The Impact of Supervision on Counselor Self-efficacy: Working with Suicidal Clients

by

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Abstract

Crises are becoming more prevalent in today's society leading to increased preparedness of counselors to work in crisis interventions. Given that suicide rates have increased by 60% in the last 50 years counselors must be trained in risk assessments and feel confident in effectively providing care to individuals who are suicidal. Supervision has been found to promote counselor self-efficacy (Bernard & Goodyear, 2013; Cashwell & Dooley, 2001; Kozina, Grabovari, Stefano, & Drapeau, 2010), but limited research has studied how supervision plays a role in counselor's self-efficacy when working with suicidal clients specifically. The current study examined the relationship between elements of supervision (e.g. Rapport, Client Focus, Feedback, and Goal setting) on counselor's self-efficacy when working with suicidal clients. Ninety individuals participated in the study who identified as either counselors-in-training who are currently enrolled in a master's program or two years post master's. Participants completed the following measures: The Counselor Suicide Assessment Efficacy Survey (CSAES;Douglas & Wachter Morris, 2015), The Supervisory Working Alliance Inventory (SWAI; Efstation et al., 1990), and The Evaluation Process with Supervision Inventory (EPSI ; Lehrman-Waterman & Ladany, 2001). Results indicated that goal setting in supervision is an important predictor and positively related to counselor self-efficacy when working with suicidal clients. The results of the study provide implications for supervisors and counselor educators in the field by demonstrating the importance of developing specific goals for the supervisee to work toward. Limitations, directions for future research, and implications are further discussed.

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CHAPTER I

Introduction

The Council for Accreditation of Counseling and Related Educational Programs (CACREP, 2016) Standards require counselors in training and counselor educators to be aware of their responsibilities in crisis intervention and prevention models (Section II. G.5.g.). Crisis situations are becoming more prevalent and receiving more attention by society each year, and as a result counselors and counselor educators need to be more prepared and feel more confident in crisis intervention counseling techniques (Sawyer, Peters, & Willis, 2013). Although CACREP has identified specific student learning outcomes to measure crisis intervention preparedness, little is known about practice implications of the learning outcomes. Multiple trainings related to crisis intervention have been developed to improve practice of counselors (ACA, 2011; FEMA, 2015); however, such trainings do not include information specific to supervision, which may affect counselor preparedness and self-efficacy with crisis interventions.

Crisis is a state of emotional disequilibrium, a time when events overwhelm a person's problem solving abilities (Roberts, 2005). Crises can include multiple events; however for this study, the focus is placed on suicidal crises. Suicidal thoughts and attempts disrupt the flow of one's life, triggering strong emotions that are not easily resolved (Dupre, Echterling, Meixner, Anderson, & Keitly, 2014; Echterling, Presbury, & McKee, 2005). The Centers for Disease Control and Prevention (CDC) reported in 2014 that suicide was the tenth leading cause of death, resulting in 42,773 reported suicides. In addition, suicide was the second leading cause of death for ages 10-14, 15-24, and 25-34 and the fourth leading cause of death for ages 35-44 and 45-54.

It has been estimated that suicide rates have increased approximately 60% in the last 50 years (World Health Organization, 2006).

The World Health Organization (WHO) (2006) estimated that possibly 90% of individuals who commit suicide have a mental disorder and about 60% of them were depressed at the time. With statistics as startling as those provided by the CDC and WHO, reducing suicides and suicidal behaviors have become a critical role for counselors. Counselor educators and supervisors have a role to ensure counselors are prepared to assess and intervene with little notice when a client is suicidal (Douglas & Wachter Morris, 2015).

Statement of the Problem

Given the realities of suicide, counselors must be trained in suicide assessment and intervention, while believing they are capable of using these practices effectively. Douglas and Wachter Morris (2015) stated suicide assessment is an area in which counselors may experience low self-efficacy. King, Price, Telljohann, and Wahl (1999) found that only 38% of school counselors surveyed believed in their ability to effectively recognize a student at risk for suicide. This study was later validated by Wachter Morris and Barrio Minton (2012) who found 26.95% of counselors in their first two years of practice indicated having little to no training in suicide assessment.

Self-efficacy is particularly relevant to counselor development. Literature has shown self-efficacy to have a significant impact on counselors' perceptions of their own abilities, commitment, motivation, and resilience in the profession (Bandura, 1986b, Cincotti, 2013; Douglas & Wachter Morris, 2015; Larson, 1998). Larson (1998) suggests self-efficacy serves as

the link between preparedness and performance of skills. This leads to effects on counselor behavior, decision making, and ability to cope with occupational stress (Bandura, 1986b). Considering the role counselors' self-efficacy plays in clinical decisions, the paucity of literature is concerning (Douglas & Wachter Morris, 2015; Larson & Daniels, 1998).

Significance of Study

Effective supervision can prevent counselors from the hazardous effects of working with suicidal clients. Supervision has the potential to reduce vicarious trauma and burnout, and to promote counselor self-efficacy (Dupre et al., 2014). However, supervision related to crisis work is frequently not provided to developing counselors and is rarely addressed in literature, as mentioned above. Literature and research has led to the development of multiple supervision models, but one has yet to meet specific needs for crisis counselors (Dupre et al., 2014). A large amount of literature has recently focused on supervision and its effect on counselor self-efficacy (Cashwell & Dooley, 2001; Cincotti, 2013; Kozina, Grabovari, Stefano, & Drapeau, 2010; Lorenz, 2009), but no research has looked exclusively at supervision and counselors' self-efficacy when working with suicidal clients.

A thorough review of the literature revealed a paucity of research on the relationship between crisis interventions and supervision. One qualitative study looked at crisis supervision and the experiences of licensed professional counselors who received crisis supervision, while performing crisis counseling (Dupre et al., 2014), while other studies addressed counselors and crisis preparedness. One study reviewed crisis preparation in CACREP-accredited master's level programs (Barrio Minton & Pease-Carter, 2011) and three studies specific to school counselor

preparation (Allen, Burt, Bryan, Carter, Orsi, & Durkan, 2002; King, Price, Telljohann, & Wahl, 1999; Wachter, 2006). Two studies have addressed beginning counselor's self-efficacy in working with clients in crisis (Wachter Morris & Barrio Minton, 2014; Sawyer, Peters, & Willis, 2013). Without a clear idea of practice implications or research of supervision and crisis intervention, counselor educators may struggle to develop evidenced-based supervision practices. Counselor educators and supervisors have an opportunity to enhance counselors' development in providing crisis intervention competently and with confidence.

Purpose of Study

Counselor educators and supervisors are called to assess the effectiveness of supervisees and counselors-in-training to manage crisis interventions. The majority of research in this area has focused on how curriculum has prepared counselors, and the proposed study will expand this line of research by providing implications for clinical supervision. The purpose of this survey study is to assess the degree to which supervision impacts counselor's self-efficacy when working with suicidal clients. Supervision, the independent variable, will be defined as an intervention that is provided by a senior member of a profession to a junior member of that same profession. The supervision relationship is evaluative and serves to enhance the professional functioning of the junior member, monitoring the quality of professional services offered to the clients, and serving as a gatekeeper (Bernard & Goodyear, 2013). The dependent variable, counselor self-efficacy, will be defined "as one's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p.180). More specifically, the study will be looking at counselor's beliefs about effectively working with

suicidal clients who demonstrate suicidal ideation, plan, means, or intent and require immediate intervention to reduce risk.

Research Questions

Q1. What is the effect of the supervisory alliance (e.g. rapport, client focus) on counselor self-efficacy for working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?

Q2. What is the effect of the supervisor evaluation (e.g. goal setting, constructive feedback) process on counselor self-efficacy for working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?

Q3. What is the effect of the supervisory alliance (rapport, client focus) and the supervisor evaluation process (goal setting, constructive feedback) on counselor's self-efficacy when presently working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?

Definition of Terms

It is important to define the key terms that are used throughout this study. Three terms refer to the circumstances, dynamics, and consequences of suicidal crisis situations (crisis, suicide, and self-efficacy). Six terms are related to the counseling profession (crisis intervention, supervision, indirect and direct observation, and supervisor).

A *crisis* involves an overwhelming stimulus which is perceived by the client, impacts the client, and leads to a time in which the client feels they are unable to cope (Collins & Collins, 2005). *Suicide* describes the act or desire to take one's own life (Merriam-Webster's dictionary, 2016). The term *self-efficacy* is defined as the degree in which individuals believe they are capable to perform a specific task (Bandura 1986b).

Crisis intervention occurs when a counselor focuses on stabilizing the situation, reducing heightened emotion, ensuring safety, and providing linkage to appropriate resources (Roberts & Ottens, 2005). *Supervision* is defined as an intervention provided by a senior member of the profession to a junior member of the same profession. Its purpose is to enhance professional growth and ensure quality of services provided to clients (Bernard & Goodyear, 2013). A *supervisor* is a professional counselor or counselor educator who provides supervision to a practicing counselor or counselor in training to foster development of counseling skills and ensure ethical standards are upheld. Supervisors serve as gatekeepers to people entering the profession (Bernard & Goodyear, 2013). *Direct observation* is defined as the type of supervision provided to the counselor. Direct observation occurs when the supervisor and supervisee are face to face processing present concerns.

Supervisory working alliance is defined as "the strength of the alliance between the person seeking change and the change agent" (Bordin, 1979, p.35). For this study, supervisory working alliance asserts that the supervisee and supervisor must have mutually developed goals with a relationship that promote professional development and change (Ladany, Ellis, & Friedlander, 1999). Supervisory working alliance will be measured using the *Supervisory*

Working Alliance Inventory (SWAI; Efstation, Patton, & Kardash, 1990). *Rapport* and *client focus* are subscales of SWAI. Rapport addresses the counselor's perception of support from the supervisor, whereas client focus addresses the trainees' perceptions of how closely they work with their supervisors to improve their clinical skills.

Evaluation process is defined as the degree to which counselors feel their supervision is characterized by effective goal setting and feedback, and it will be measured by *The Evaluation Process Within Supervision Inventory* (EPSI; Lehrman-Waterman & Ladany, 2001). *Goal setting* is a subscale of EPSI where the measure assess the extent to which counselors feel supervisors have facilitated achievable goals for the supervision experience. *Client focus* is the second subscale of EPSI and addresses how the counselors feel about feedback from their supervisor is relayed and if it helps them make progress toward their goals.

CHAPTER II

Review of the Literature

The Concept of Crisis

Crisis situations are becoming increasingly more prevalent in our society today, creating a need for counselor preparedness in crisis interventions (Sawyer, Peters, & Willis, 2013). Crises have a significant impact on clients with serious mental and emotional health problems (SAMSHA, 2009). Counselors encounter various types of crisis on a daily basis that can lead to affective, behavioral, and cognitive stressors for the counselors and clients (Collins & Collins, 2005; Wachter Morris & Barrio Minton, 2012). A crisis has been defined various ways in literature. Flannery and Everly (2000) defined crisis as, "a crisis occurs when a stressful life event overwhelms an individual's ability to cope effectively in the face of a perceived challenge of threat," (p. 119) whereas Rogers (2005) considered a crisis to be a "time-limited period of distress following a specific precipitating event" (Dupre, Echterling, Meixner, Anderson, & Kielty, 2014, p. 91). Similarly, Slaikeu (1990) defined crisis as a "temporary state of upset and disorganization, characterized chiefly by an individual's inability to cope with a particular situation using customary methods of problem solving, and by the potential for a radically positive or negative outcome" (p. 15). James and Gilliland (2005) defined crisis as "a perception of experience of an event or situation as an intolerable difficulty that exceeds the person's current resources and coping mechanisms" (p. 3). It is clear that literature has developed various definitions for a crisis; however, each agree that a crisis involves an overwhelming stimulus

which is perceived by the client, impacts the client, and leads to a time in which the client feels they are unable cope (Collins & Collins, 2005).

Crisis intervention

Crisis intervention was originally developed in response to a growing demand for services in situations where immediate assistance was required. The limited availability of helping professionals, in training or in practice, for this type of counseling contributed to the development of crisis interventions and appropriate treatment for many individuals with sudden stressors (Poal, 1990).

Clients in crisis are considered to be in a state of psychological disequilibrium because of stressful events that challenge their ability to cope (Caplan, 1964; Sandoval, Scott, & Padilla, 2009). Counselors intervene in a way that helps clients return to previous level of functioning and helping them gain new coping skills to promote personal growth (Sandoval, Scott, & Padilla, 2009). In 2011, ACA developed 1:1 crisis intervention that focuses on safety, stability, and connection. The goals of 1:1 are to ensure the client is safe and stable with a plan for emergency, while providing the client with connections to resources and support. Crisis intervention ranges in duration and frequency; however, statistics report crisis intervention occurs with the same client about one to three times (ACA, 2011).

The ultimate goal of crisis intervention is to systematically organize client information related to personal characteristics, factors of the crisis, the intensity, frequency, and duration of the crisis, and to utilize this information to develop appropriate treatment plan (Roberts, 2002). When employing crisis interventions, counselors are encouraged to utilize techniques that

provide guidelines to resolve clients' current concerns, stress, and emotional distress and restore to optimal level of functioning (Roberts, 2002; Poal, 1990, Puryear, 1979). Crisis interventions are time limited and goal oriented to facilitate recovery in order to reduce duration and severity of the crisis episode (Roberts, 2000; Poal, 1990).

Centre for Applied Research in Mental Health and Addiction (CARMHA) (2004) conceptualized crisis interventions, specifically suicidality, as intervention efforts that focus on reducing current suffering, while concurrently building client resilience and coping mechanisms from emotional, cognitive, and behavioral perspectives. In 2009, SAMSHA published a booklet to help provide guidelines for counselors responding to mental health crises of individuals with serious mental illness. SAMSHA's (2009) principles closely align with CARMHA's conceptualization. SAMSHA recommended ten essential values that helping professionals should maintain and uphold during crisis interventions. The first value is to avoid harm by establishing safety, physically and psychologically, while responding in a person-centered style. SAMSHA (2009) encouraged counselors to promote client engagement and reduce feelings of helplessness by empowering the client involved in the crisis intervention. Next, it is important for counselors to gain awareness of the client's trauma history by asking questions empathically and incorporating this information in their approaches to reduce further trauma and increase comfort. Similarly, assisting the client in establishing feelings of personal safety and security is appropriate to reduce vulnerability and increase emotional distress. After personal safety is established, counselors can help the client focus on strengths and draw on resources they already possess or know about. Likewise, it is important to remember the client as a whole person, rather than focusing on their mental illness only. This will allow the counselor to continue to see the

client as a credible source despite symptom presentation, which is important when understanding the individual. Lastly, it is important for the counselor to help the client look toward future recovery and develop relapse prevention plans. SAMSHA (2009) recommended counselors foster a sense of hope and plan for the future by addressing clients' unmet needs and promote systemic improvements. Overall, SAMSHA (2009) hoped to encourage crisis interventions that are future-oriented rather than strictly reactive to help the client learn to adapt to situations appropriately while learning ways to manage personal crises with resilience and community resources.

Imminent Risk: Suicide

Bobele (1987) noted that "life-threatening behavior is a relatively common encounter in the day-to-day practice of many clinicians" (p. 225-226). Literature indicates nearly one-third of mental health counselors will work with a suicidal client during their career, while about two-thirds should expect a client's suicide attempt (McAdams & Keener, 2008; Rogers, Gueulette, Abbey-Hines, Carney, & Werth, 2001; Schwartz & Rogers, 2004). With suicide rates increasing approximately 60% worldwide in the past 45 years (World Health Organization, 2012), McAdams and Foster (2000) and Firestone (n.d.) reported that about one-third of counselors will work with a client who will die by suicide, while Firestone (n.d.) also indicated that 71% of clinicians reported having at least one client who has attempted suicide during their career.

Literature states there are many misconceptions about suicide. One major misconception is that clients exhibiting suicidal behaviors have a desire to die and cannot be helped (CARMHA, 2004; Firestone, n.d.). However, research indicates that suicidal clients are treatable and can

benefit vastly from tools and techniques counselors possess (Firestone, n.d). An important factor and tool for counselors to utilize is the therapeutic alliance. Literature has stated the relationship between counselors and the client is probably the most important aspect of treatment of suicidal behavior. The therapeutic alliance can help the counselor attend to the client's loneliness and provide a sense of safety and/or support during crises (CARMHA, 2004). Counselors who have low self-confidence may experience challenges developing rapport contributing to poor self-efficacy in crisis interventions (Hill, Sullivan, Knox, & Schlosser, 2007).

Suicide Assessment and Management

Core Competencies for Suicide Assessment. A curriculum developed by the American Association of Suicidology (AAS) identified core competencies for counselors to help assess and manage individuals at risk for suicide (Suicide Prevention Resource Center, 2006). AAS identified eight core competencies: (a) working with individuals at risk for suicide: attitudes and approaches, (b) understanding suicide, (c) collecting accurate assessment information, (d) formulating risk, (e) developing a treatment and services plan, (f) managing care, (g) documenting, and (h) understanding legal and ethical issues related to suicidality. The core competencies help increase counselors awareness of knowledge, skills, and attitudes required to successfully perform a suicide risk assessment. AAS provides clear guidelines for clinical evaluation and treatment for individuals at risk for suicide by promoting safety and protecting client welfare (SPRC, 2006).

Although very limited at this point, literature has developed empirical foundation for the core competencies in suicidality including the various aspects of assessment, management, and

treatment (Rudd, Cuckrowicz, & Bryan, 2008). However, it should be noted the empirical literature is compromised by several problems including brief follow-up and target outcomes not directly related to suicidality (e.g. depression and hopelessness rather than attempts and deaths by suicide.).

Oordt, Jobes, Fonseca, and Schmidt (2007) found that core competency training could change counselors' confidence in assessing and managing suicide risks, as well as alter behaviors in counselors' clinical practice. Fenwick, Vassilas, Carter, and Haque (2004) reported role plays were viewed as the most effective component in training counselors in suicide risk assessment. The most important data for core competencies is found in treatment outcome studies. Rudd, Brown, Jobes, Joiner, Cukrowicz, and Silverman (2009) provided a review of controlled treatment trials where suicidality was targeted. They found that effective treatments are those that reduced suicide attempt rates. Cognitive-behavioral treatment orientations demonstrated strong evidence of effectiveness when combined with core competencies (i.e. models for understanding suicide, collecting information, and developing appropriate treatment plan for suicidality).

Suicide Assessments. Research has developed multiple suicide assessments to help counselors manage risks and prevent death by suicide. In 1983, the SAD PERSONS suicide assessment was developed by Patterson, Dohn, Bird, and Patterson to offer better accuracy for prediction for suicidal risk. SAD PERSONS scale is widely used risk assessment tool for suicidal behavior despite the paucity of supporting data. Bolton, Spiwak, and Sareen (2012) studied SAD

PERSONS scale and its effectiveness in predicting suicide attempts. SAD PERSONS did not predict suicide attempts better than chance.

More recently, the AAS developed a simple tool to help counselors remember the warning signs of suicide: IS PATH WARM (Juhnke, Granells, & Lebron-Stricker, 2007). Each letter corresponds with specific risk factors of suicide: Suicide **I**deation, **S**ubstance Abuse, **P**urposelessness, **A**nger, **T**rapped, **H**opelessness, **W**ithdrawing, **A**nxiety, **R**ecklessness, and **M**ood. Similarly, McGlothlin (2008) developed the acronym SIMPLE STEPS to help counselors scan for risk based on salient risk factors and/or warning signs. SIMPLE STEPS corresponds with the follow risk factors of suicide: **S**uicidal, **I**deation, **M**eans, **P**erturbation, **L**oss, **E**arlier attempts, **S**ubstance Use, **T**rouble-shooting, **E**motion, **P**arents/family history, and **S**tress. Mnemonic suicide assessment should be taught to counselors and utilized regularly by all who encounter those who may be at risk for suicide (Juhnke, Granello, & Lebron-Striker, 2007).

Counselor Training in Crisis Intervention

After a thorough search of current crisis intervention trainings, multiple trainings were available, but costly, which may lead to challenges for counselors to utilize these resources. Some trainings were specific to trauma and disaster crises where the counselor learns techniques such as Psychological First Aid, a crisis assessment and intervention manual-based program to aid individuals after a nature or human caused disaster (ACA, 2016; SAMSHA, 2009; FEMA, 2015). Other training models were integrated in to Psychological First Aid and provided lessons related to various aspects of crisis intervention such as suicide prevention, crisis responses models, and diversity considerations (American Institute of Health Care Professionals, 2016).

FEMA (2015) and SAMSHA (2009) utilize the same crisis intervention model, Crisis Counseling Assistance and Training Program (CCP). The mission of CCP is to help individuals who are recovering from the effects of a natural or human-caused disaster. The CCP focuses on employing short term interventions to help individuals manage stress, understand current reactions, develop new coping strategies, and provide individuals with links to community resources for continued recovery process. This approach calls for counselors to uphold five key principles when using CCP: strength based, anonymous, outreach oriented, conducted in nontraditional settings, and designed to strengthen existing community support systems to help crisis counselors promote safety, stability, and recovery after a crisis occurs (SAMSHA, 2009; FEMA, 2015).

Trainings specific to suicide prevention are limited for counselors, because most trainings for suicide prevention are available for the public and primary care physicians. These trainings help the participants recognize and respond to suicide risk and warning signs appropriately. One training is offered by the Suicide Prevention Resource Center (SPRC) strictly for mental health professionals. The training provides mental health professional with a research and skills based training (Education Development Center, 2015). SPRC recommends key activities that can strengthen suicide prevention efforts: (a) finding and using data, (b) identifying people at risk for suicide, (c) working with survivors of suicide loss, (d) engaging suicide attempt survivors, (e) reporting about suicide, and (f) upstream prevention (e.g. preventing "the causes of the causes" of suicide) (Education Development Center, 2015). Utilizing these activities will help society understand suicide and reduce stigma, while helping the public recognize individuals who are risk for suicide. SPRC helps counselors helps protect people from emotional trauma from the

suicide of a family or friend, while also meeting the needs of people who have survived suicide attempts to prevent future suicidal behaviors. Lastly, SPRC can encourage responsible reporting of suicidal behaviors to reduce the profound impact of poor portrayals of suicide in the media and enhance protective factors (Education Development Center, 2015).

Question, Persuade, and Refer (QPR) is a suicide prevention method that was created to train non-mental health professionals to save lives and reduce suicidal behaviors. QPR trains people to recognize the warning signs of suicide crisis and how to question, persuade, and refer someone for help (QPR Institute, n.d.). QPR helps educate about the warning signs of suicide crises by reducing stigma and teaching appropriate ways to respond. Using the resources provided by SPRC and QPR will help counselors and the public implement effective suicide prevention practices by helping them use research-informed skills and lead to increased self-efficacy when assessing and managing suicide risk.

Counselor Self-Efficacy with Crisis Interventions

Research indicates that nearly 30% of practicing school counselors endorsed no training regarding suicide (Watcher, 2006), and only 38% believed they could identify a student at risk for suicide (King, Price, Telljohann, & Wall, 1999). Research of practicing mental health counselors indicated similar percentages of unpreparedness, even though they were aware they have a higher probability of encountering clients in crisis (Shields & Kiser, 2003; McAdams & Keener, 2008). These statics and limited research are particularly alarming because counselors' confidence in their capabilities plays a large role in their decisions when counseling their client (Larson & Daniels, 1998; Douglas & Wachter Morris, 2015). Consequently, Larson and Daniels

(1998) reviewed the literature of counselor self-efficacy and determined that it influences the multiple aspects of the counseling experience (e.g. decisions with clients, actions with clients, and responses given to clients.) They also found counselor self-efficacy to be a predicator of how counselors will approach situations and manage challenging situations. Larson and Daniels (1999) also stated that counselor self-efficacy is the connection between "knowing how to counsel a client and actually counseling through effective actions" (p. 59).

More recently, Douglas and Wachter Morris (2015) found that a counselor's self-efficacy related to suicide assessment is multidimensional and that counselors may not lack the ability to ask questions related to suicide, but they may lack confidence in their ability to take appropriate action. Therefore, a counselor may have the techniques to appropriately counsel a client in a suicidal crisis, but low self-efficacy may cause the counselor to perform poorly. It is posited that the more self –efficacy related to working with suicidal clients, the better the crisis intervention given to the client (Douglas & Wachter Morris, 2015).

Impact on Counselors

Crisis interventions have shown to be challenging for counselors, as well as clients, contributing to increased vocational and personal stress. When counselors encounter crisis on a regular basis, the effects may be detrimental to the counselor, clients, and others. While crisis intervention has been researched more extensively in the past few years, the intricacy of crisis interventions have not been adequately described (Dupre et al., 2014). Crisis interventions can involve the individual in crisis, family, counselors, other helping professionals, and legal justice workers (e.g. police officers, probate courts). With multiple individuals collaborating and the

focus on ensuring safety, crisis interventions lead to potential risks for counselors as well as clients. Counselors are encouraged to recognize the unique stressors of working with suicidal clients (CARMHA, 2004); yet, often report feelings of "guilt, sadness, anger, and increased fear in dealing with at-risk clients" after imminent risk crises, such as suicide (McAdams & Keener, 2008, p. 389). The risk of professional impairment has been considered a greater risk when crises occur while the counselor is a student, possibly contributing to a sense of incompetence and failure as a counselor (McAdams & Keener, 2008, McAdams & Foster, 2002; Trimble, Jackson, & Harvey, 2000).

Counselors may need to consider adjusting or monitoring their professional and personal beliefs about suicide and the value of life, because it is possible for a counselor to experience an existential crisis regarding purpose of life and work after working with a suicidal client (CARMHA, 2004). Counselors are also at risk for transference and countertransference, while this is a natural occurrence in relationships, it may cause the counselor to bring feelings that are harmful to the client or elicit unexpected reactions for the counselor during the intervention (CARMHA, 2004).

Burnout is a common concern of counselors who routinely provide crisis interventions. Freudenberger (1990) suggested that burnout is a state of fatigue that develops because of the level of devotion one has to a particular aspect of their life that failed to produce an expected reward. In recent literature, extensive research has led to the suggestion that "burnout is a psychological syndrome that develops in response of chronic emotional and interpersonal stress" (Thompson, Amatea, & Thompson, 2014, p. 58). Burnout is currently characterized by emotional

and psychological exhaustion leading to the perception of low energy, increased inflexibility, and disbelief of treatment effectiveness (CARMHA, 2004; Miller, Iverson, Kemmelmeier, MacLane, Pistorello, Fruzzetti, Watkins, Pruitt, Oser, Katrichak, Erikson, & Crenshaw, 2011; Thompson, Amatea, & Thompson, 2014). When burnout occurs, personal, organization, and social costs accrue leading to increased professional challenges for the counselor and poor treatment for the clients (CARMHA, 2004).

Similar to burnout, vicarious trauma is also an occupational hazard that impacts counselors who work with suicidal clients. Clinicians can feel strained as they engage and maintain empathy with suicidal clients in a way that similar to burnout, but vicarious trauma happens suddenly and without warning (Figley, 1995; CARMHA, 2004). Literature describes the core symptoms of vicarious trauma as flashbacks, nightmares, and intrusive thoughts (Galek, Flannelly, Greene, & Kudler, 2011; Thompson, Amatea, & Thompson, 2014; CARMHA, 2004). Compassion fatigue can be used interchangeably with vicarious trauma (Figley, 1995a; CARMHA, 2004; Thompson, Amatea, & Thompson, 2014). Counselors experience compassion fatigue after helping or wanting to help clients who are suffering. Figley (1995b) stated that counselors who work with suicidal clients "may feel similar fear, pain, and suffering because they care" (CARMHA, 2004, p. 68). This experience reduces counselors' ability to bear the suffering of others, reducing the ability to be compassionate for clients (Figley, 2002).

However, counselors can also experience positive outcomes from crisis intervention with positive supervision experiences, such as resilience and professional growth (Dupre et al., 2014). Supervisors can significantly enhance resilience and professional growth by being readily

available, engaging in the meaning-making process, regulating powerful emotions, and taking immediate action (Echterling & Stewart, 2008). Supervisors can help counselors manage negative outcomes of crisis intervention and produce positive outcomes (Dupre et al., 2014).

Counselors can experience positive outcomes of helping, such as "compassion satisfaction" (Stamm, 2010, p.8). Compassion satisfaction embodies aspects of altruism, confidence, and happiness about work. Counselors may experience positive change from their work with suicidal clients and emerge feeling stronger and more successful (Dupre et al, 2014). Similarly, Hernandez, Gangsei, and Engstrom (2007) discussed "vicarious resilience" in which therapist are empowered by their client's resilience (p.237). Resilience is defined as a pattern of positive adaption to challenges (Masten & Coatsworth, 1998). This phenomenon can lead to insight, independence, creativity, humor, and morality (Wilon & Wilon, 1993). Vicarious resilience increases counselors' ability to reframe negative events, enhances coping mechanism, and reinforces the healing process (Hernandez, Gangsei, & Engstrom, 2007). This literature highlights the idea that crisis events can enhance appreciation for life and work.

Supervision and Counselor Self-efficacy

Bernard and Goodyear (2013) described supervision as an intervention that is provided by a senior member of a profession to a junior member of that same profession. This relationship is evaluative and has the purpose of enhancing the professional functioning of the junior members, monitoring the quality of professional services offered to the clients, and serving as the gatekeeper of those who are to enter the particular profession. Supervision helps counselors maintain focus on skills and theoretical orientation that they obtain in academia (Cashwell &

Dooley, 2001). Supervision provides structure, feedback, and support that promote professional growth (Cashwell & Dooley, 2001; Bernard & Goodyear, 2013). Clinical supervision is a major component in the development of counselors and it is essential when research suggests that is establishes core competencies in counselors (Bernard, 2006).

Bandura (1982) proposed four components that increase or decrease self-efficacy, which are present in counselor development as well: (a) performance enactment (e.g., performing a specific behavior successfully); (b) vicarious learning (e.g., observing and modeling a specific behavior); (c) verbal persuasion (e.g., listening to someone correctly explain how to perform a specific behavior); and (d) emotional arousal (e.g., emotional states that either inhibit or enhance self-efficacy). Supervisors understand counselor self-efficacy is an important step in practicing effectively; therefore, literature has stated that a primary goal of supervision is to foster counselors' confidence in their skills (Bernard & Goodyear, 2013; Cashwell & Dooley, 2001; Kozina, Grabovari, Stefano, & Drapeau, 2010). Even though the benefits of consistent and effective supervision are addressed in counseling literature, a significant amount of counselors continue to receive inadequate supervision (Cashwell & Dooley, 2001; Cincotti, 2013; Oberman, 2005; Somody, Herderson, Cook, & Zambrano, 2008). Literature suggests counselors who receive minimal or poor supervision may experience a decline in the level of their counseling. Therefore, effective supervision is important to prevent counselor growth from ceasing (Cashwell & Dooley, 2001).

Supervision is often based on weekly cases or self-selected materials that focus on the counselors' best work, while also encouraging supervisees to process their challenges (Webb &

Wheeler, 1998; Kozina et al., 2011); therefore, addressing counselor's self-efficacy could help supervisors focus on areas in which the supervisee needs more attention. Using purposeful supervision goals and interventions, while establishing a supervisory working alliance, will allow supervisees to develop professional self-efficacy, a strong theoretical foundation, self and personal awareness, and may lead to more positive outcomes for the counselor and client (Lorenz, 2009).

In 1992, Larson, Suzuki, Gillespie, Potenza, Bechtel, and Toulouse developed the *Counselor Self Estimate Inventory* (COSE) that was used to study counselor self-efficacy. Larson et al., (1992) found that individuals who received a range from one to seventeen semesters of supervision reported significantly higher levels of counselor self-efficacy while the individuals' scores on the COSE increased as more supervision was received. The development of COSE reinforced that supervision plays an important role in the development of counselors (Cashwell & Dooley, 2001). Literature has suggested the use of COSE in supervisory relationships may help monitor counselors' self-efficacy growth on a continuous basis that could promote positive changes and become an indicator of effective supervision (Cashwell & Dooley, 2001; Kozina et al.,2011). Consequently, self-efficacy measures may serve as evidence to support outcome based supervision (Kozina et al., 2011).

Although it should be noted, Lent, Hill, and Hoffman (2003) while supportive of COSE, described several limitations of the measure. They argued that the COSE is grounded in theory and it may be measuring other constructs (e.g. values). To reduce these limitations, Lent, Hill, and Hoffman (2003) developed the *Counselor Activity Self-Efficacy Scale* that yields scores on

subscales measuring exploration, insight, session management skills, and therapeutic relationship skills. They hypothesized that a combination of knowledge, skills, and self-efficacy paired with challenging and purposeful supervision can lead to counseling effectiveness. Supervision can provide a source of efficacy by providing specific feedback, vicarious learning experiences, affect management, and empowerment (Hanson, 2006).

Similarly, Larson and Daniels (1998) suggested that one major task of supervisors is to continuously assess the counselor's self-efficacy and technique performance. Since counseling self-efficacy is considered a component of performance, it may determine if the counselor will yield efficacious results with their clients. Research has viewed supervision as an environment in which counselor can work successfully with extremely low or extremely high self-efficacy if the supervisor provides a supportive setting that fosters development (Larson & Daniels, 1998). Even though, research is still needed to evaluate the specific role supervision plays counselor self-efficacy (Heppner, Multon, Gysbers, Ellis, & Zook, 1998; O'Brien, Heppner, Flores, & Bikos, 1997). Hanson (2006) looked specifically at the relationship between counselor self-efficacy and supervision and found the supervisory working alliance was the most important predictor. This study also suggested Attractiveness (e.g. warm, supportive, friendly) and Interpersonally Sensitive (e.g. relationship-oriented, invested, therapeutic) supervision styles were positively related to self-efficacy. Studying counselor self-efficacy and its relationship with supervision may help understand counselors' concerns and reduce anxiety in reaction to particular client types which may improve counselors' ability to respond appropriately to suicidal crises (Leach, Stoltenberg, McNeill, & Eichenfield, 1997).

Elements of Supervision. Several studies have examined the supervisory working alliance and its effect on counselor self-efficacy. A purposeful supervisory relationship is necessary for feedback to be transmitted from the supervisor to the supervisee (Sterner, 2009), which adds the effectiveness of the supervision process (Mena & Bailey, 2007). A strong supervisory relationship leads to trust and respect leading to higher levels of exploration of personal and professional concerns of the supervisee, facilitating growth and progress through development stages of becoming an effective counselor (Bradley & Ladany, 2001). Multiple studies have examined the relationship between strong supervisory relationships and client outcomes (Dodenhoff, 1981; Halverson et al., 2006; Steinhelber, Patterson, Cliffe, & Legoullon, 1984). These studies indicate there is a relationship between to the variables, linking positive client outcomes with a positive supervisory working alliance.

A strong supervisory working alliance develops when the supervisor and supervisee agree on goals and establish rapport, which leads to increased counselor self-efficacy and supervisee satisfaction (Crockett & Hays, 2015). Research indicates the importance for supervisees to be satisfied with supervision, because supervisees indicate increased willingness to accept supervisor feedback when satisfied (Ladany, Ellis, & Friedlander, 1999), contributing to improved development as a counselor (Crockett & Hays, 2015).

Supervisee's who perceived the supervisory working alliance to be weak also experienced high levels of burn out, stress, decline in skill development, and feelings of isolation and low self-efficacy (Bernard & Goodyear, 2004). Similarly, beginning counselors are less likely to discuss their skills and increase confidence over time if they do not perceive the

supervisory working alliance as effective (Marmarosh, Nikityn, Moehringer, Ferraioli, Kahn, Cerkevich, Choi, & Reisch, 2013). A strong supervisory working alliance has demonstrated improvements with supervisee self-efficacy after a severed supervisory relationship, less role conflict and ambiguity, and increased supervisee willingness to be open with supervisor (Goodyear & Guzzard, 2000; Ladany & Freidlander, 1995; Patton & Kivlighan, 1997). Bernard and Goodyear (2004) discussed how aspects of social influence (e.g. trustworthiness, expertness) lead to a strong supervisory working alliance and willingness to learn for the supervisee. Consequently, a strong working alliance is associated with positive outcomes in supervision. (Patton & Kivlighan, 1997; Teyber & McClure, 2000).

Some researchers have suggested goal setting is an important aspect of supervision, including that supervisee-initiated goals helped established a collaborative relationship (Talen & Schindler, 1993). Furthermore, Lehrman-Waterman and Ladany (2001) found that goal setting increased level of satisfaction and strengthened the supervisory working alliance. Bernard and Goodyear (2004) recommended supervisors develop a contract with supervisees that helps establish goals and identifies how the goals will be achieved and evaluated. Furthermore, goal setting is an effective way to help beginning counselors focus on important development issues, which may lead to optimal learning experiences (Curtis, 2000), because setting specific goals helps the supervises perceive feedback from their supervisor as both fair and relevant to their growth as a counselor (Martin, Hiebert, & Marx, 1981).

Goal setting directs attention and enhances persistence of the supervisees by specifying exact behaviors they should focus on during their counseling session (Locke, Shaw, Saari, &

Latham, 1981), which decreases the likelihood the counselor will become overwhelmed (Curtis, 2000). Instead, the counselor feels more self-confident and they begin to improve their counseling (Borders & Leddick, 1987). However, there remains little empirical evidence on the effects of goal setting and the supervisory working alliance, but research is recommended in this area to further understand whether enhancing beginning counselor's self-efficacy with goal setting creates a stronger working alliance with the supervisee and supervisor.

Similar to the relationship between supervision and self-efficacy, supervision has also shown to influence counselors' performance. Bernard and Goodyear (2004) stated the central purpose of supervision is to support and enhance performance. Holloway and Neufeldt (1995) inferred that supervision impacts counselors' attitudes, techniques, and behaviors, which have all been linked to performance. However, Goodyear and Guzzardo (2000) suggest supervision likely affects treatment outcomes indirectly, and the relationship between supervision and performance should be conceptualized in terms of developmental models.

Development models believe supervisees continuously grow while identifying new areas of growth in life-long learning process (Leddick, 2000). Development models consider supervisees move through three levels: beginning, intermediate, and advanced (Stoltenberg & Delworth, 1987). Research noted a trend where supervisees move from a rigid, imitative way toward competence and self-assurance. Each of three levels includes three processes: awareness, motivation, and autonomy. Stoltenberg and Delworth (1987) suggest eight areas of growth for each supervisee: intervention, skills competence, assessment techniques, interpersonal assessment, client conceptualization, individual differences, theoretical orientation, treatment

goals and plans, and professional ethics. Supervisors should help supervisees identify their own strengths which enables growth and contributes to self-efficacy.

Feedback and evaluation are essential roles in enabling growth and increase self-efficacy within the supervisory relationship. Feedback should be timely, frequent, objective, clear, specific, reciprocal, and includes both formative and summative evaluations (Bernard & Goodyear, 2014). Constructive feedback is effective in producing change and is preferred by many supervisees to other supervisory methods (Westberg & Jason, 1993). According to Bernard and Goodyear (2014), supervisees often remember the quality of feedback they received when they reflect on past supervision experiences. Consequently, the failure to provide adequate feedback and evaluation has been the focus of majority ethical complaints regarding supervisory relationships (Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999).

Research Related to Supervision and Counselor Self-efficacy. Research specifically examining the relationship between supervision and counselor self-efficacy is scarce, and the results are discrepant with limitations due to methodological concerns. In Beverage's (1989) dissertation, a positive relationship was found between supervisors' evaluations and counselor self-efficacy, but an unpublished measure was used to measure counselor self-efficacy. Degraff (1996) and Humeidan (2002) looked specifically at the supervisory working alliance and self-efficacy and found contradictory results. Degraff (1996) found no relationship between supervisory working alliance and self-efficacy, while Humeidan (2002) did. In Daniels (1997) dissertation, supervisors' positive feedback and negative feedback impacted self-efficacy, but findings are limited due to the use of unpublished measures. As stated, more research is needed

on this topic to fully influence practice (Larson & Daniels, 1998). In the proposed study the relationship between supervision and counselor self-efficacy will be tested on various levels of supervisory working alliance and how it affects counselors confidence in working with suicidal clients.

Supervision for Crisis Counselors

Clinical supervision has been recommended to help promote counselor resilience during crisis intervention (Dupre et al., 2014; McAdams & Keener, 2008). Supervision during and after working with a suicidal client can help the counselor process their feelings about the event and ensure that these feelings do not negatively interfere with the client's future treatment (CARMHA, 2004). If a counselor is aware of his/her feelings about the client's crisis, it may facilitate therapeutic growth (Kernberg, 1994; CARMHA, 2004). Regular and formal supervision is the best technique to prevent counselor burnout with crisis interventions and enhance professional development (MacFadden, 1985; CARMHA, 2004). However, this relationship between crisis counseling and supervision has not been thoroughly explored in literature.

Some research has looked at supervision of trauma counselors, which may have some implications for crisis supervision. Pearlman and Saakvitne (2005) identified four components of trauma sensitive supervision, a strong theoretical grounding in trauma therapy, awareness of conscious and unconscious aspects of treatment, interpersonal respect, and educational material that addresses vicarious trauma (Sommer, 2008). Consequently, Etherington (2000) encouraged trauma sensitive supervisors should be mindful of changes in counselors' behaviors or reactions,

signs of burnout, signs of withdrawal from clients or supervisor, and challenges engaging in self-care. Supervision with trauma counselors should be an open atmosphere for counselors to process their feelings with a collaborative strength-based approach by the supervisor (Sommer & Cox, 2005; Sommer, 2008).

Crisis Supervision

More than 25 years ago, two articles studied crisis intervention and supervision. Doyle, Foreman, and Wales (1977) explored the effect of supervision of training of nonprofessional crisis workers that indicated counselors require immediate and continuous supervision to be able to deliver effective crisis techniques. Tracey, Ellickson, and Sherry (1989) surveyed 78 practicum counselors in training about their preference of supervision structure. Responses indicated counselors prefer structure in supervision when clients present in crisis.

In the past ten years, a few articles have researched clinical supervision with various types of crisis; however, some are not related to the current area of investigation (e.g. suicide). Although, Knox, Burkard, Jackson, Schaack, and Hess (2006) examined the role of supervision after counselors experienced a client suicide, which emphasized the restorative functioning supervision can play and recommended supervisors self-disclose about personal experiences with client suicide, normalize counselors reactions to suicide, and provide a safe environment for counselors to process.

More recently, an article was published in 2014 that provided information relevant to the current investigation. Dupre et al. (2014) explored the supervision experiences of 13 licensed professional counselors who routinely provided crisis interventions. Five themes were identified

from the individual interviews and the findings supported intensive and immediate crisis supervision was viewed as most beneficial by participants. Three of the five themes relate specifically to the proposed study: Crises are considered “clinically, systemically, and culturally complex;” counselors experience both positive and negative effects from crisis intervention; and “crisis supervision is essential, beneficial, and potentially harmful” (Dupre et al., 2014, p. 86).

The literature review led to two major conclusions. First, counselors work with suicidal clients on a routine basis. Suicidal clients are highly complex and poses a number challenges for even the most experienced counselor. Counselors are involved in the suicidal crisis in various ways and the treatment process can lead to negative and positive outcomes for the counselor and client.

A second conclusion is that supervision can help counselors be resilient and experience positive outcomes while working with suicidal clients. Despite the benefits, crisis supervision is not frequently provided or addressed in literature. Consequently, there are no clear recommendations or models of supervision working with counselors who work in crisis interventions and additional research is warranted. This study focuses on identifying elements of supervision that can play a role in increasing counselor self-efficacy when working with suicidal clients.

CHAPTER III

Method

This chapter describes the methods used to test the research questions presented below. Specifically, this chapter addresses the research design, proposed sample, instrumentation, and procedures. The literature review provided the basis for the questions, which investigated the relationship between supervision and counselor self-efficacy when working with suicidal clients.

Q1. What is the effect of the supervisory alliance (e.g. rapport, client focus) on counselor self-efficacy for working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?

Q2. What is the effect of the supervisor evaluation (e.g. goal setting, constructive feedback) process on counselor self-efficacy for working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?

Q3. What is the effect of the supervisory alliance (rapport, client focus) and the supervisor evaluation process (goal setting, constructive feedback) on counselor's self-efficacy when presently working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?

A survey was used to measure the variables examined in each research question, which addressed the relationship between counselor's self-efficacy and supervision. Specifically, how supervision impacted counselors' self-efficacy when working with clients who are suicidal. Supervision, the independent variable, which was defined as an intervention that is provided by a

senior member of a profession to a junior member of that same profession, will be measured using four subscales (e.g. Rapport, Client Focus, Goal setting, and Constructive feedback) that were explored to view their unique impact on self-efficacy. The dependent variable, counselor self-efficacy, was defined "as one's beliefs or judgments about his or her capabilities to effectively counsel a client in the near future" (Larson & Daniels, 1998, p.180). For this survey, the dependent variable will be further measured using the four factors of the *Counselor Self-Efficacy Suicide Assessment Scale* (Douglas & Wachter Morris, 2015).

Procedure

After receiving IRB approval, data collection occurred during the fall 2016 and spring 2017 semesters. During the last month of the fall semesters of 2016, about 100 recruitment letters were distributed via listservs and emailed to counseling programs in the United States. In the first method, the primary researcher posted an informational email with a link to participate in the study to the following listservs: the Counselor Education and Supervision Network Listserv (CESNET), the American Counseling Association (ACA), the American College Counseling Association (ACCA), CESNET and Alabama Counseling Association listservs. In the second method, the primary researcher sent emails to faculty from counseling programs across the United States requesting them to send the informational email with link to their students and recent graduates. The recruitment email briefly described the purpose of the study and inclusion criteria to participate. After participants clicked on the link to participate in the study, they were asked to identify if they were currently in a master's program and receiving weekly supervision or if they graduated with their counseling master's degree less than two years

ago and receiving weekly supervision. By clicking the boxes of the criteria they met, they were directed to the Information Letter. The Information Letter fully described the purpose of the study, expectations of participants, and the minimal risks associated with participating. The participants were directed to a demographic form and then completed an anonymous survey, lasting approximately 20 minutes. When completing the survey instruments, participants were asked to reflect on their present supervisor when answering questions related to supervision.

Participants

Participants (N=90) consisted of a purposeful sample of master's level counseling students and two years post master's counselors. Inclusion criteria for the potential master's level counseling students and counselors who are within two years post master's included the following: (a) currently practicing face-to-face counseling with clients, and (b) receiving at least one hour of weekly supervision. A total of 172 participants began the survey; however, only the data sets of the 90 who completed the entire survey were included in the analysis. There was no observed trend of participant drop out during the survey.

Participants ranged in age from 22 to 60, with an average of 24 years old. The majority were female (90%) and identified their ethnicity/race as White (83%). Table 1 presents demographic information related to gender, age, race, and ethnicity. Sixty-eight percent of the participants were currently enrolled in a master's level counseling program, and the remaining participants graduated less than two years ago (32%). The majority of participants indicated Clinical Mental Health Counseling (65%) as their area of specialty. Other specialties identified were School Counseling (20%), College Counseling (4%), Marriage, Couple, and Family

Counseling (3%), and Clinical Rehabilitation (2%), and four participants selected "Other" indicating they were enrolled in a program other than those listed above. The majority of participants reported that they were currently enrolled or had graduated from a CACREP accredited program (89%), and that they completed a course specific to crisis intervention in their master's program (70%). The majority of participants indicated experience working with suicidal clients (77%), and 79% of participants reported they have discussed working with suicidal clients with their supervisors. Participants were asked to indicate what type of supervisor they were seeing weekly for supervision and they were encouraged to focus on this one supervisor when responding to the item in the survey instruments. Sixty-two percent of participants completed the surveys related to supervision with clinical/site supervisors in mind, 23% with faculty supervisors, and 14% with doctoral student supervisors.

Table 1

Demographic Variables

Variables	Frequency	Percentage
Gender		
Male	9	10
Female	81	90
Age		
20-25	30	33.3
26-30	29	32.3
31-35	13	14.4
36-40	3	3.3

41-45	3	3.4
46-50	7	7.7
51-55	2	2.3
56-60	3	3.3
Ethnicity		
White	75	83
Black	12	13
Native Hawaiian or Other Pacific Islander	1	1
American Indian or Alaskan Native	2	2
Hispanic or Latino	3	3
Other	2	2

Instruments

Counselor Self-efficacy. *The Counselor Suicide Assessment Efficacy Survey* (CSAES) (see Appendix A for instrument) (Douglas & Wachter Morris, 2015) assesses a four factor model of General Suicide Assessment, Assessment of Personal Characteristics, Assessment of Suicide History, and Suicide Intervention. Items 1-7 include the factor General Suicide Assessment (e.g. "I can effectively inquire if a student has had thoughts of killing oneself."), items 8-17 measure Assessment of Personal Characteristics (e.g. "I can help prevent a suicide attempt."), items 18-20 evaluate Assessment of Suicide History (e.g. "I can effectively ask a student about his or her personal history of self-harming behavior.", and items 21-25 belong to Suicide Intervention (e.g. "I can appropriately intervene if a student is at imminent risk of suicide.")(Douglas & Wachter

Morris, 2015, p. 67). The item responses are based on Len, Hill, and Hoffman's (2003) *Counselor Activity Self-Efficacy Scale* with a 5-point Likert scale, 1- *not confident* to 5- *highly confident*.

Psychometric data of the CSAES was established using 324 respondents with various levels of counseling (e.g. PhDs, master's degrees). Exploratory factor analysis of the scale items were found to be high (alpha=.954). Confirmatory factor analysis supported the four factor model with General Suicide Assessment α =.882 (7 items), Assessment of Personal Characteristics α=.88 (10 items), Assessment of Suicide History α=.81 (3 items), and Suicide Assessment α=.93 (20 items).

Perception of Supervision. The *Supervisory Working Alliance Inventory* (SWAI; Efstation et al., 1990) (see Appendix B for instrument) is a 19 item self-report instrument of a counselor's beliefs about their supervisory relationship (e.g. "I feel comfortable working with my supervisor," "My supervisor makes the effort to understand me."). Items are based on a 7-point likert scale (almost never-1; 7-almost always).

Psychometric data was collected from 185 supervisors and 178 supervisees in counseling and clinical psychology training programs. Confirmatory factor analysis indicated two factors; counselors' feelings of support from supervisor, *Rapport*, and perception of the relationship and how it improved their clinical skills, *Client Focus*. Internal consistency reliability was α=.90 for Rapport, .77 for Client Focus. Convergent and divergent validity was found adequate using the Supervisory Styles Inventory (SSI; Friedlander & Ward, 1984). Item scale correlations were above .3 and ranged between .3-.7 on all scales.

The *Evaluation Process with Supervision Inventory* (EPSI; Lehrman-Waterman & Ladany, 2001) (see Appendix C for the instrument) asks participants to indicate how strongly they feel their supervision is characterized by effective goal setting and constructive feedback (e.g. My supervisor and I created goals that were easy for me to understand," "My supervisor told me what he wanted me to learn from the experience without inquiring what I wanted to learn."). The two subscales are rated using a 7 point likert-type scale, 1- strongly disagree to 7- strongly agree.

Psychometric properties were established using 274 counselors in training. Confirmatory factor analysis supported a two factor model and internal consistency estimates for *Goal Setting* and *Feedback* subscales were alpha= .89 and .69. Construct validity was evidenced by both subscales having significant relationship with supervisory working alliance (WAI-T; Bahrick, 1990), increased general self-efficacy (S-EI; Friedlander & Snyder, 1983), and increased satisfaction with supervision (SSQ; Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999).

Analysis

To measure the relationship between the dependent and independent variables, a backward regression analysis was performed to understand how counselor self-efficacy changes when elements of supervision vary. More specifically, supervision, the independent variable included the levels rapport, client focus, goal setting, and feedback, while the dependent variable was counselor self-efficacy. One dependent variable was derived from the mean score of the following subscales of *The Counselor Suicide Assessment Efficacy Survey* (CSAES): General Suicide Assessment, Assessment of Personal Characteristics, Assessment of Suicide History, and

Suicide Intervention. Two backward multiple regressions analyses were conducted to evaluate how well the variables of supervision strengthen counselor's self-efficacy with suicidal clients (Table 2). The total scores of each independent variable were computed to create a continuous variable which allowed the regression analysis to explore the relationship between the variables to determine significance.

Table 2

Research Questions and Analysis

Factor	Description	
Research Questions	Q1. What is the effect of the supervisory alliance (e.g. rapport, client focus) on counselor self-efficacy for working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)? Q2. What is the effect of the supervisor evaluation (e.g. goal setting, constructive feedback) process on counselor self-efficacy for working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?	Q3. What is the effect of the supervisory alliance (rapport, client focus) and the supervisor evaluation process (goal setting, constructive feedback) on counselor's self-efficacy *when presently* working with suicidal clients (i.e. assessing for suicide, assessing for characteristics of suicide, employing suicide interventions)?
Independent Variable (IV)	Rapport, Client Focus, Goal Setting, Constructive Feedback	Rapport, Client Focus, Goal Setting, and Constructive Feedback
Dependent Variable (DV)	Counselor self-efficacy for working with suicidal clients.	Counselor self-efficacy when presently working with suicidal clients.
Assumptions	1. The predictor variables are nonrandom and the values are	1. The predictor variables are nonrandom and the values are

	independent across all subjects. 2. The values are measured without error 3. The predictor variables are assumed to be linearly independent of each other i.e., multicollinearity where there are moderate to high inter-correlations among the predictor	independent across all subjects. 2. The values are measured without error 3. The predictor variables are assumed to be linearly independent of each other i.e., multicollinearity where there are moderate to high inter-correlations among the predictor
Statistical Test Performed	Multiple Regression Backward Elimination	Multiple Regression Backward Elimination
Test Statistics	The correlation coefficient (Pearson's r) T-test R2 Change F- Change Statistic Standardized β Partial Correlation	The correlation coefficient (Pearson's r) T-test R2 Change F- Change Statistic Standardized β Partial Correlation

CHAPTER IV

Results

This chapter will report the results of the two overall research questions and four sub-questions designed to explore the relationships between counselor self-efficacy with suicidal clients and supervision. To assess the research questions, internal consistency was examined to determine reliability of each predictor and a multiple regression was used to test the effects of each predictor and learn which variable of supervision was significantly influencing counselors' self-efficacy with working with suicidal clients. Before beginning regression analysis, each variable's internal consistency was explored (Table 3).

Table 3

Reliability of Variables

Factor	Cronbach's Alpha Current Study	Cronbach's Alpha Original	Mean	SD
Goal setting	.838	.89	52.0	11.67
Rapport	.949	.90	52.0	11.67
Client Focus	.936	.77	52.8	10.32
Feedback	.823	.69	69.2	13.1
Self-efficacy	.927	.954	99.0	13.20

After reliability was verified, a multiple linear regression was calculated to predict counselor self-efficacy with suicidal clients based on all variables together: supervisory rapport,

client focus, goal setting, and feedback. Each assumption was met for a multiple regression analysis. Linearity was assessed by observing a scatterplot of counselor self-efficacy with suicidal clients against all independent variables. Visual inspection of these plots indicated a linear relationship between the variables. There was independence of residuals, as assessed by a Durbin-Watson statistic of 2.010. Homoscedasticity was determined, as assessed by visual inspection of a plot of standardized residuals versus standardized predicted values. Residuals were normally distributed as assessed by visual inspection of a normal probability plot.

After evaluating this statistical test, further exploration of each variable was needed due to some of the variables used in the regression analysis being highly correlated, so multicollinearity was assessed. The first step in assessing multicollinearity was to examine a correlation matrix of the variables being used in regression analysis (see Table 4). In general, correlations greater than .80 between independent variables are regarded as problematic (Berry & Feldman, 1985). Correlations among Client Focus and Rapport in supervision passed this mark ranging from .828 to .845; therefore, further investigation of multicollinearity was warranted. Statistical analysis of the full model indicated variable tolerances ranging from .099 to .542 and Variation Inflation Factors (VIF) ranging from 1.844 to 11.229. This indicated multicollinearity between Client Focus (10.138) and Rapport (11.229). Due to the multicollinearity between these variables, Client Focus and Rapport were combined resulting in the Supervisory Working Alliance Inventory (SWAI) being used as one independent variable.

Table 4

Pearson Correlation of Full Model (N=90)

	Self-Efficacy	Client Focus	Feedback	Goal Setting	Rapport
Self-Efficacy	1.000	.071	.093	.199	.123
Client Focus	.071	1.000	.828	.637	.948
Feedback	.093	.828	1.000	.646	.845
Goal Setting	.199*	.637	.646	1.000	.652
Rapport	.123	.948	.845	.652	1.000

p<.05*

To examine research questions one and two, a backward regression was run to evaluate the three predictors (Goal Setting, Feedback, and SWAI) individually A nonsignificant regression equation was found ($F(3,86)= 1.250$, $p =.297$), with an R^2 of .042. Supervisor's Supervisory Working Alliance, Feedback, and Goal setting accounted for 4.2% of the variation in counselor self-efficacy with an adjusted $R^2=0.8\%$, a small size effect according to Cohen (1988). The independent variables were not significant predictors of counselor self-efficacy when looking at all variables combined. A significant bi-variate correlation was calculated between goal setting and counselor self-efficacy ($r=.199$, $p<.05$), indicating a correlation between these two variables (see Table 5). Goal setting was retained in the restricted model with a p-value of .060, indicating goal setting with supervisors demonstrated a relationship that was nearly approaching significance ($F(1,88)=3.628$, $p=.060$).

Table 5

Regression Findings for Full Model (n=90) – Backward Regression

Factor	R^2	S.E Estimate	r	Semi-partial	Beta
Full Model (N=90)	.042[a]	13.15			
SWAI			.107	.006	.011
Goal Setting			.199*	.174	.236
Feedback			.093	-.069	-.036
Restricted Model	.040[b]	13.01			
Goal setting			.199*	.199	.199

*p<.05

[a] F(3,86) = 1.250, p =.297

[b] F(1,88) = 3.628, p=.060

To further investigate how Goal setting, Feedback, and the Supervisory Working Alliance impacts counselor self-efficacy while presently working with suicidal clients and address research question three, a backward elimination regression was calculated with participants who indicated they have had experience working with suicidal clients (N=69). The variables remained linear with independence of residuals, as assessed by a Durbin-Watson statistic of 2.140. Residuals were normally distributed as assessed by visual inspection of a normal probability plot. The full regression model was not found to be significant (F(3,65)=1.542, p=.212). Table 6 demonstrates two bi-variate correlations between SWAI

(r=.194, p<.05) and Goal Setting (r=.244, p<.05) were found to be significant with counselor self-efficacy with suicidal clients, indicating a relationship between these variables. Most importantly, the restricted regression model was found to be overall significant with the predictor Goal Setting (F(1,67)=4.257, p<.05), indicating Goal Setting in supervision significantly predicted counselor self-efficacy when working with suicidal clients. Goal Setting in supervision accounted for 6% of the variation in counselor's self-efficacy with suicidal clients with adjusted R^2=4.6%, a small effect size according to Cohen (1988). It was found that Goal Setting in supervision significantly predicted counselor self-efficacy with suicidal clients (β=.244, p<.05), this impact is not likely due to chance. An F change test was conducted to conclude if the amount of variance Goal Setting explained was significantly different than the full model. F Change test was not found to be significant because the F observed (-.214) does not exceed the critical F (4.257); therefore, concluding SWAI and Feedback variables did not explain above and beyond what Goal Setting explained. This indicated that adding SWAI and Feedback to the full model would not add to the overall regression model.

Table 6

Regression Findings for Participants who have Experience with Suicidal Clients (n=69)– Backward Regression

Factor	R^2	S.E Estimate	r	Semi-partial	Beta
Full Model (N=69)	.066[a]	13.53			
SWAI			.194*	.074	.164
Goal Setting			.244*	.166	.253
Feedback			.156	-.079	-.175
Restricted Model	.060[b]	13.37			
Goal Setting			.244*	.244	.244

*p<.05

[a] F(3,65) = 1.542, p =.212

[b] F(1,67) = 4.257, p=.043

Observed F = -.214

CHAPTER V

Discussion

This study sought to examine the relationship between counselors' self-efficacy with suicidal clients and supervision. Results from this study can help to better understand how supervision components (e.g. Rapport, Goal Setting, Feedback, and Client Focus) impact counseling self-efficacy when working with suicidal clients. These results will allow for a better understanding as to how supervisors could interact more effectively with the supervisees. This chapter provides an overview of study results and its implications for training, practice, and research. Additionally, limitations of the research design and methodology will be provided.

Findings

The present study's results did not indicate a relationship between Supervisory Working Alliance and counselors' self-efficacy when working with suicidal clients. Literature has indicated mixed results between supervisory working alliance and counselors' self-efficacy, in that Degraff (1996) found no relationship, whereas Humeidan (2002) did. Literature suggests that performing specific skills successfully, observing a specific behavior, and listening to someone correctly explain how to perform a specific behavior are key components to increasing counselor self-efficacy (Bandura, 1982). These components demonstrate the importance of structured and focused supervision practices and the benefits supervisees perceive from clear, goal oriented skill development discussions and activities. Goals allow the supervisee to focus on specific skills, provide clear guidelines for behavior changes which help decrease anxieties. Perhaps these results indicate that beginning counselors prefer a supervisor who is structured and

direct versus one who is focused on the supervisee's feelings of support and the how the relationship improves their clinical skills. Future research should build upon these results found here and examine further how the supervisory working alliance contributes to counselor's self-efficacy in general and when specifically working with suicidal clients.

The lack of significance feedback had on counselor's self-efficacy while working with suicidal clients was surprising, considering the emphasis placed in the literature on the influence of specific and constructive feedback on the supervision process. Perhaps these results indicate that feedback does not directly impact counselor self-efficacy, but may still play a prominent role in effectiveness of supervision and supervisees' satisfaction with supervision (Westberg & Jason, 1993; Borders & Goodyear, 2014; Ladany et al., 1999). Although the results of this study suggest that feedback does not have a significant effect on the outcome of counselor self-efficacy with suicidal clients, future research should further explore this influence.

Overall, the results were encouraging by demonstrating a relationship between goal setting in the supervisory relationship and counselor self-efficacy. The results suggest that goal setting in the supervisory relationship is important to help counselors develop self-efficacy when working with suicidal clients. The analysis found that goal setting lead to an increase in counselor's self-efficacy when working with suicidal clients. This is promising and aligns with current literature in the field as goal setting has been found to help establish a collaborative relationship (Talen & Schindler, 1993), increase satisfaction and strength with the supervisory working alliance (Lehrman-Waterman & Ladany, 2001), and provide structure to help supervisees understand ways there development will be evaluated and positive changes will

occur (Bernard & Goodyear, 2004). Goal setting is especially important in the beginning stages of counselor development. When a supervisor's supervisee is in the initial stages of development structure and clear goals will help minimize anxiety, while providing support and identifying skill strengths and deficits to improve upon (Stoltenberg, Delworth, & McNeil, 1998). Literature expands on the importance of structure and clear goals in supervision, by indicating supervisees prefer a structured style when their clients are in crisis (Tracey, Ellickson, & Sherry, 1989). By increasing attention to specific behaviors, goal setting helps counselors focus on the development of crucial skills versus ambiguous changes (Locke et al., 1981). This leads to decreased feelings of stress as a counselor and contributes to increased self-efficacy and improved counseling skills (Curtis, 2000).

Implications for Counselor Educators and Supervisors

Reflecting on the population used in the study, the results of the study provide implications for supervisors and counselor educators in the field by demonstrating the importance of developing specific goals for the supervisee to work toward. Supervisors should be cognizant of the importance of establishing goals early in the supervision process to enhance supervisee understanding of suicidal risk assessments, clinical decision making when clients are suicidal, and appropriate courses of actions when clients exhibit suicidal risk. For example, supervisors may consider developing a goal that focuses on the counselor recognizing when to utilize a risk assessment, then using role plays in session to help the counselor practice and reach this goal. It seems that counselor educators and supervisors should pay close attention to the supervisee's current development level as a counselor and set appropriate goals to focus

developmentally appropriate skills. Literature indicates alarming rates of low self-efficacy in counselors who are working with clients in crisis, particularly suicidal clients (Watcher, 2006; King et al., 2000). With low self-efficacy demonstrating poor impacts on clinical decision making skills (Larson & Daniels, 1998), establishing goals in supervision may help increase self-efficacy leading to improve clinical decisions, actions with clients, and responses given to the client. Goals allow the counselor to focus their attention on specific skill development when experiencing natural insecurities as a beginning counselor. Goals reduce the counselor from feeling overwhelmed and ensure they understand how they will be evaluated by the supervisor and in what ways they will need to develop their skills. This is especially helpful during their work with clients who are suicidal; therefore, developing goals to help counselor learn how to respond appropriately and effectively to clients who are suicidal may increase confidence leading to a better crisis intervention given to the client (Douglas & Watcher, 2015). For instance, including skill development that expands past risk assessment questions and ensures confidence in employing various steps that follow risk assessments (e.g. consultation, hospitalization). Supervisors may consider using role plays or case studies to help the counselor practice implementing risk assessment questions and then following through with a course of action by demonstrating consultation skills and appropriate referrals based on their clinical decisions.

Limitations of the Study

Although the results of this study are encouraging, there are limitations to consider. The sample is comprised mostly of clinical mental health counselors and contains mostly White, female participants. Although comparable to samples in other studies, there is a lack of diversity

in gender, age, and race in the sample. Therefore, the results of this study have limited generalizability to all areas in counseling and supervision.

The participants in this study participated voluntarily and with knowledge of the topic and goals of the research. As a result, counselors with strong feelings, either positive or negative, regarding their supervisory experience may have been more likely to participate. The results were based on the supervisee's perceptions of one supervisor rather than on actual observations. It is quite possible that the participants may have used perceptions related to various supervisors leading to inaccurate reporting.

Experience with suicidal clients was not a participation criterion. As a result, participants with no experience with suicidal clients may not accurately perceive the supervisor's influence on their self-efficacy in this area. It is recommended future research include this as criteria to ensure accurate understanding of the supervisor's role in their self-efficacy when they are working with suicidal clients. Furthermore, various levels of experience with suicidal clients were not considered in this study. Considering the impact experience has on self-efficacy, future research should further explore how supervision impacts counselor's self-efficacy with suicidal clients in varying levels of experience with suicidal clients.

Lastly, as stated above, the high level of correlation between Rapport and Client Focus in the *Supervisory Working Alliance Inventory*, may have led to mixed results, despite validation and reliability that has been measured in various studies.

Future Research Recommendations

As mentioned throughout this chapter, there are numerous areas of research that should be examined further in order to better understand the influence of supervision has on counselor's self-efficacy when working with suicidal clients. First, an area that needs further investigation is counselor self-efficacy with suicidal clients and the supervision with participants that have different levels of experience with suicidal clients. Many years or experience with clients who are suicidal may play a role in their perception of the supervision's role in their confidence. Second, the impact of the supervisory working alliance on counselor's self-efficacy in general and with suicidal clients is needed due to mixed results in the literature currently. Also, more research is needed to explore the impact of feedback in supervision has on counselor's self-efficacy in general and with suicidal clients. Due to the role it plays in supervision satisfaction and effectiveness, more research is needed to fully understand the effect feedback has on counselor's confidence levels. Consequently, future research should explore other aspects in supervision to study there impact on counselor's self-efficacy when working with suicidal clients. Better understanding the relationship between supervision variables and counselor's self-efficacy with suicidal clients may lead to improved clinical decisions and actions during crisis interventions increasing level of care for clients and improving the process of supervision.

It also seems relevant to further explore the instrument Supervisory Working Alliance Inventory further due to the high level of correlation between the two subscales in this study's results. This may lead to a better understanding of how the supervisory working alliance impacts a counselor's self-efficacy in general and with suicidal clients contributing to a more productive

supervision process, improve counseling skills, and improve provided care during crisis interventions.

Summary

Bandura, a leader in self-efficacy literature, made a statement that, “If self-efficacy is lacking, people tend to behave ineffectually, even though they know what to do” (Bandura, 1986a, p. 425). Supervisors and counselor educations have to be aware of the possible implications of their supervision practices on counselors’ self-efficacy when working with suicidal clients due to the high risk nature of this work. Feelings of confidence are vital to counselor development and growth; therefore it is important for supervisors to development a supervisory relationship that fosters growth and involves techniques that will foster self-efficacy. This study served to provide a picture of how supervisors impact counselor’s self-efficacy when working with suicidal clients.

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Appendix 1

The Counselor Suicide Assessment Efficacy Survey

There are a number of different factors that can make doing a suicide assessment and intervention on a student difficult for a counselor. Below are listed several warning signs, risks, and potential situations that a counselor may have to face in performing a suicide assessment or intervention. Please read each statement and circle the number that most closely corresponds with your level of confidence, using the following scale:

1	2	3	4	5
Not Confident	Slightly Confident	Moderately Confident	Generally Confident	Highly Confident

1. I can effectively inquire if a student has had thoughts of killing oneself.
2. I can effectively assess hopelessness.
3. I can effectively assess whether a student has means to carry out a suicide plan.
4. I can effectively inquire whether a student has a suicide plan.
5. I can effectively counsel a student who has had a history of making suicidal threats, but has had no attempts.
6. I can effectively counsel a student who has previously attempted suicide.
7. I am able to assess a student's level of risk for a suicide attempt.
8. I can help prevent a suicide attempt.
9. I can effectively ask a student about his or her drug or alcohol abuse.
10. I can effectively ask a student about his or her history of sexual abuse.
11. I can effectively ask a student about his or her history of mental illness.
12. I can effectively ask a student questions to assess whether he or she has low self-esteem.
13. I can effectively inquire whether a student has withdrawn from relationships.
14. I can effectively assess a student's acceptance of sexuality.
15. I can effectively talk with a student about his or her hygiene.
16. I can effectively discuss with a student his or her writings about death.
17. I can appropriately inquire whether a student has been a victim of abuse.
18. I can effectively ask a student about his or her previous suicide attempts.
19. I can effectively ask a student about his or her personal history of self-harming behavior.
20. I can effectively ask a student about his or her family history of suicide.
21. I know the point at which I need to break confidentiality.
22. I am able to appropriately intervene if a student reports suicidal thoughts, but I do not believe him or her.
23. I am able to intervene appropriately if a student denies suicidal thoughts, but I do not believe him or her.
24. I can appropriately take action if I determine a student is moderately at risk for suicide.
25. I can appropriately intervene if a student is at imminent risk for suicide.

Appendix 2

Supervisory Working Alliance Inventory

Directions: Following are a number of statements that reflect various activities that can occur in supervision. Please indicate the extent to which the activity in each statement is characteristic of your work with your supervisor in supervision. Circle the number that best fits for each statement and do not leave any unanswered.

Please Circle a number for each statement using the following scale:

Almost Never_____Almost Always

1 2 3 4 5 6 7

1.	I feel comfortable working with my supervisor.	1 2 3 4 5 6 7
2.	My supervisor welcomes my explanations about the client's behavior.	1 2 3 4 5 6 7
3.	My supervisor makes the effort to understand me.	1 2 3 4 5 6 7
4.	My supervisor encourages me to talk about my work with my clients in ways that are comfortable for me.	1 2 3 4 5 6 7
5.	My supervisor is tactful when commenting about my performance.	1 2 3 4 5 6 7
6.	My supervisor encourages me to formulate my own interventions with the client.	1 2 3 4 5 6 7
7.	My supervisor helps me to talk freely in our sessions.	1 2 3 4 5 6 7
8.	My supervisor stays in tune with me during supervision.	1 2 3 4 5 6 7
9.	I understand client behavior and treatment technique similarly to the way my supervisor does.	1 2 3 4 5 6 7
10.	I feel free to mention to my supervisor any troublesome feelings I might have bout him/her.	1 2 3 4 5 6 7
11.	My supervisor treats me like a colleague in our supervisory sessions.	1 2 3 4 5 6 7
12.	In supervisor, I am more curious than anxious when discussing my difficulties with my clients.	1 2 3 4 5 6 7
13.	In supervision, my supervisor places high priority on our understanding the client's perspective.	1 2 3 4 5 6 7
14.	My supervisor encourages me to take time to understand what the client is saying and doing.	1 2 3 4 5 6 7
15.	My supervisor's style is to carefully and systematically consider the material I bring to supervision.	1 2 3 4 5 6 7
16.	When correcting my errors with a client, my supervisor offers alternative ways of intervening with the client.	1 2 3 4 5 6 7
17.	My supervisor helps me to work within a specific treatment plan with my clients.	1 2 3 4 5 6 7
18.	My supervisor helps me to stay on track during our meetings.	1 2 3 4 5 6 7
19.	I work with my supervisor on specific goals in the supervisory session.	1 2 3 4 5 6 7

Appendix 3

Evaluation Process with Supervision Inventory

Indicate the extent to which you agree or disagree with each of the following statements. For each, circle the appropriate number on a 7-point scale, where 1 = *strongly disagree* and 7 = *strongly agree*.

1. The goals that my supervisor and I generated for my training seem important.	1 2 3 4 5 6 7
2. My supervisor and I created goals that were easy for me to understand.	1 2 3 4 5 6 7
3. The objectives that my supervisor and I created were specific.	1 2 3 4 5 6 7
4. My supervisor and I created goals that were realistic.	1 2 3 4 5 6 7
5. I think my supervisor would have been against my reshaping/changing my learning objectives over the course of our work together.	1 2 3 4 5 6 7
6. My supervisor and I created goals that seemed too easy for me.	1 2 3 4 5 6 7
7. My supervisor and I created objectives which were measurable.	1 2 3 4 5 6 7
8. I felt uncertain as to what my most important goals were for this training experiences.	1 2 3 4 5 6 7
9. My training objectives were established early in our relationship.	1 2 3 4 5 6 7
10. My supervisor and I never had a discussion about my objectives for my training experience.	1 2 3 4 5 6 7
11. My supervisor told me what he/she wanted me to learn from the experience without inquiring about what I wanted to learn.	1 2 3 4 5 6 7
12. Some of the goals that my supervisor and I established were not practical in light of the resources available at my site (e.g. requiring videotaping and not providing equipment.)	1 2 3 4 5 6 7
13. My supervisor and I set objectives that seemed practical given the opportunities available about my site (e.g. if career counseling skills was a goal, I was able to work with people with career concerns.)	1 2 3 4 5 6 7
14. My supervisor welcomed comments about his/her style as a supervisor.	1 2 3 4 5 6 7
15. The appraisal I received from my supervisor seemed impartial.	1 2 3 4 5 6 7
16. My supervisor's comments about my work were understandable.	1 2 3 4 5 6 7
17. I didn't receive information about how I was doing as a counselor until late in the semester.	1 2 3 4 5 6 7
18. I had a summative, formal evaluation of my work at the end of the semester.	1 2 3 4 5 6 7
19. My supervisor balanced his/her feedback between positive and negative statements.	1 2 3 4 5 6 7
20. The feedback I received from my supervisor was based on direct observation of my work.	1 2 3 4 5 6 7
21. The feedback I received was directly related to the goals were established.	1 2 3 4 5 6 7

Appendix 4

Demographic Survey

In order to participate in this study, you must be a counselor-in-training or have graduated less than two years ago from master's level counseling program. Please identify which statement applies to you.

- o I am currently a counselor in training and enrolled in a master's level counseling program.
- o I graduated from a counseling program less than two years ago.
- o Neither of the above options apply to me

Do you provide individual face-to-face counseling services AND engage in weekly clinical supervision?

- o Yes
- o No

What gender do you identify as?

- o Male
- o Female
- o Transgender
- o Other

What is your age?

What is your race/ethnicity. Check all that apply.

- o White
- o Black or African American
- o Native Hawaiian or Other Pacific Islander
- o American Indian or Alaskan Native
- o Hispanic or Latina
- o Other

What is your area of specialty in counseling?

- School Counseling
- Clinical Mental Health Counseling Clinical Rehabilitation Counseling
- Marriage, Couple, and Family Counseling Addiction Counseling
- Career Counseling College Counseling
- Other

Are you currently enrolled or did you graduate from a Council for Accreditation of Counseling & Related Education Program (CACREP) accredited program?

- Yes
- No
- I do not know

Please check all that apply to your crisis intervention experiences:

- I have had courses specific to crisis intervention in my master's program.
- I have attended trainings specific to crisis intervention, that were not part of my master's curriculum.
- I have had experience working with suicidal clients.
- I have discussed my work suicidal clients with my supervisor.

Appendix 5

(NOTE: DO NOT AGREE TO PARTICIPATE UNLESS IRB APPROVAL INFORMATION WITH CURRENT DATES HAS BEEN ADDED TO THIS DOCUMENT.)

INFORMATION LETTER
for a Research Study entitled
"The Impact of Supervision on Counselor Self-efficacy: Working with Suicidal Clients"

You are invited to participate in a research study that will examine the relationship supervision has on counselor self-efficacy with crisis interventions. The study is being conducted by Dixie Powers, M.Ed., LPC, NCC, Counselor Education and Supervision Student, under the direction of Dr. Melanie Iarussi, Assistant Professor in the Auburn University Department of Special Education, Rehabilitation, and Counseling. You are invited to participate because you are a counselor in training or you graduated within two years ago from master's level counseling program and are age 19 or older.

If you decide to participate in this research study, you will be asked to complete a brief survey about crisis counseling self-efficacy and experience with clinical supervision. Your total time commitment will be approximately 15 minutes.

If you experience any discomfort while completing this survey, we recommend you seeking appropriate counseling from your local college or community counseling agencies.

If you change your mind about participating, you can withdraw at any time during the study. Your participation is completely voluntary. If you choose to withdraw during the survey, your data will not be used. Your decision about whether or not to participate or to stop participating will not jeopardize your future relations with Auburn University, the Department of Special Education, Rehabilitation, and Counseling.

Any data obtained in connection with this study will remain anonymous. We will protect your privacy and the data you provide by not asking identifying information. Information collected through your participation may be used to fulfill an educational requirement, published in a professional journal, or presented at a professional conference.

If you have questions about this study, please contact Dixie Powers at daf0002@auburn.edu or Dr. Melanie Iarussi at mmi0004@auburn.edu.

If you have questions about your rights as a research participant, you may contact the Auburn University Office of Research Compliance or Institutional Review Board by phone (334)-844-5966 or e-mail at IRBadmin@auburn.edu or IRBChair@auburn.edu

HAVING READ THE INFORMATION ABOVE, YOU MUST DECIDE IF YOU WANT TO PARTICIPATE IN THIS RESEARCH PROJECT. IF YOU DECIDE TO PARTICIPATE, PLEASE CLICK ON THE LINK BELOW.
YOU MAY PRINT A COPY OF THIS LETTER TO KEEP.

The Auburn University Institutional Review Board has approved this document for use from 11/8/2016_ to _10/12/2019_. Protocol #_16-378 EX 1610_