

**Suggested APA style reference:**

Wozny, D. A., & Zinck, K. (2007). *Development of a suicide intervention training workshop: Utilizing counselor focus groups*. Retrieved August 28, 2007, from <http://counselingoutfitters.com/vistas/vistas07/Wozny1.htm>

---

# **Development of a Suicide Intervention Training Workshop: Utilizing Counselor Focus Groups**

---

***Darren A. Wozny***

Mississippi State University-Meridian Campus

***Kirk Zinck.***

The University of Texas at Tyler

Wozny, Darren A., PhD, is currently an assistant professor of counselor education at Mississippi State University-Meridian Campus. His areas of specialty include counseling suicidal clients, suicide prevention, marriage and family therapy, ethics, and multicultural issues in counseling.

Zinck, Kirk, PhD, is an assistant professor of psychology at The University of Texas at Tyler. His areas of specialty include marriage and family therapy, school counseling, and juvenile sex offender treatment.

*This project was made possible based on a Best Practices Grant from SACES.*

---

## **Introduction**

### **Magnitude of Suicide**

Suicide is a major social issue that will regularly enter the professional lives of

counselors and counselors must be prepared to address the threat of suicide with their clients when it happens. In 2004, suicide was the 11th leading cause of death in the US general population and the 2nd leading cause of death among the young (15 to 24 years of age) (Granello and Granello, 2007). The 2004 mortality rate (most recent available data) for suicide in the United States is 11.1 suicide deaths per 100,000 in the population (Centers for Disease Control, 2004). However, the national suicide mortality rate is underestimated due to the difficult nature of establishing a cause of death as suicide. Similarly, suicide attempts are also hard to measure in the population due to many suicide attempts that occur but are not reported. Therefore, we must rely on estimates of suicide attempts in the population. There are estimated to be 25 suicide attempts for each suicide (25:1 ratio) in US general population but the suicide attempt estimates rise rapidly for the younger population (15 to 24 years of age) where estimates are 100-200 suicide attempts per suicide (Centers for Disease Control). Given the magnitude of suicide, chances are high that most people in their lifetime will encounter suicide directly or indirectly and may need the assistance of a counselor to cope with the issues associated to suicide.

### **Suicide and the Counselor**

In a study of 241 mental health counselors, Rogers, Gueulette, Abbey-Hines, Carney, and Werth (2001) found that 71% of those surveyed reported working with a client that attempted suicide. Granello and Granello (2007) indicated that approximately one in four mental health professionals will experience a client commit suicide. Moreover, every mental health professional will encounter clients that threaten suicide and must be

prepared to appropriately intervene to keep the client safe from harm.

Are mental health professionals prepared to handle clients that threaten suicide? Wozny (2005) found that the vast majority of both CACREP-Accredited Counseling (98%; 49 of 50 programs) and COAMFTE-Accredited MFT programs (94%; 47 of 50 programs) lacked a course in suicide assessment/intervention in their curriculums. Similarly, King, Price, Telijohann, and Wahl's (1999) survey of 186 high school counselors regarding their self-perceived abilities to recognize students at-risk for suicide found that high school counselors only were mildly confident in their suicide assessment/intervention skills with adolescents. Conversely, King (2000) in a study of those same surveyed high school counselors identified that the majority could accurately distinguish between appropriate and inappropriate steps to take when a student threatens suicide and differentiate between known suicide risk factors and fictitious risk factors. Wozny (2007) presented a potential explanation of these contradictory findings that school counselors can differentiate known suicide risk factors from fictitious risk factors (and appropriate suicide intervention actions) if presented in list-form (recognition-level learning)(p.224-225).

Wozny's (2007) study presented 38 counselors a case vignette where a client indirectly threatens suicide and instructed the counselors to write the most salient clinical assessment questions. The counselors' questions were analyzed against Carrier's (2004) top 11 suicide risk factors and found that 68.5% of counselors' questions assessed Carrier's top 11 indicators of suicide risk, and just 52.3% of questions assessed the top

five suicide risk factors. Wozny found that the study's results supported the finding that even experienced counselors (5.6 years of clinical experience – participant average) have competency gaps related to suicide risk assessment. Wozny's findings are consistent with the King et al. (1999) survey of high school counselors' mild confidence in their suicide assessment/intervention skills with adolescents but still in contrast to King's (2000) finding related to high school counselors' knowledge of suicide risk factors and appropriate suicide intervention steps. It seems that counselors can differentiate known suicide risk factors from fictitious risk factors and appropriate from inappropriate steps to take to intervene with a suicidal student (recognition-level learning) but have not yet developed the higher-levels of learning necessary to pose appropriate clinical questions to assess the known suicide risk factors.

Overall, we know that suicide is a major social issue that impacts the general population and counselors will encounter suicide in their clinical work with their clients. However, we also know that counselors do not receive adequate education in suicide assessment/intervention in their counseling curriculums and that even experienced counselors still have significant competency gaps in regards to suicide assessment/intervention. Therefore, as counselor educators, we must explore methods to address this competency gap for counseling students and experienced counselors in our state. Thus, we focused the development of our suicide intervention workshop to begin to address the competency gaps of our counseling students and practicing counselors in our respective states.

## **Project Design**

The suicide intervention workshop project design involves: (1) conducting two pre-workshop focus groups with counseling students from two southern university campuses; (2) incorporating the pre-workshop focus group ideas into the development of the suicide intervention workshop; (3) presenting the suicide intervention workshop with the same focus group participants on both campuses; and (4) conducting two post-workshop focus groups with the same workshop participants.

### **Pre-Workshop Focus Groups: Participant Ideas/Questions**

Analysis of the two pre-workshop focus group transcripts resulted in two main themes.

The two main themes were “need for suicide-related knowledge” and “need for suicide assessment/intervention skills.”

The first theme of “need for suicide-related knowledge” included the following focus group participant exemplars:

- “What groups are at risk for suicide?”
- “What makes certain groups more at-risk?”
- “What is the difference between normal adolescent behaviors and kids who need help?”
- “What are the warning signs that someone may be contemplating suicide?”
- “What are the signs of preparation for suicide?”
- “What are the indicators of possible suicide risk in a school setting?”
- “Cutting vs. suicide – what is the difference in assessing the situation?”

The second theme of “need for suicide assessment/intervention skills” included the following focus group participant exemplars:

- “How to distinguish if someone is truly suicidal or just bidding for attention?”

- “How to respond to the signs of potential suicide?”
- “How to provide a safe place for someone who is feeling suicidal?”
- “People who were suicidal in the past – how to know if he/she is considering suicide again?”
- “How do I work with people who have a history of suicidal ideation?”
- “Avoid over-dramatization in vignettes.”
- “Cover student-teacher scenarios – where a student confides in a teacher that he/she is contemplating self-harm or teacher suspects from conversation that the student may harm self.”
- “Need more information on suicide intervention strategies.”
- “Information/help to give family of person threatening suicide – what can family members do?”

### **Suicide Intervention Training Workshop Outline**

The three-hour suicide intervention workshop was developed based on a three component model that included an attitudes component, a knowledge component, and a behavioral skills component. The premise of our basic suicide intervention model is that all three components (attitudes, knowledge, and behavioral skills) are necessary for a counselor to be prepared to intervene effectively with a client that threatens suicide. If any component of the suicide model is lacking, effective intervention will be negatively impacted. For example, a counselor can have a conducive caregiver attitude toward suicide but if the counselor lacks knowledge of suicide warning signs, the counselor will miss opportunities to intervene. Similarly, if a counselor has the necessary knowledge of suicide warning signs, and the skills to clinically assess for suicide risk but has a non-conducive attitude toward suicide (suicide as manipulation), then the counselor will not see the need to utilize their knowledge and skills. Moreover, if a counselor has a conducive caregiver attitude toward suicide and the necessary knowledge of warning signs and risk factors but lacks the clinical skills to elicit suicide ideation, assess for

suicide risk, and implement safety-based interventions, then the client will not receive the standard of care necessary to keep the client safe from harm.

### ***Suicide Intervention Workshop Outline*** (3 hours)

#### *Attitudes and Knowledge Components* (1 hour)

- Suicide model (attitudes/knowledge/behavioral components)
- Myths of suicide (quiz & discussion of myths)
- Conducive caregiver attitudes toward suicide

#### *Knowledge Component* (1 hour)

- Suicide warning signs (small group exercise – different domains of warning signs)
- Suicide risk factors (primary & secondary suicide risk factors)

#### *Knowledge and Behavioral Components* (1 hour)

- Suicide risk assessment framework
- Case vignette exercises
- Safety-based suicide interventions

### **Examples of Suicide Workshop Training Exercises**

One example of a training exercise from the attitudes component is the “conducive caregiver attitudes toward suicide exercise.” The training exercise involves participants viewing a training video vignette of a group of counselors talking in a break room about dealing with clients that “threaten suicide.” Participants are instructed to identify each counselor’s attitude toward suicide in the group conversation. The counselors in the video vignette display several conducive and non-conducive attitudes toward suicide including: suicide is manipulation; suicide is irrational/crazy behavior; suicide is irresponsible in

duties to others (selfish behavior); and suicide is a cry for help. Participants are asked to discuss if each counselor attitude in the video is conducive or non-conducive for working with suicidal clients.

A training exercise utilized in the knowledge component is the “suicide warning signs exercise.” Workshop participants are divided into small groups and each small group is assigned the task of listing suicide warning signs associated with each of the following domains: physical functioning; emotional functioning; cognitive functioning; academic functioning (if applicable); social functioning; behavioral functioning; and preparations for death. Each group then presents their assigned domain’s list of suicide warning signs and other workshop participants and workshop presenters have the opportunity to add any suicide warning signs that have been omitted.

A behavioral component training exercise is the “case vignette exercise.” Workshop participants are presented the following case vignette: “Sally, 14, just had a major fight with her best friend. As a result of the argument with her best friend, rumors have been spread about her at school and her usual circle of friends has now ostracized her. Sally’s teacher noticed that Sally was unusually withdrawn in her class and tried to talk with her but to no avail. The teacher refers Sally to you for an assessment.” Participants in their same small groups are challenged to pose a clinical question for all risk factors (write down & report to large group) in a suicide risk assessment. Each small group reports the clinical questions they developed to utilize in their suicide risk assessment and the large group and workshop presenters provide feedback on each question in terms of whether



the question addresses the intended suicide risk factor and on the wording of the clinical question itself (questioning skill development).

Another behavioral component training exercise is the “safety-based suicide intervention strategies exercise.” Participants view a video vignette of a counselor explaining to a student’s parents that she has concerns that their son may be suicidal and the parents respond by “minimizing the problem.” Workshop participants are invited to take the role of the counselor in the video vignette. Participants are asked to role-play what they would say and do to emphasize to the parents of this at-risk student the potential seriousness of the situation with their son. Participants are asked to go as far as each person can in the role-play and then have the option to trade with another participant if they get stuck in the process.

### **Post-Workshop Focus Groups: Participant Feedback**

Analysis of the two post-workshop focus group transcripts yielded three main themes.

The first theme of “feeling that the suicide intervention workshop addresses the gap in the counseling curriculum” included the following focus group participant exemplar:

- “This is something I’m very concerned about, because I know I’m going to encounter it when I’m out there on my own. So, it feels good to have more information and more practice working with this issue, than we get in school.”

The second theme of “positive feedback related to the suicide intervention workshop exercises” included the following focus group participant exemplars:

- “I liked the clinical questions exercise (suicide risk assessment) because it was always a mystery what you would ask a potentially suicidal client.”

- “I think discussing it and trying to come up with the questions was good, because you realize... Oh! I don’t...that’s not...maybe it’s not easier to phrase as I might have thought it was.”
- “I thought that the filling out of the warning signs exercise was helpful in learning what to look for.”

The third theme of “constructive feedback on how to improve the suicide intervention workshop” included the following focus group participant exemplars:

- “The thing that I would like to know more about was...what would you do to help a suicidal client have that support of a suicide watch? How would you bring in other people (family members & friends)?”
- “I would like more case vignettes exercises.”
- “If this person is going to harm themselves, now what do I do? Where do I go about getting them committed? Like...how does that process work? Who do I call?”

### **Discussion**

One of the main future directions of the suicide intervention training workshop that was suggested in the focus groups was to develop and integrate more case vignettes exercises (role-plays and video training vignettes) into the workshop. Some of the proposed additional case vignettes are the following: video vignette of aborted suicide risk assessment (participants identify the missing parts of the assessment); video vignette of a suicide risk assessment with a couple (husband depressed) rather than individual client (to demonstrate how the clinical risk assessment and intervention is different with multiple clients present); audio case vignette of a client in crisis over the phone (conduct a suicide risk assessment with a client over the phone exercise); audio vignette of crisis call clients making “veiled suicide threats” and practice judging seriousness from vocal qualities (as well as conducting a suicide risk assessment for each client). In order to have

time to add the additional case vignettes into the suicide intervention training workshop, we may potentially explore the option of dividing the workshop into either a full day workshop or two levels (basic and advanced).

The target population for this suicide intervention training workshop is counseling students and practicing counselors, therefore counselor educators need to consider implementation issues inherent in offering this workshop to counselors. One issue is the optional nature of the suicide intervention training workshop whereby counseling students and practicing counselors can simply choose not to receive the training. Part of the problem is that the workshop is not a required training for counselors though counselor educators can offer the workshop in different settings and ways to encourage counseling students and practicing counselors to receive the training. One of the presenter's colleagues developed a counseling training institute that offered low-cost half-day workshops monthly for the counseling students and counselors in the community. Local training institutes are a way to decrease barriers (location, cost, and time) in counselors receiving the suicide intervention training workshop. As counselor educators, we often give our counseling students extra credit for attending the counseling institute workshops. Another venue to offer the suicide intervention training workshop is regional counseling professional meetings where presenters are invited to present half-day workshops on current issues in counseling. Similarly, other places to reach large numbers of counselors are to offer pre-conference workshops (typically half-day workshops) at the state and national counseling conferences. Given that most settings that

offer workshops to counselors are briefer in nature (half-day or less), it seems more useful to offer suicide intervention training workshop in different levels (basic and advanced) of half-day workshops rather than full-day workshops that are difficult for counseling students and practicing counselors to access. Regardless, unless counselor educators can find a workable method of training counseling students and practicing counselors in suicide assessment/intervention, counselors will continue to have a competency gap in a commonly encountered issue in counseling.

### References

- Carrier, J.W. (2004). Assessing suicide risk. In D. Capuzzi (Ed.) *Suicide across the lifespan: Implications for counselors* (pp.139-162). Alexandria, VA: American Counseling Association.
- Centers for Disease Control and Prevention. (2004). National Center for Injury Prevention and Control. Fatal injury reports and leading cause of death reports. Retrieved December 12, 2006 from <http://www.cdc.gov/ncipc/wisquars/>.
- Granello, D.H. and Granello, P.F. (2007). *Suicide: An essential guide for helping professionals and educators*. Boston, MA: Pearson Prentice Hall.
- King, K.A., Price, J.H., Telijohann, S.K., and Wahl, J. (1999). How confident do high school counselors feel in recognizing students at risk for suicide? *American Journal of Health Behavior*, 23(6), 457-467.
- King, K.A. (2000). Preventing adolescent suicide: Do high school counselors know the risk factors? *Professional School Counseling*, 3(4), 255-263.
- Rogers, J.R., Gueulette, C.M., Abbey-Hines, J., Carney, J.V., and Werth, W.L. (2001). Rational suicide: An empirical investigation of counselor attitudes. *Journal of Counseling and Development*, 79(3), 365-372.
- Wozny, D.A. (2005). The prevalence of suicide and violence assessment/intervention courses in CACREP and COAMFTE-Accredited counseling curriculums? In G.R. Waltz, and R. Yep (Eds.) *VISTAS: Compelling perspectives on counseling 2005* (pp. 271-274). Alexandria, VA: American Counseling Association.

Wozny, D.A. (2007). Suicide risk assessment: Counselor competency. In J.R. Rodgers (Ed.), *Suicide 2006: Proceedings of the 39 th Annual Conference of the American Suicidology Association* (pp. 224-227). Washington, DC: American Association of Suicidology.

---

### **VISTAS 2007 Online**

*As an online only acceptance, this paper is presented as submitted by the author(s). Authors bear responsibility for missing or incorrect information.*