowed for an in-depth examination of the perspectives of counselor supervisors. The foundation for the emergent theory was guided by the participants’ reports of how they facilitated supervision with trainees for suicidal clients. Participants noted that they believed their role as a supervisor of a counselor trainee in suicidal situations was multifaceted and complex, and largely dependent on the needs of both the counselor trainee and the complexity and lethality of the client. Participants’ conceptualization of the process of counselor supervision was influenced by their own knowledge and previous counseling experiences with suicide and suicidal clients.

The emergent theory, *Supervision for Suicidal Clients as an Immediate, Versatile Collaboration Between Counselor Trainees and Counselor Supervisors*, was grounded in the descriptions of counselor supervision provided by the five participants. No previous published research had examined the process of counselor supervision for suicidal clients. The intent of the present study was to contribute to the counselor supervision literature by adding a description of counselor supervisors’ process of supervision for counselor trainees working with suicidal clients.

*Role of the Supervisor*

Counselor supervisors have to demonstrate an ability to shift roles throughout the supervisory process (Bernard & Goodyear, 2004). Participants expressed the importance of the role of the supervisor in modeling appropriate counseling reactions and responses to client suicidal behavior. Overall, participants appeared to appreciate their
responsibility in the supervisory relationship to model a calm response to client suicidal ideation.

Charles et al. (2005) suggested that the supervisor’s theoretical views about the counseling process and the model of supervision he or she endorses are critical elements that shape how counselor trainees respond to crisis situations. In the current study, participants noted that their responsibility was to provide a framework to help trainees work with suicidal clients. Participants reported that they felt it was important to challenge trainees to develop their own views on how to be effective with clients. Michael explained that he believed trainees were sometimes too willing to simply rely on his expertise with suicidal clients, rather than developing thoughts of their own. He reported that he encouraged trainees to process their own ideas about being helpful to suicidal clients:

Clinically, [suicide assessment] often comes down to an opinion . . . counseling is a very subjective process. It’s helpful for me [as a supervisor] to give my opinion, but it’s just as helpful for me to help facilitate the trainee sharing their perspective and understanding how to make a [clinical] decision [regarding the client’s potential for lethality] based on that. (Michael, I, 8, 335)

Counselor trainees tend to report fear about making counseling mistakes and may rely heavily on their supervisors for direction and guidance (Rak, MacCluskie, Toman, Patterson, & Culotta, 2003). In the current study, participants explained that counselor trainees needed to have the opportunity to develop confidence in their ability to effectively work with suicidal clients. Thus, participants noted that they were supportive
and helpful to trainees when they were working with a suicidal client. Their stated goal was to help trainees develop confidence in their ability to make clinical decisions in the future.

Working with suicidal clients can be a beneficial learning experience for trainees and the current study underscored the importance of a supportive supervisory presence. Contact with a supervisor can help a counselor trainee working with a suicidal client remain client-centered instead of becoming anxiety-driven (Reeves & Seber, 2004). Although a difficult task, participants noted the importance of helping counselor trainees remain calm and composed during situations involving suicidal clients. Angela explained that it is important for trainees to have experiences working with suicidal clients, and she hopes that her trainees have the opportunity to build competence: “It’s extremely important for them to have the experience to do suicide assessments and continuing to work with suicidal clients after the ideation has been revealed” (Angela, I, 4, 159).

Participants also underscored the importance of ensuring that counselor trainees understand their professional boundaries with regard to client suicidal behavior. Participants noted that often counselor trainees need to be reminded that they cannot predict or control whether a client will eventually commit suicide. Participants expressed the importance of helping trainees navigate the boundaries of meeting the clinical needs of the trainee (i.e., completing a thorough suicide assessment), while also helping trainees deal with the ambiguity that oftentimes accompanies work with suicidal clients. It appears that helping supervisees navigate the boundary of professional responsibility would be especially important for new trainees, as they may have a tendency to feel that
they are completely responsible for the actions of their clients. Andrew expressed the importance of helping counselor trainees understand how to act ethically and according to counseling standards of practice. Andrew also noted that he cautions his trainees to avoid accepting complete responsibility for the actions of their clients. He stated:

As long as they follow the steps [of suicide assessment], as long as they go through the [suicide assessment] process thoroughly, and use their consultation and supervision time wisely and don’t try to hide things [from me] . . . Then even if someone completes [suicide] we have taken every step to ensure that they wouldn’t. (Andrew, II, 2, 81)

As a key category, *The Role of the Supervisor* informed the emerging theory through participants’ explanation of the versatility that they employed when they provided supervision to counselor trainees working with suicidal clients. Participants explained that this versatility was realized in adapting to the needs of both counselor trainee and client. Participants suggested that supervising trainees working with suicidal clients led to pronounced versatility in their supervisory interactions with trainees. Participants noted that supervising a trainee’s work with a suicidal client requires the ability to simultaneously attend to complex client and counselor trainee needs. The importance of supervisor versatility for counselor trainees working with suicidal clients appears to mirror the results of McAdams and Foster’s (2000) study that found that a comprehensive and flexible supervisory framework was important in addressing counselor trainees’ needs following a client suicide.
Novice supervisors may have anxiety about their ability to provide adequate supervision to counselor trainees (Hess, 1986; Nelson et al., 2006; Shohet & Wilmot, 1991). In the current study, however, participants reported that they felt little anxiety about their ability to be effective supervisors. Considering Watkins’ (1993) four stages of counselor supervisor development (i.e., role shock, role recovery and transition, role consolidation, and role mastery), all five participants appeared to be operating well within the fourth stage, role mastery. In this stage, supervisors experience a sense of confidence with regard to their role and performance of supervisor-related behaviors. Because all five participants had earned a doctoral degree and worked for a minimum of five years as a counselor, it is likely that they had achieved some level of mastery in counseling techniques and skills. Participant responses to interview questions demonstrated an ability to simultaneously attend to various supervisory responsibilities (e.g., maintain client welfare, help supervisees develop skills, attend to liability concerns). Although participants reported concerns with regard to effectively managing trainees’ learning needs and client welfare, all participants noted that they felt well-prepared to deal with these challenges. Ryan explained that he had been well-trained in supervision during his doctoral studies:

[University’s] Doctoral program is very highly focused on supervision. We started supervising the first semesters that we started [the doctoral program] . . . Every semester, every doctoral student was assigned at least one master’s student, who was in practicum, to supervise . . . When I graduated, I had like 200 hours of
supervision that I had provided. . . So, I’ve never once been nervous teaching a first practicum course because I got all of that out of my system in my doctoral program. (Ryan, I, 1, 25 & 46)

Little research has addressed developmental learning experiences of supervisors. The current study explored what counselor supervisors had learned about the supervision process from providing supervision to a counselor trainee working with a suicidal client. Michael explained that he had noticed a change in his reaction to clients presenting with suicidal ideation:

Years ago, when I was newer as a supervisor or clinician, [having a suicidal client] would have been more of an “Uh-oh” and a nervousness, and a cognitive “What should I do?” and emotional fear to a degree . . . But I don’t think at this point, 10 years later, that the cycle goes as quickly or as far . . . [I still] have the “Uh-oh” feeling [that] there are things I need to assess here, but I can catch that emotional reaction much more quickly and move to a more cognitive support, guidance, assessment, kind of process. (Michael, III, 2, 87)

It is worthwhile to note Michael’s use of the word “catch” in the preceding quote. In his statement, Michael noted that he can “catch that emotional reaction much more quickly,” which may indicate that Michael continues to experience an emotional reaction to suicidal clients, yet he has some ability to control his emotions.

Participants reported specific adjustments to the policies and procedures of counselor training that they modified after working with suicidal clients. Angela
recounted a learning experience that took place after she had assumed the supervisory responsibilities for her practicum training lab:

In the beginning [of the clinic] . . . if a client really had issues about being [video] recorded we would give them the choice that we wouldn’t turn on the recording . . . and we had a student who had one of those clients who didn’t want to be on film . . . so she wasn’t filming it [the session]. The client wasn’t really coming out and expressing suicidal ideation . . . [the client] was just saying things that were concerning to the trainee . . . [the counselor trainee] came out of session [to consult with me] and it was a situation where I really did want to have this one [video recorded], for the student’s protection and also for [the clinic’s] protection. And so we changed our rules such that they can’t see a client unless they are taping . . . If a client doesn’t want to be taped we refer them out. (Angela, I, 10, 423)

Angela’s description of this event suggests that the potential liability concerns must be considered when trainees work with a suicidal client. In Angela’s experience, having a video recording of the counseling session may help guard against the potential for liability and may also help supervisors ensure that clients are receiving appropriate counseling services.

All participants reported that their process of supervision was continually evolving and changing to meet the needs of counselor trainees, clients, and administrative polices. None of the participants in the current study viewed the process of supervision as static, and each participant appreciated the dynamic nature of the supervisory
relationship. Participants expressed that supervision for counselor trainees who work with suicidal clients necessarily dictates a developmental approach to supervision.

The key category *Working with Suicidal Clients as a Formative Learning Experience* reflects the collaborative learning process that occurs when counselor trainees work with suicidal clients. Participants noted that working with suicidal clients was a mutual learning experience; that is, learning takes place for both the counselor trainee and the counselor supervisor. Participants underscored the importance of helping trainees develop self-confidence about their ability to effectively help suicidal clients. However, participants also mentioned that learning should take place outside of the supervision session, and they noted that counselor education curriculum should include some component of suicide assessment and prevention.

*Effect of Client Suicidal Behavior on the Supervisory Relationship*

Pearson (2000) suggested that supervisors need to provide support and safety so that counselor trainees feel comfortable enough to challenge themselves and to accept challenges from the supervisor. Participants verbalized their understanding of the potential for suicide to affect the trainee on multiple levels. Meredith explained:

I think for trainees the idea that they could have a suicidal client is very much overwhelming, and so sometimes they’ll feel out of control, just that the situation is out of control, or a loss of security . . . that sort of thing. (Meredith, III, 1, 29)

Participants reported that an important component of their work as a supervisor was to help trainees manage their emotional responses to suicide. Results suggested the importance of helping trainees work through feelings of discomfort, but not necessarily
attempting to alleviate those feelings. Participants suggested that there may be a potential benefit in trainees experiencing some uncomfortable feelings (e.g., anxiety, uncertainty), especially during their initial counselor training experiences. Andrew explained that he felt it was important to simply allow participants to verbalize their emotional reactions after working with a suicidal client:

> What doesn’t work so well is normalizing the process for them—that this is going to be a staple of clinical mental health . . . I think we need to really help them deal with their own feelings around the suicidal client, and not just leave them on their own to work through that. (Andrew, II, 1, 29)

A strong supervisory relationship is important in developing a productive working environment for the supervisor and supervisee. Participants believed it was important to develop a relationship in which the trainee feels supported and respected. Participants reported that a positive supervision relationship appeared to help motivate the supervisee to work with difficult client presentations (i.e., suicidal behaviors) and helped infuse confidence regarding clinical skills. Participants believed that when counselor trainees worked with suicidal clients under their supervision it served to strengthen the supervisory relationship, specifically developing greater trust and mutual respect. Ryan provided the following observation:

> I don’t know if I’ve ever had someone with a suicidal client where it didn’t make my relationship with that student a bit stronger . . . Because we spend more time together, they are able to ask me questions, they get to know that I am a resource
. . . So it almost always makes it stronger . . . Sometimes extremely strong. (Ryan, I, 11, 469)

Michael responded similarly to Ryan, noting that after working with a suicidal client, trainees develop a greater sense of trust in his supervisory abilities: “If it happens again, they can trust and rely on their supervisor to be there . . . Clinically, for supervision purposes, but also to be there for them personally” (Michael, I, 5, 213). Michael appeared to value the need to respond to trainees’ emotions related to working with suicidal clients in an effort to help them handle the situation in the future.

Participants also expressed that they generally gained a greater appreciation for the trainee’s skills and competence after the experience of working with a suicidal client. Participants appeared to develop more trust in their trainee’s abilities after reviewing their work with suicidal clients. Additionally, participants believed that trainees who work with suicidal clients have a valuable opportunity to develop their clinical skills (e.g., suicide assessment, crisis counseling) compared to those who do not work with suicidal clients.

Direct and honest communication can help minimize the counselor trainee’s concerns and can increase the potential for a successful supervisory alliance (S. S. Rubin, 1989). In the present study, all participants noted the potential for supervisory rupture; however, they reported taking proactive steps (e.g., developing a plan for supervision, developing clear expectations for supervisee and supervisor) that helped to decrease the likelihood for supervisory rupture, or misalliance. Participants also indicated that
supervisor self-disclosure may help increase a connection between supervisor and supervisee.

A common pitfall of counselor supervision is that supervisors focus exclusively on client care at the expense of other issues (e.g., counselor trainee interpersonal issues; Bernard & Goodyear, 2004; Borders, 1992). It would be logical to assume that in situations involving a suicidal client, supervisors may be more likely to focus on client care, and as a result, may neglect the other foci of supervision. However, in the present study, participants appreciated the importance of maintaining a balance between attending to client issues and ensuring that adequate attention was devoted to trainee-related issues (e.g., processing emotional content). Participants seemed to understand that there is a risk of becoming too involved in issues of client safety when the threat of suicide is present; however, they maintained that they had been able to maintain a balance in their supervisory interactions. In other words, participants noted that it was important to attend to issues of client welfare and issues related to the learning and growth of counselor trainees. Meredith described an example of this balance in her approach to supervision for suicidal clients:

After we had some assurance that [the client] was not presenting an imminent threat of suicide, I worked with trainee first to process [the trainee’s] emotional response to the session, and to asking the questions [on the suicide assessment], and then, we also worked to set up a pretty concrete plan for how [the trainee] would need to continue to reassess the potential for suicide [in future counseling sessions]. (Meredith, I, 4, 150)
Supervisors must be cognizant of how threatening the practicum experience may be for some students, as practicum often serves as the student’s first exposure to the behavioral requirements of the counseling profession (e.g., ensuring client safety, effectively documenting services; Ronnestad & Skovholt, 1993). Participants reported the benefits of trainees having early experience with suicidal clients; however, they also noted that too many overwhelming experiences could be detrimental to the learning and growth of the trainee. Participants believed in the importance of helping counselor trainees feel competent and confident in their abilities when working with suicidal clients. Andrew explained that following a session with a suicidal client, he often works to help trainees establish a sense of control:

Part [of what I do in supervision] is to give the counselor trainee a little bit of power, and say, “How would you handle this differently?” I ask them to reflect on how they felt and what kind of coping skills they need in the short term while the crisis situation is going on, as well as right after. And really just helping them get some information [about themselves] for the next time [they have a suicidal client]. (Andrew, I, 9, 380)

Lower levels of supervisee development have been associated with weaker supervisory alliance; thus, supervisors who work with students in earlier stages of training (i.e., practicum) may need to place emphasis on developing a strong relationship with their trainee (Ramos-Sanchez et al., 2002). Participants agreed on the importance of developing a strong supervisory alliance, and they actively worked to develop a productive relationship with their trainees. Participants did not report that working with
suicidal clients caused a rupture in their relationship with practicum trainees, although they did acknowledge that the potential for a supervisory relationship rupture certainly exists. As previously mentioned, all participants were members of ACES, and all were actively involved in contributing to scholarly research on supervision and counselor education. Thus, it is likely that because of their immersion in supervision research, participants may have devoted more attention to supervisory processes, compared to supervisors who were not similarly engaged in supervision research. Participants reported taking steps to actively guard against supervisory relationship rupture in their relationships with their trainees.

Historically, counselor supervision has been steeped in problems; counselor trainees are conditioned to focus on negative aspects of their counseling session (Morrisette, 2001). In other words, the supervision process may be dominated with problem-saturated talk and the focus of supervision may be identifying weaknesses and deficits within the supervisee. However, postmodern approaches to supervision (e.g., Anderson & Swim, 1995; Bob, 1999) encourage trainees to feel comfortable and confident voicing their opinions and to engage in discussions that capitalize on their strengths. In collaborative supervisory relationships, the supervisor has a responsibility to create and facilitate the counselor trainee’s ability to consider alternative options to problems. An important component of collaborative supervision is helping counselor trainees develop self-confidence (Anderson & Swim). Participants in the current study indicated that working with suicidal clients can be frightening and stressful, especially for
beginning counselor trainees. Yet, they also noted the importance of reinforcing that
trainees are capable of working through difficult and challenging cases.

Although all five participants reported working from a collaborative approach to
supervision, each participant seemed cognizant of inherent hierarchical elements of the
supervisory relationship (e.g., supervisor evaluation of the trainee, assignment of a letter
grade for the semester). Angela explained that she was aware of the hierarchical nature of
supervision: “When it comes to supervision, it’s such a vulnerable position for the
students and I’m acutely aware of that” (Angela, III, 5, 207). Thus, although participants
endeavored to have collaborative relationships, they also recognized that suicide triggers
a more directive supervisory stance. Providing a safe environment where counselor
trainees can openly discuss their thoughts and feelings is important to the supervisory
process (Barnett, Cornish, Goodyear, & Lichtenberg, 2007; Peake, Nussbaum, & Tindell,
2002) and it may help decrease the hierarchical nature of supervision.

Contributing to the supervisee’s growth and development was a major goal for the
participants in this study. Although participants noted the potential for supervisee
disempowerment during situations involving suicidal clients, they mentioned
collaborative supervisory behaviors (e.g., providing guidance to a trainee even if “taking
over” a counseling session) which helped guard against the potential for
disempowerment. Meredith provided an example:

If I believe the trainee is just not competent to handle the situation, or maybe the
client situation is just really complex, I do think there are ways to balance and still
empower, but to do so in a much more collaborative way . . . almost like a co-
counseling role, or kind of a live mentor role. The supervisee gets to experience what the [suicide] intervention looks like, and ideally, gets to participate . . . [after the session] I would be reinforcing and encouraging [with the trainee] and looking at what went right and looking for opportunities for growth. So, I think there’s a way that it can be empowering and growth-producing even if I take over the session. (Meredith, II, 3, 134)

Participants seemed to value a collaborative approach to supervision, which they attributed to their own training and development as supervisors. Participants expressed the importance of helping trainees develop their own conclusions about effective counseling, and they noted that they valued the opportunity to engage in generative discussions with trainees.

The key category *Client Suicidal Behavior Affects the Supervisory Relationship* supported the development of the emerging theory through participants’ conceptualization of the nature of the supervisory relationships when counselor trainees work with suicidal clients. Participants noted the potential for a rupture in the supervisory relationship; however, participants indicated that they guarded against rupture through their use of a collaborative supervisory relationship. Participants noted that working collaboratively with a trainee appeared to strengthen the supervisory relationship because the supervisor and trainee mutually explored strategies for working with the client. Participants emphasized the importance of helping trainees develop the ability to work autonomously and they noted the value in encouraging trainees to express their cognitions and emotions related to working with suicidal clients.
Supervision Differs When a Client is Suicidal

Participants agreed with Reeves and Seber’s (2004) assertion that the role of the supervisor is central to working with suicidal clients. Working with suicidal clients may elicit numerous feelings in the trainee (e.g., anxiety, fear, incompetence) and a strong supervisory presence is often an important precursor to the trainee’s ability to be effective with a suicidal client. Borders (1989) noted that even in non-crisis situations, beginning supervisees may tend to rely on supervisors to tell them the “right” thing to do. During crisis situations, trainees may attempt to defer to their supervisor’s expertise. Participants noted that this was common and they stated that trainees often attempted to enlist their assistance in completing suicide assessments and making clinical decisions. Although participants indicated that it was helpful to be a supportive presence in these situations, they reported that, in most cases, they avoided simply providing the trainee with one directive. Instead, they allowed trainees to navigate the decision-making process under their supervision. Meredith explained her process of helping trainees develop a plan for completing an assessment with a suicidal client. She stated that she often asks them to step out of session for a couple minutes so that she can help them prepare a plan of action:

I would basically ask them to role play with me. “Okay, what do you need to know first, how are you going to find that out?” “Now, what about after that?” “And what about if this comes up, what’s next?” And generally speaking, I will try to draw that from them and to encourage them, I say: “I know you can do this or I wouldn’t let you go back in there.” And there have been times when I’ve
gone into the room with the supervisee, if they were at a very high level of anxiety, or if I thought that the client was at very high level of risk. But, I try not to take over completely. (Meredith, I, 7, 313)

Counselor supervisors have a responsibility to maintain the ethical and legal standards of the counseling profession (Bernard & Goodyear, 2004). Supervisors are held accountable for the interventions and clinical decisions of their supervisees (Falvey & Cohen, 2003). Although participants indicated that they were aware of the potential for vicarious liability, they admitted that they felt that they were actively taking steps to guard against the potential for liability due to their strong supervisory presence. Participants utilized a variety of supervision strategies, including live supervision and videotape review, to ensure that they were aware of the content of trainees’ sessions. Participants reported the importance of directly observing trainees instead of simply relying on their verbal account of their counseling sessions. Participants reported that engaging in live supervision and videotape review helped them to manage liability concerns, while simultaneously enabling them to assess the trainee’s growth and development.

Participants’ discussion of the role of immediacy in situations involving suicidal clients informed the key category *Supervision Differs When a Client is Suicidal* and contributed to the development of the grounded theory. Participants noted differences in their supervision practices when their trainees provided services to suicidal clients compared to situations that did not involve suicidal clients. The most notable difference appeared to be the increased sense of immediacy. Participants described the importance
of ensuring the client’s safety from harm, while also attending to trainees’ needs and processing their emotions to the potentially frightening experience of working with a suicidal client. Participants also indicated that they generally spent an increased amount of time helping the trainee debrief from the experience of working with a suicidal client.

Implications for Counselor Education

It is important for mental health professionals to know how to work with potentially suicidal clients (Ellis et al., 1998; Pieters et al., 2003; Remley, 2004). Researchers have recommended that suicide education become a routine part of counselor preparation (Jobes & Maltsberger, 1995; Juhnke, 1994; Kleespies, 1993; McAdams & Foster, 2000). Participants in the current study agreed, suggesting that CACREP training standards should infuse suicide assessment training in counselor education curriculum. It is important to note that the 2009 CACREP Standards do include language that mandates counselor training in crisis intervention and suicide prevention strategies.

There is limited agreement among mental health professionals regarding adequate training in suicide preparation (Bongar, 1992). Participants noted, however, that at minimum, counselor preparation programs need to incorporate training in suicide assessment, and should include experiential components (e.g., role plays) to help trainees develop competence in administering various suicide assessments. Participants’ views on the importance of role-play activities were in agreement with other researchers (Gibbons & Studer, 2008; Juhnke, 1994) who suggested experiential activities to help trainees learn
suicide interventions before they are faced with these issues, rather than being trained “on-the-job” as a consequence of experiencing a client suicide or attempted suicide.

Jobes and Maltsberger (1995) suggested that the lack of suicide prevention training may reflect an unconscious discomfort among mental health professionals about suicide. Andrew supported this idea:

For some reason, suicides are still pretty taboo . . . people want to shy away from it . . . they don’t want to see it, they don’t want to get involved in it, and they don’t want to believe it happens. Yet, the numbers [of attempted and completed suicides] say that this is a huge problem, both with adolescents and adults . . . I gave you the numbers here [at this university], they are not low. (Andrew, III, 5, 218)

Participants reported that they had encountered a number of suicidal clients who presented for services in their practicum training lab. Participants’ estimate of the scope of suicidal behaviors in their clients appeared to mirror Benton et al.’s (2003) findings of an increase in the number of college-aged students presenting with complex mental health conditions. During the current study’s four-month interview period, each participant provided supervision to at least one master’s level practicum trainee who worked with a suicidal client. The fact that each training lab had at least one suicidal client during a four-month period clearly suggests a need for counselor training in suicide assessment and interventions. Participants reported a great sense of responsibility about teaching trainees to accurately assess and respond to suicidal ideation. However, the counseling profession may need to consider whether it is the sole responsibility of
counselor supervisors to prepare trainees to work with a suicidal client or whether the responsibility lies, in part, with counselor educators. Perhaps infusing suicide assessment and prevention into several courses across the counseling curriculum (e.g., skills / methods course, diagnosis course, counseling theories courses) would help to better prepare trainees for future practicum experiences with suicidal clients.

Although participants noted their belief that it is beneficial for trainees to have some experiences working with suicidal clients, they did offer some caution regarding the ideal developmental timing of working with such clients. Participants agreed that working with a suicidal client can be a meaningful event for counselor trainees. Confronting their thoughts about suicide and death may challenge trainees’ previously-held worldviews (e.g., suicide is a sin, suicide may be justified in some circumstances). This is consistent with Blocher’s (1983) assertion that when counselor trainees first begin to understand or empathize with a client’s perspective, they may experience profound and disturbing feelings. Similarly, client situations involving death may trigger heightened subjective distress for beginning counselors (Kirchberg et al., 1998). In the current study, participants indicated that they had a supervisory responsibility to help trainees develop a framework for understanding client suicide.

Participants identified the important role of supervision in situations involving suicidal clients. They reported that their supervisory role became largely focused on helping the trainee develop confidence and skills in working with suicidal clients. However, Ramberg and Wasserman (2003) cautioned that supervision alone cannot compensate for inadequate basic knowledge of how to treat and care for suicidal patients.
In the current study, participants seemed to support the value of education in suicide assessment and prevention and they overwhelmingly supported the inclusion of curricular experiences aimed at developing proficiency in assessing and counseling suicidal clients.

Implications for Future Research

Conducting qualitative research is a generative process and the findings of the current study have identified several areas for future inquiry in counselor supervision and counselor education research. The current study identified the importance of increased attention to the dynamics of the supervisory relationship in situations involving suicidal clients. Continuing this line of research, a potential study could examine the counselor supervisor role after a client’s *completed* suicide. It may be worthwhile to investigate the differences in supervisory behaviors and the supervisory relationship when a client completes suicide, as opposed to attempting suicide or verbalizing suicidal ideation. It is likely that supervisors would identify additional needs for which they would be expected to attend (e.g., increased attention to liability related concerns, processing trainee’s grief).

As previously mentioned, no published research has examined the perspectives of counselor supervisors regarding the process of counselor supervision for suicidal clients. The current study may serve as a springboard for future research, both qualitative and quantitative, regarding counselor supervisors’ perspectives on suicide and crisis situations. Additionally, future research may investigate the experiences of master’s-level counselor supervisors and those who work in community mental health agencies and school counseling settings, as there may be differences between the supervisory styles of doctoral-level clinic directors and master’s-level counselor supervisors.
Similarly, additional research could examine the experiences of counselor supervisors who provide supervision at an off-campus practicum location. In the current study, all participants occupied the role of director of a counselor education counseling clinic/practicum training lab, a site on the premises of a counselor education program. Participants noted the importance of consulting with their faculty colleagues when their trainees provided counseling services to a suicidal client. Thus, it would be worthwhile to investigate how those supervisors at an off-campus practicum location provide counselor supervision to trainees who work with suicidal clients. For example, off-campus practicum supervisors often have responsibilities (e.g., maintaining productivity, adhering to agency guidelines) that differ from supervisors who work in a counselor education training lab. It seems that supervisors at an off-campus practicum location may contribute a different perspective to the process of supervision for suicidal clients.

Additional research should also examine trainee perspectives regarding the role of supervision in working with suicidal clients. It would be helpful to investigate whether supervisors and trainees had similar views about the importance of supervision for situations involving suicidal clients. It would also be useful to hear trainees’ perspectives on the value, if any, of additional counselor education curriculum in suicide assessment and prevention. According to Borders et al. (1991), the supervisor is responsible for evaluating the quality of the supervisory relationship. However, it may be worthwhile to determine how, if at all, trainees differed in their interpretation of effective supervision for suicidal clients. For example, future research may examine how supervisors and trainees define effective supervision for suicidal clients.
Additionally, the current study examined the experiences of counselor supervisors who appeared to be operating from Watkins (1994) role mastery stage of supervisory development. Thus, it appears worthwhile for future research to investigate the perspectives of counselor supervisors who may be operating from the other stages of supervisor development (i.e., role shock, role recovery and transition, and role consolidation). It is likely that novice supervisors experience reactions to client suicidal behavior that differ from those counselor supervisors who have had more experience working with counselor trainees.

Another consideration with regard to effective supervision is the outcome of the supervisory process. As mentioned in Chapter III, Angela recounted a story that involved a trainee who worked with an actively suicidal client. The trainee worked closely with Angela during supervision, completed a thorough suicide assessment on the client, and ultimately referred the client for hospitalization due to the high risk of suicide. Although Angela believed that the process of supervision had been effective, and the trainee had conducted the suicide assessment well, the client ultimately did not return for services. Thus, in this case, if the effectiveness of supervision is determined by the client’s progress, supervision would be deemed ineffective by the client’s decision not to return for services.

Additional research using quantitative methodology may help further expand the current research. For example, a survey distributed to directors of counselor education counseling clinics/practicum training labs may help develop a better understanding of
the specific strategies (e.g., debriefing, instruction on suicide assessments) used by 
counselor supervisors of counselor trainees with suicidal clients.

Another area for future investigation relates to the length of time that trainees and 
supervisors spend interacting when there is a possibility for client suicide. All 
participants reported spending additional time with their trainees when a suicidal client 
was involved. As previously mentioned, participants reported that they felt they had a 
strong rapport after going through the experience of working with a suicidal client. Thus, 
a possible line for future research would be to examine if the length of time that trainees 
and supervisors spend together contributes to trainee satisfaction with the supervisory 
relationship and increases supervisor-supervisee alliance.

Guarding against counselor trainee disempowerment is another area for future 
investigation. All participants mentioned the potential for counselor trainees to 
experience disempowerment during crisis situations. Future research should examine 
ways to guard against trainee disempowerment. For example, what are specific strategies 
that supervisors could use to help empower the trainee and to reinforce his or her ability 
to help suicidal clients? What types of supervisor behaviors (e.g., negativity, becoming 
too involved in the counseling session) lead to trainee disempowerment? Finally, if 
disempowerment does occur, what can a supervisor do to help re-empower the trainee?

As previously mentioned, the 2001 CACREP Standards did not require training in 
suicide or crisis counseling; however, the 2009 CACREP Standards do include language 
that mandates counselor training in crisis intervention and suicide prevention strategies. 
Thus, it would be worthwhile to assess whether these changes to the CACREP standards
affect counselor trainees’ ability to work with suicidal clients. It would appear likely that counselor trainees would demonstrate increased proficiency in their work with suicidal clients compared to those trainees who did not receive such instruction.

It would also be useful to assess the perspectives of counselor educators regarding the inclusion of crisis intervention and suicide prevention. Participants (i.e., counselor supervisors) in the current study supported additional training in suicide assessment and prevention as reflected in the updated CACREP standards; however, it would be worthwhile to assess counselor educators’ experiences with incorporating the new training into counselor preparation.

Throughout the current study, participants discussed the importance of simultaneously attending to the needs of both the counselor trainee and the suicidal client. Although it was beyond the scope of the current study, it would be helpful to determine the specific strategies and behaviors that counselor supervisors employed in order to help maintain the balance of attending to these needs simultaneously.

Participants discussed the importance of emotionally debriefing counselor trainees after they work with suicidal clients. Future research could examine the specific strategies employed by supervisors and the impact of these strategies on the counselor trainee. For example, does debriefing help the trainee emotionally process the experience of working with a suicidal client, or does debriefing serve more of a calming, or re-centering function for the trainee? The timing of debriefing may also be an important area to investigate. Should debriefing take place immediately after the counselor trainee works
with a suicidal client or should the supervisor wait some length of time (e.g., 1 hour) to begin processing the experience with the trainee?

Future research should examine supervisors’ past professional experiences with suicide to determine how those experiences inform their current practice as a supervisor. For example, Meredith explained that she had several experiences as a counselor trainee working with suicidal clients and she found that her supervisor experienced some difficulty helping her conceptualize those experiences. She stated, “I think those experiences are what led me to want to research [suicide] and understand it more” (Meredith, III, 2, 72). Another line of future inquiry would be examining counselor supervisors’ past personal experiences with suicide. It would be interesting to research the effect, if any, of supervisors’ personal experiences with suicide (e.g., their own suicidal ideation, completed suicide of a loved one) on their current practice as a counselor supervisor.

Similarly, it would be worthwhile to examine the impact of working with a suicidal client as a counselor trainee. Specifically, how does the experience of working with a suicidal client as a counselor trainee impact that individual’s future work as a counselor? Participants reported that they were able to identify differences among trainees who worked with suicidal clients compared to those trainees who did not work with suicidal clients, especially with regard to their ability to assess and treat complex clients. A longitudinal study of the long-term effects of working with a suicidal client as a counselor trainee would illumine the positive and negative effects of working with suicidal clients during the training experience.
Experience of the Researcher

Throughout the interview process, I thought that the participants were open and honest regarding their experiences of supervision. Participants seemed to be able to articulate both their strengths and their limitations as supervisors. Participants reflected upon their own developmental process and they discussed ways in which they had grown and developed as supervisors.

My conversations with the participants helped me to refine my own views on supervision for suicidal clients. I gained insight into the multidimensional role of the counselor supervisor. In my work as a professional counselor, I became more cognizant of the dynamics involved in working with suicidal clients. I realized that I had some thoughts about being effective with suicidal clients; however, my conversations with participants enabled me to further refine those ideas and thoughts. It was interesting to review the similarities among the participants; despite their differences in individual experiences and years of experience as a counselor supervisor, participants noted many commonalities in their approaches to providing supervision for suicidal clients.

Summary

Research estimates are that approximately 800,000 people in the United States attempt suicide each year (AAS, 2007). Attempted suicide is a prevalent mental health concern and future research should continue to determine effective methods to help treat these concerns. The current study sought to generate an emerging theory of counselor supervision grounded in the views of five counselor supervisors. The emergent theory contributes to the understanding of the process of counselor supervision for suicidal
clients. Grounded theory research methods allowed the researcher to develop themes and explore content as reflected through the participants’ view. Further research is needed to continue to clarify the emergent theory identified in this study and to articulate additional understandings of the process of supervision for suicidal clients.
APPENDIX A

HSRB APPROVAL
October 8, 2008

Rachel M. Hoffman
Counseling and Human Development Services

Re: # 08-679: "The Process of Counselor Supervision for Suicidal Clients"

Dear Ms. Hoffman:
I am pleased to inform you that the Kent State University Institutional Review Board has reviewed and approved your Application for Approval to Use Human Research Participants as level II research through the expedited review process. This was approved on October 8, 2008. Approval is effective for a twelve-month period, October 8, 2008 through October 7, 2009.

Federal regulations and Kent State University IRB policy require that research be reviewed at intervals appropriate to the degree of risk, but not less than once per year. The IRB has determined that this protocol requires an annual review and progress report. The IRB will forward an annual review reminder notice to you by email as a courtesy. Please note that it is the responsibility of the principal investigator to be aware of the study expiration date and submit the required materials. Please submit review materials (annual review form and copy of current consent form) one month prior to the expiration date. HHS regulations and Kent State University Institutional Review Board guidelines require that any changes in research methodology, protocol design, or principal investigator have the prior approval of the IRB before implementation and continuation of the protocol. The IRB must also be informed of any adverse events associated with the study. The IRB further requests a final report at the conclusion of the study. Kent State University has a Federal Wide Assurance on file with the Office for Human Research Protections (OHRP); FWA Number 00001853.

If you have any questions or concerns, please contact me at 330-672-2704 or tfreder2@kent.edu

Sincerely,

Tonya Frederick, R.N., B.S.N.
Research Compliance Administrator
Division of Research and Graduate Studies
Office of Research Safety and Compliance
APPENDIX B

PARTICIPANT RECRUITMENT LETTER
Dear -----,

I am writing to request your participation in my dissertation research. My dissertation co-directors, John D. West, Ed.D., and Cynthia J. Osborn, Ph.D., suggested you as a potential participant. I am conducting a grounded theory study on the perspectives of counselor supervisors who provided supervision to a counselor trainee (i.e., practicum student) who counseled a suicidal client.

Please allow me to briefly review the inclusion criteria for this study. One inclusion criterion is that you are currently the Director of a counselor education practicum training lab. A second inclusion criteria is that you provided direct (i.e., individual, face-to-face) supervision to a practicum student who counseled a suicidal client. (For purposes of the current study, a suicidal client is defined as a client who reported experiencing current thoughts of suicide, reported having a suicide plan, or attempted while in counseling with a counselor trainee).

If you meet the inclusion criteria above and you are interested in learning more about the study, please email me at your earliest convenience at rhoffman@kent.edu, or if you prefer, you may call me at (330) 550-5767. My dissertation co-directors, Dr. Cynthia Osborn (cosborn@kent.edu) and Dr. John West (jwest@kent.edu), may be contacted as well. The project has been approved by the Kent State University Human Subject Review Board (Log # 08-679).

Thank you,

Rachel Hoffman, M.S.Ed., PC, NCC
Doctoral Candidate
Kent State University
APPENDIX C

INCLUSION CRITERIA
Inclusion Criteria

1. Consult CACREP website to obtain a list of CACREP-accredited counseling programs.
   a. Visit all CACREP-accredited websites to determine if they have a counseling clinic housed within their counseling department.
   b. Develop a list of all CACREP-accredited programs with a counseling clinic housed within the counseling department.

2. Review the contact information for counseling clinic directors.

3. Email potential participants to inform them of the study and ask if they would be willing to consider participating.

4. For those participants who express interest in possibly participating in the study, ask the following questions:
   a. Are you a currently a clinic director?
      i. If yes, move to question b.
      ii. If no, have you been a clinic director in the past 2 years.
         1. If yes, move to question b.
         2. If no, ask if there is a new director and ask for information.
   b. Do you provide direct clinical supervision to master’s level mental health counseling or community counseling practicum students?
      i. If yes, move to question c.
      ii. If no, stop.
c. Did you earn your doctoral degree in Counselor Education and Supervision?
   i. If yes, move to question d.
   ii. If no, stop.

d. In your current position as clinic director, have you provided supervision services to a supervisee who worked with a suicidal client?
   i. If yes, move to question f.
   ii. If not, stop.

e. How long ago did you provide supervision to a supervisee who worked with a suicidal client?
   i. If in the past two years, participant is appropriate for study.
   ii. If no, stop.
PARTICIPANT CONSENT FORM

Research Project: The Process of Supervision With Suicidal Clients

I am conducting qualitative research on the process of supervision with suicidal clients in partial fulfillment of the requirements of my Ph.D. dissertation. I believe this study will illuminate the process supervisors undertake (e.g., decision-making when clients their supervisees are working with are suicidal). Based on your experiences as a counselor supervisor and counseling training clinic director, I would like to invite you to be one of the five participants in this study. If you interested in participating in the study, you will be asked to engage in a 20-minute telephone interview to determine your participation eligibility. If you meet criteria, you will then be asked to participate in three one-hour (approximately) individual telephone interviews, as well as a member check interview lasting approximately 30 minutes to one hour. All interviews will be audio recorded and will occur over a 4-month period of time. Also, you should plan on being in a location that is private and free from distraction during the telephone interviews (e.g., your private office).

Once I have conducted and transcribed all interviews with all five participants, you will be asked to review a portion of your transcript, the preliminary organization of the data (e.g., researcher coding of your transcript), the tentative emerging theory, and to participate in a 30-minute to one-hour member check telephone interview to clarify your responses and provide feedback. The materials for you to review will be sent to you through e-mail to an e-mail address of your choosing approximately one month after the final individual interview has been conducted with all five participants (materials can also be sent via postal mail, if preferred). A date and time will be scheduled for the member check interview within two weeks of receiving
the data analysis for review. The entire process, from the first individual telephone interview to
the member check, is anticipated to take approximately four months. Before committing to the
study, please be sure to check your availability between the months of October 2008 to January
2009. If you agree to participate, I ask that you participate throughout the duration of the study.

Your confidentiality will be protected throughout the study, within the limits of the law. Your identity will be known only to the interviewer and her dissertation co-directors, John D. West, Ed.D. and Cynthia Osborn, Ph.D. A peer reviewer will be consulted throughout the data collection and analysis process to provide feedback to the researcher. Identifying information (i.e., name, institutional affiliation) will not be given to the peer reviewer. Pseudonyms will be used for the discussion and dissemination of the study’s findings. Interviews will be digitally recorded. If you would like, you may listen to the recordings before they are transcribed. Interview responses will be coded by number to avoid having the participant’s name associated with the responses. Transcripts and audiotapes will be kept in a secure location and will be destroyed at the conclusion of the study. Results of the study will be written as in partial fulfillment of my dissertation requirements. Results will also be presented at professional meetings and conferences, and the data will be included in future professional publications.

If you take part in this project you will have an opportunity to contribute to the understanding of supervision for suicidal clients. Participation in this project is entirely voluntary. If you take part, you may stop at any time without incurring any penalty.

Those who do take part in the study will be provided with a gift card for Barnes and Noble Booksellers as a token of the researcher’s appreciation. If you have questions at any time during the study, please contact me at 330-550-5767 or via e-mail at rhoffman@kent.edu.

John D. West, Ed.D. (jwest@kent.edu) and Cynthia Osborn, Ph.D. (cosborn@kent.edu) are my dissertation co-directors and may be contacted at 330-672-2662. The project has been approved
by the Kent State University Human Subject Review Board (Log # 08-679). If you have questions about Kent State University's rules for research, please call Dr. John L. West, Vice President and Dean, Division of Research and Graduate Studies, at 330-672-2581.

You will get a copy of this consent form.

Sincerely

___________________________________
Signature
___________________________________
Date

* Please sign and return this form in the enclosed pre-addressed, postage paid envelope.
APPENDIX E

FLOW CHART FOR GROUNDED THEORY

DATA COLLECTION AND ANALYSIS PROCEDURES
### Flow Chart for Grounded Theory Data Collection and Analysis Procedures

| I. Pre-Interview Procedures | Approval sought from the KSU Human Subjects Review Board  
|                            | Peer reviewer contacted and provided with information regarding the current study  
|                            | Researcher conducted a pilot interview with a participant not affiliated with the current study |
| II. Interviews (Round I) | Round I interviews completed with participants and process notes written during/after each interview  
|                           | Peer reviewer consulted for feedback after round I interviews |
| III. Data Analysis (Round I) | Round I interviews transcribed  
|                            | Process notes transcribed  
|                            | Memo created for each individual interview transcript and corresponding process notes |
| IV. Interviews (Round II) | Round II interviews completed with participants and process notes written during/after each interview  
|                            | Peer reviewer consulted for feedback after round II interviews |
| V. Data Analysis (Round II) | Round II interviews transcribed  
|                            | Process notes transcribed  
|                            | Memo created for each individual interview transcript and corresponding process notes |
| VI. Interviews (Round III) | Round III interviews completed with participants and process notes written during/after each interview  
|                            | Peer reviewer consulted for feedback after round III interviews |
| VII. Data Analysis (Round III) | Round III interviews transcribed  
|                             | Process notes transcribed  
|                             | Memo created for each individual interview transcript and corresponding process notes |
| VIII. Verification Procedures | Member check materials sent to participants two weeks before member check interview  
|                             | Individual member check interviews completed and process notes written after member check interviews  
|                             | Member check interviews and process notes transcribed  
|                             | Memo created for member check interviews and process notes  
|                             | Peer reviewer consulted for feedback after member check |
| IX. Coding Process | Final data interpretation resulted in key categories and an emergent theory  
|                            | Peer reviewer consulted for feedback after final data interpretation completed by the researcher  
|                            | Peer reviewer’s feedback considered by researcher and revisions made to final data interpretation to reflect feedback |
APPENDIX F

SAMPLE MEMO FORMAT
### Sample Memo Format

<table>
<thead>
<tr>
<th>Data Unit</th>
<th>Meaning Unit</th>
<th>Subcategory</th>
</tr>
</thead>
<tbody>
<tr>
<td>In some situations, very, very acute, high-risk situation can be vicariously traumatizing in and so that’s a potential risk as well. So, I wouldn’t say in all situations it could be beneficial or growth producing—that’s the hope, and I would say in the majority of situations that’s the case—but maybe not all situations (<em>A, II, 5, 213</em>)</td>
<td>Working with Suicidal Clients as a Formative Learning Experience</td>
<td>Potential Pitfalls: Vicarious Trauma</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Selective</td>
</tr>
<tr>
<td>I think the biggest thing for me that’s not helpful is to just really come down on the trainee and to focus most or all on just the negative - what the person didn’t do . . . . to be very judgmental and critical (<em>A, II, 6, 247</em>)</td>
<td>Working with Suicidal Clients as a Formative Learning Experience</td>
<td>Potential Pitfalls: Disempowering</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Axial</td>
</tr>
<tr>
<td>I do think it’s important to give constructive feedback and to be collaborative and learn what was done positively and what could have been done differently (<em>A, II, 6, 249</em>)</td>
<td>Role of the Supervisor</td>
<td>Supervisor Reaction / Educator Role</td>
</tr>
<tr>
<td></td>
<td>Open</td>
<td>Axial</td>
</tr>
</tbody>
</table>
Hi, ____________.

Thank you for your willingness to serve as the Peer Reviewer for my dissertation research. Your commitment to provide feedback throughout data collection and analysis is much appreciated. We will communicate via telephone and email on multiple occasions throughout the data collection and analysis process. As previously mentioned, the time commitment for your role as peer reviewer will consist of about 10 hours over a four month period (i.e., October 2008-January 2009).

I have attached the purpose of the current study, research questions, and memo format to this email. Please review these documents and I will contact you within the next couple weeks to answer any questions you have about the current study. Then, as I begin the process of data collection, I will contact you for feedback. Examples of our consultations may include: (a) feedback related to the interview process after the completion of Round I, Round II, and Round III interviews with participants; (b) feedback on the memo format utilized for the each Round of interviews; (c) you may also be asked to independently code a section of each transcript and complete a memo; and (d) lastly, you will be asked to compare the final data interpretation to a portion of each transcript and comment on the accuracy of my representation of each participant’s response, and identify areas where my personal biases may have influenced data interpretation.

As a token of my appreciation, please plan to enjoy a $30 gift certificate following completion of the peer review process. I will be in contact soon. Please contact me if you have questions or comments by email rhoffman@kent.edu or phone (330-550-5767). You may also
contact my dissertation Co-Directors, Dr. John West (jwest@kent.edu) and Dr. Cynthia Osborn (cosborn@kent.edu), at any time throughout the peer review process.

In closing, I would like to sincerely thank you for agreeing to serve as my peer reviewer.

Sincerely,

Rachel Hoffman, M.S.Ed., PC, NCC
Doctoral Candidate
Kent State University
rhoffman@kent.edu
(330) 550-5767
APPENDIX H

MEMBER CHECK INSTRUCTIONS
Hi, Dr. ---

Thank you for your time and assistance throughout my dissertation process. As discussed in our last telephone interview, I am emailing materials for you to review prior to our conversation. You will be asked to verbally provide the results of your member check during a 30-45 minute interview scheduled for DATE. During this interview, I will ask for your feedback on the accuracy of my interpretation of your process of supervision for suicidal clients. Prior to our member check interview, please review the attached documents for clarification, accuracy, and indicate areas that were unclear or misleading.

Attached documents:

1. Summary of the preliminary key categories (i.e., emerging categories and their properties), including each category’s properties and dimensions. The summary reflects the analysis of the data units and subcategories from all three interviews with all five participants.

2. NUMBER content maps that provide a visual representation of each of the preliminary key categories and their properties.

3. Three pages of each of your individual transcripts (e.g., 3 pages from Round I transcript, 3 pages from Round II transcript, and 3 pages from Round III transcript).

4. Preliminary Data Analysis (i.e., memo) of each of your individual interviews (i.e., Rounds I, II, and III). The memo serves as an ongoing summary of the preliminary data units and subcategories. The memo serves to make the data analysis process more clear and transparent to you as you review the materials. Please note that a capital letter (i.e.,
A, B, C, D, and E) was used to identify each participant and a roman numeral was used to identify the interview (i.e., I = Interview Round I and II = Interview Round II) from which the original data unit was associated. The page and line number of the original data unit was also recorded. For example, a data unit from page one, line three of the transcript from the Round I interview conducted with Participant A was labeled as follows: A, I, 1, 3. Each of the categories are color-coded for organization purposes.

Please feel free to contact me if you have any questions before our next interview. I can be reached via email rhoffman@kent.edu or via telephone at (330) 550-5767.

Again, thank you so much for your devoting your time and energy to helping me with my dissertation process!

Best Regards,

Rachel
APPENDIX I

EXEMPLARY FROM TRANSCRIPT AND HIGHLIGHTED DATA UNITS
Researcher
In your own practice as a counselor, how do you feel like your work with suicidal clients as a counselor has impacted your practice as a supervisor?

Michael
I think overall it made me feel more calm during situations and less afraid. I feel that stress and the nervousness that we just talked about not as intense initially, and it also . . . whatever stress or nervousness is there when that situation happens, it also dissipates more quickly. I think it’s given more of a sense of confidence and like I said, just more calmness, and I think I find that I respond more cognitively than emotionally because of the experiences I’ve been through, I find that am much more able to think through the situation and, have better decision making than letting emotions take over or influence what I do. Which is a very helpful thing.

Researcher
To go along with that, what are some of those emotions that you have when your supervisee comes to you and says, “I have a client who I think might be suicidal?”

Michael
Well, I mean, I think sometimes the first reaction emotionally is “uh-oh”. It’s hard to describe what that feeling is, but it’s one of, maybe the adrenaline starts pumping a little more and you become on heightened alert, and I wouldn’t say for me—right now, it’s not strong to the point that it’s like a flight or fight reaction – but certain biochemicals do start pumping out a little more—and it just puts you on heightened alert and it kind of triggers me to go on a different mode like, let’s—it triggers me to start thinking rather than reacting to those emotions talking through the situations and starting to assess what’s going on and what the trainee knows and doesn’t yet know that would be important to make decisions and that sort of thing

Researcher
So, I hear you saying your initial reaction may be, “uh oh” but then you sort of find yourself sort of thinking it through and spending some time focusing on how you can be helpful instead of just perseverating on that “uh oh” feeling.

Michael
Right. And that came through experiences as a supervisor and as a clinician dealing with these types of clients myself. Initially, years ago, when I was newer as a supervisor or clinician, it would have been more of an “uh-oh” and a nervousness, and a cognitive, “what should I do?” and emotional fear to a degree. But I don’t think at this point, 10 yrs later, that that cycle goes as quickly or as far—and I have the “uh-oh” feeling there are things I need to assess here et cetera, but, it—I can catch that emotional reaction much more quickly and move to a more cognitive, supportive, guidance, assessment, kind of a process.
REFERENCES


Commentaries on the ethical and effective practice of clinical supervision.
*Professional Psychology: Research and Practice, 38,* 268-275.


