To my parents-
With love and appreciation
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Abstract of Dissertation Presented to the Graduate School of the University of Florida in Partial Fulfillment of the Requirements for the Degree of Doctor of Philosophy

CRISIS INTERVENTION TRAINING FOR STUDENTS IN SCHOOL COUNSELOR PREPARATION PROGRAMS

By

Michelle Lynn Murphy

August 2004

Chair: Larry C. Loesch
Major Department: Counselor Education

Despite the increasing demand for school counselors to provide crisis intervention services within school settings, education and training have not kept pace with this growing need. In order to address the current concerns that school counselors are not adequately prepared to respond to individuals in crisis, this research provided a basis from which to initiate discussion regarding strategies for increasing the crisis intervention knowledge, skill, and confidence levels of school counseling students.

The purpose of this experimental study was to examine the impact of a two-hour crisis intervention training module on school counseling students' knowledge of crisis intervention/suicide prevention theories, concepts, and techniques and their skills for responding to individuals in a variety of crisis scenarios. The students' feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with individuals who are in crisis and/or suicidal were also explored.
The sample included 69 graduate students enrolled in school counselor preparation programs at three different southeastern universities. A pretest-posttest, control-group design was used. Students who agreed to participate were randomly assigned to one of two group conditions. All participants received the crisis intervention training. Data were collected from a survey that included a demographic data sheet and two instruments to assess the effects of the intervention: the (revised) Suicide Intervention Response Inventory (SIRI-2) and the Crisis Intervention and Suicide Prevention Questionnaire (CISP).

Results indicated a significant increase in school counseling students' crisis intervention knowledge and their feelings of comfort, preparation, and confidence to intervene with individuals in various states of crisis. However, no significant improvement in students' ability to produce the most facilitative responses to individuals in crisis was found. Thus, increases in knowledge and self-efficacy were not translated into significant skill improvement. Recommendations for modifying training strategies included increasing the use of experiential activities and role-play scenarios to provide valuable skill-building experiences. Further studies should be conducted to determine the most effective methods for increasing intervention competence in a wide variety of crisis situations.
CHAPTER 1
INTRODUCTION

The Chinese symbol for crisis is a combination of two characters that represent both danger and opportunity. The *Encarta World English Dictionary* (2002) defines crisis as “a time when something very important for the future happens or is decided” and “a situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid complete disaster or breakdown.” A crisis entails the unexpected and usually involves change and loss (Erickson, 1963; Hendricks & Thomas, 2002; Lindemann, 1944). Erickson extended early definitions of crisis to include changes that occur naturally throughout the human growth and aging cycle. This expanded definition of crisis suggests that it is “an acute emotional upset arising from situational, developmental, or sociocultural sources and resulting in a temporary inability to cope by means of one’s usual problem-solving devices” (Hoff, 1995, p.4). A typical crisis consists of the following five components: a hazardous event, a vulnerable state, a precipitating factor, an active crisis state, and the resolution of the crisis (Roberts, 1990).

Crisis is an intrinsic part of life and, despite efforts aimed at prevention, crises will continue to occur. Timely, efficient intervention frequently leads to the positive resolution of a crisis and minimizes the likelihood of future physical or emotional deterioration. Furthermore, the absence of effective intervention causes the crisis victim/survivor to reach a physical and psychological breaking point and increases the likelihood of permanent or long-term damage (Brock, 1998; Hendricks & Thomas, 2002; Palmatier, 1998; Poland & McCormick, 2000; Terr, 1983; Terr, 1992; Weinberg, 1993).
However, increased awareness and understanding of the nature and impact of crisis as well as comprehensive intervention and postvention strategies can increase the likelihood that individuals will emerge through a crisis stronger and more enriched, as opposed to hopeless and defeated. Thus, within each crisis lies the opportunity to gain new awareness and insight and the potential for growth and improved coping abilities.

**Scope of the Problem**

Nationwide, there is increased awareness of the need for effective crisis prevention and intervention in schools (Allen et al., 2002; Brock, 1998; Dwyer, Osher, & Hoffman, 2000; Klicker, 2000; Malley, Kush, & Bogo, 1994; Poland & McCormick, 2000; Wittmer, 2000). Prior to 1990, responsibility for school crisis intervention was not clearly defined; community mental health professionals, in fact, provided the bulk of mental health care for students impacted by crises (Johnson, 2000). However, schools are now increasingly relying on professionals within school systems for crisis intervention services (Brock, Sandoval & Lewis, 2001; Johnson, 2000; Poland, 1994). Although there is heightened emphasis on crisis response in the schools, the field of school crisis intervention is still in its infancy (Pitcher & Poland, 1992). Unfortunately, education and training have not kept pace with the mounting need for the application of crisis intervention skills in the schools. As a result, many school professionals feel they have inadequate training for the crisis intervener role (Allen et al., 2002; Brock et al.; King, Price, Telljohann, & Wahl, 2000). The growing need for crisis preparedness and trauma response has highlighted the need for programs designed to provide educators with specialized crisis response skills.

According to Hoff and Adamowski (1998), "Excellence in crisis care requires appropriate education and training, access to consultation, and smooth interagency coordination" (p. xiii). School counselors have the opportunity to become the response
initiator, trainer, service provider, and advisor for crisis situations in the schools.

However, their current roles must be expanded to include planning and implementing interventions to address crises that impact school staff and students. Therefore, school communities need to educate themselves about crisis intervention and become involved in crisis prevention, intervention, postvention, education, training, and support services.

Suicide is an inherent risk associated with crisis because of the hopelessness and despair that often accompanies the crisis response. Suicide is the second leading cause of death for adolescents and thus an integral part of any discussion of school crises. Statistics indicate that between 5,000 and 6,000 adolescents take their lives each year, with another 500,000 teens making unsuccessful suicide attempts (Wittmer, 2000). Each year, on average, three students in a typical high school class attempt suicide in one form or another (American Association of Suicidology [AAS], 1997; King et al., 1999). The impact of suicidal ideation and behavior on individuals and the school community is widespread, and often with devastating effects.

**Theoretical Framework**

Crisis intervention is typically defined as a short-term, goal-directed helping process focused on resolution of an immediate problem and stabilization of resulting emotional conflicts. Prompt intervention should be geared toward reestablishing emotional and behavioral stability, providing support, and facilitating the needs of those most closely impacted by the crisis (Klicker, 2000). As an organized body of knowledge, skills, and practice, the field of crisis intervention is relatively young. However, it has experienced heightened momentum in the last decade because of the growing number of school tragedies and the ripple effect felt in school communities throughout the country (Hoff, 1995). Today, school personnel and students are exposed to an increasing number
of personal crises and traumatic events. In particular, according to Stephens (1994),

schools today face two types of crises: those they are currently dealing with and those
about to happen.

Despite the increase in the number of children exposed to traumatic events and the
increasingly violent nature of many of these events (including both outward aggression
and suicide), many school counselors are not trained in crisis intervention. Although it is
clear that school counselors must be prepared to deal with a wide variety of crisis
situations, learning the skills necessary to intervene effectively with students in crisis is
fundamental because these skills often are not a part of their repertoire of basic
counseling skills. School counselors, by definition, are knowledgeable of the human
condition and comfortable with the psychosocial aspects of client care. However, the
same comfort level does not necessarily apply to crisis situations because of the unique
knowledge, attitudes, and skills necessary to intervene in acute crisis episodes (Hoff &

School counselors should emphasize preventative measures (but not ignore
intervention) and should be proactive in the development and implementation of a
systematic crisis management plan. Hoff and Adamowski (1998) wrote, “In contrast to
psychotherapy, crisis intervention avoids probing into deep-seated psychological
problems; hence its main features and strategies can be understood and effectively
practiced in relatively short training courses” (p. 28). Appropriate crisis management
training should include the following: (1) knowledge of the nature of crisis and crisis
responses, assumptions and logic necessary for dealing with a crisis; (2) a general model
and practical guidelines to prepare schools for crisis situations; (3) information on
implementing a crisis plan; and (4) preparation activities, including role plays and crisis drills.

Statement of the Problem

It has been demonstrated consistently that many school counselors do not feel adequately trained to identify or intervene with suicidal students. Also known is that school counselors have need for effective preparation in suicide and crisis intervention (Coder, Nelson, & Aylward, 1991; Fitch, Newby, Ballestero, & Marshall, 2001; King, Price, Telljohann, & Wahl, 1999; King, Price, Telljohann, & Wahl, 2000). School counselors should be knowledgeable about the nature and extent of adolescent suicide; the warning signs and risk factors for adolescent suicide; student-at-risk profiles; appropriate prevention, intervention, and postvention techniques; and the available mental health resources in the community (Kalafat, 1990; King et al., 2000; Remley & Sparkman, 1993).

According to Hoff and Adamowski (1998), "the growth of professionalism emphasizes the training of various experts across settings and provider disciplines. A major outgrowth of this trend is the development of the crisis model as a distinct body of knowledge and practice" (p. 7). An increased understanding of crisis theory and training in crisis intervention skills can increase the efficiency with which crises are both recognized and handled. Early recognition of potential crises encourages timely, proactive responses that may prevent or minimize the impact of crises. Crisis training thus will help to increase knowledge, skills, and confidence levels and maximize opportunities for efficient intervention (Poland & McCormick, 2000; Weinberg, 1993; Wellman, 1984).
Need for the Study

As the role of the school counselor changes, counselor education programs also must adapt to support the new vision of school counseling. According to Sears and Granello (2002), "the preparation of counselors with individual and group counseling and guidance skills for academic, career, and personal/social counseling continues to be necessary, but is no longer sufficient" (p. 170). In light of the current emphasis on crisis response in the schools, it is imperative that school counselor preparation programs expand their curricula to prepare for this growing demand. Sears and Granello encourage counselor education programs to instill school counselors with the leadership skills necessary to impact systemic change and to transform school counseling to better meet the increasingly complex needs of today's school communities.

As expectations for school crisis response and preparedness continue to increase, "educators must further their ability to consciously reflect on the provision of these services. Soon it will no longer be acceptable to respond in a reflexive fashion to crisis events ... school crisis preparedness will be expected" (Brock, Sandoval, & Lewis, 2001, p. 7). Although feedback from school counselors suggests that recent graduates are receiving more preparation for crisis intervention than in the past, almost one-third of school counselors continue to enter the profession with no formal course work or supervised experiences (Allen, Burt, et al., 2002).

Crisis intervention programs are a relatively new responsibility for school systems in the United States. As a result, empirical support for the long-term effects of crisis intervention programs is unavailable. However, numerous qualitative accounts of school personnel who have "weathered" actual school crises attest to the value of having well-trained crisis teams and structured intervention programs in place (Brock et al., 2001;
Purpose of the Study

The purpose of this study was to determine the effectiveness of a crisis intervention training module for improving the crisis intervention knowledge and skill levels of graduate students in school counselor preparation programs. Specifically, this experimental study examined the impact of a two-hour crisis intervention training module on school counseling students' knowledge of crisis intervention/suicide prevention theory, concepts, and techniques as well as their skill at responding to individuals in a variety of crisis scenarios. The students' feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with individuals who are in crisis and/or suicidal were also explored. The goal of this research was to provide a basis from which to initiate discussion regarding strategies for increasing the crisis intervention knowledge, skill, and confidence levels of counselor education students in order to address the current concerns in the literature that school counselors do not feel adequately prepared to respond to individuals in crisis. The information provided in this study can be used by counselor educators to better prepare school counselors to fulfill the expectations of their positions.

Hypotheses

This was an experimental study in which data from students randomly assigned to an experimental group were compared with data from students randomly assigned to a control group. Data were collected for the following: (1) demographic variables; (2) knowledge of crisis intervention/suicide prevention theory, concepts, and techniques; (3) skill at responding to individuals in crisis; and (4) self-reported feelings of adequacy,
comfort level, and confidence. The following null hypotheses were investigated in this study:

$H_{01}$: There is no difference in counselor education students' mean scores on the Suicide Intervention Response Intervention (SIRI-2) and the Crisis Intervention and Suicide Prevention Questionnaire (CISP) based on participation in the training.

$H_{01a}$: There is no difference in counselor education students' mean scores on the revised Suicide Intervention Response Intervention (SIRI-2) based on participation in the training.

$H_{01b}$: There is no difference in counselor education students' mean scores on the True/False portion of the Crisis Intervention and Suicide Prevention Questionnaire (CISP) based on participation in the training.

$H_{01c}$: There is no difference in counselor education students' ability to generate appropriate responses identifying important factors for assessing suicide lethality, recognizing warning signs for suicide, and naming risk factors that increase the likelihood an individual will attempt suicide (as measured by the FWR scale of the CISP) based on participation in the training.

$H_{01d}$: There is no difference in counselor education students' feelings of comfort, confidence, and preparation with regards to their ability to identify and respond to individuals who are in crisis and/or suicidal (as measured by the CCP scale of the CISP) based on participation in the training.
H₀₂: There is no significant relationship between experience factors (as measured by training group, age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the Suicide Intervention Response Intervention (SIRI-2).

H₀₃: There is no significant relationship between experience factors (as measured by training group, age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the True/False portion of the CISP.

H₀₄: There is no significant relationship between experience factors (as measured by age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the FWR scale of the CISP.

H₀₅: There is no significant relationship between experience factors (as measured by age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the CCP scale of the CISP.

**Definition of Terms**

**Accidental situational crisis** is one of the two primary classifications of crises developed by Erickson (1963) and still in use today. Situational crises involve trauma and/or unexpected loss triggered by an unpredictable situation that overwhelms an individual's normal coping mechanisms. Situational crises are triggered either by a single, specific occurrence or a compounded series of events. This classification is also referred to as an external crisis.
Ambivalence is the characteristic of an individual expressed in apparently inconsistent thought and action. Suicidal people usually struggle with two irreconcilable wishes—the desire to live and the desire to die (Hoff, 1995). The simultaneous consideration of both of these options produces a state of mind known as ambivalence.

Coping is the process of using various, healthy or unhealthy, cognitive and/or behavioral strategies to adapt to stressors.

Crisis is a period of psychological imbalance experienced as a result of stressors or pressures that an individual perceives as a threat. Crisis is also defined as “an acute emotional upset arising from situational, developmental, or sociocultural sources and resulting in a temporary inability to cope by means of one’s usual problem-solving devices” (Hoff, 1995, p. 4) and “a situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid complete disaster or breakdown” (Encarta World English Dictionary, 2002).

Crisis intervention involves the immediate provision of assistance to individuals experiencing a crisis. It is a short-term, goal-directed helping process focused on resolution of an immediate problem and stabilization of the resulting emotional conflicts. Prompt intervention should be geared toward reestablishing emotional and behavioral stability, providing support, and facilitating the needs of those most closely impacted by the crisis (Klicker, 2000). Crisis intervention is also referred to as secondary care (Caplan, 1964).

Crisis intervention training is a process that utilizes lectures, role-plays, and various other experiential exercises to provide individuals with the knowledge and skills necessary to intervene effectively with individuals in crisis.
Crisis resolution is the goal of crisis intervention. Resolution involves the restoration of equilibrium, cognitive mastery of the situation, and the development of new coping strategies.

Disequilibrium is the disruption of an individual’s homeostatic balance as a result of a crisis event. It is associated with the inability to maintain emotional control and characterized by confusing emotions, increased vulnerability, somatic complaints, and erratic behavior (Roberts, 1990).

Empathy is the ability to perceive and understand accurately the specific content of another person’s thoughts and feelings and the ability to infer and communicate that person’s emotional state(s).

Maturational developmental crisis is one of the two primary classifications of crises developed by Erickson (1963) and still in use today. Maturational crises are the physical, social, and emotional changes that occur as a result of the natural aging process and the transition between developmental stages. This classification is also referred to as an internal crisis.

Postvention involves the provision of services (including counseling and debriefing activities) designed to reduce the long-term effects experienced by those directly and indirectly impacted by crises. The recovery process includes learning new ways of coping with stress through positive crisis resolution (Hoff, 1995). Postvention is also referred to as tertiary care (Caplan, 1964).

Prevention is the provision of education, training, consultation, and crisis intervention designed to reduce the occurrence of mental distress, reduce the incidence of
crises, and promote growth, development, and crisis resistance in individuals and the community. Prevention is also referred to as primary care (Caplan, 1964).

Psychosocial crises are characterized by psychosocial problems such as homelessness, extreme social isolation, and unmet primary care needs and may contribute to physical and psychological trauma and illness (Roberts, 1990).

School crisis is an incident occurring either at school or in the community that negatively impacts students, staff, and/or other members of the school community (Trump, 2000). Any situation that creates, or has the potential to create, a disruption of the educational process or normal school operations can be considered a school crisis.

Overview of the Remainder of the Study

The remainder of this study consists of four chapters. Chapter 2 provides a review of the related literature. Chapter 3 contains a description of the specific procedures for the study, including methodology, subjects, and research design. In Chapter 4, the results of the study are presented. Chapter 5 includes a discussion of the results, conclusions, implications, limitations, and recommendations for future research.
CHAPTER 2
REVIEW OF THE LITERATURE

The purpose of this chapter is to review the professional literature relevant to this study. The review is organized into six major sections: (1) crisis theory, (2) school crises, (3) suicide, (4) crisis intervention, (5) counselor responsibilities, and (6) crisis intervention training.

Crisis Theory

The origins of crisis theory are grounded in works cited in psychological and medical journals dating back to the 1920s (Hendricks & Thomas, 2002). According to Hendricks and Thomas, early research, conducted without the benefit of the umbrella term “crisis intervention,” focused on diverse and seemingly unrelated areas, such as “mental conflict,” “hysteria,” “time-limited mental health care,” “short-term psychotherapy,” and “acute grief.” These early studies laid the foundation and provided support for many important crisis intervention concepts, including objective mediation, prioritizing patient treatment over problem diagnosis, directly addressing an individual’s crisis, and the use of advanced empathy.

It is generally recognized that the study of crisis intervention, theory and practice began with the groundbreaking efforts of Eric Lindemann (1944) and gained momentum through the work of Erickson (1963), Caplan (1964), and Quiendo (1968). Their numerous studies examined the effects of accidents and disasters on human functioning and shed new light on trauma response, crisis theory, and intervention practices. However, since the original work of these early pioneers, very few new theoretical
approaches have been proposed to advance the crisis field (Hoff & Adamowski, 1998). Implications from their theories and practice are so fundamental that virtually all scholars and practitioners in the crisis field rely on their major concepts as a foundation (Hoff, 1995).

In the early 1940s, 493 people were killed in the Boston Coconut Grove fire. Lindemann (1944) provided psychological assistance to survivors, family, and friends in various states and stages of crisis. His well-known study of the acute grief caused by this crisis provided the foundation on which the current understanding of crisis reactions is built. Lindemann identified five main characteristics of grief, including "somatic distress, preoccupation with images of the deceased, guilt, hostile reactions, and loss of patterns of conduct" (p. 142). He noted that acute crisis situations trigger similar patterns of grief and also discovered that individuals who were supported in expressing their grief experienced "rapid relief from stress."

Lindemann (1944) highlighted the seriousness of grief postponement, which is a type of crisis that occurs when a person faces a tragedy and displays little or no reaction, and noted the common experience of seeking to avoid the intense pain and distress associated with grief and loss. He concluded that, without intervention, denial and grief postponement were likely to lead to the development of personality disturbances, morbid reactions, and maladaptive behaviors. Lindemann's studies "were valuable in that they established a sequence of probable reactions on the problems of the victim/survivor and predicted how certain persons, depending on their reactions to grief, might proceed through a crisis" (Hendricks & Thomas, 2002, p. 9). Later studies examined the effects of crisis-related stress on the human body and revealed that crises are detrimental to a
person's physical health as well as his/her mental well-being. Current application of Lindemann's theories on acute grief, psychosomatic illness, and the crisis response emphasize the importance of immediate intervention, debriefing, and postvention efforts in order to lessen the long-term impact of crises.

In 1946, Caplan joined with Lindemann to establish one of the first community mental health programs (Brock et al., 2001). In contrast to Lindemann's view of crisis as a personal, unpredictable situation, Caplan viewed crisis from a developmental perspective. Basing his theory on Erickson's (1963) theories of lifespan development, Caplan believed that crises are (often) triggered by predictable developmental "tasks" that occur at various stages of life. The concept of preventative mental health stemmed from the notion that because developmental crises could be anticipated, they also could be prevented (Pitcher & Poland, 1992).

Caplan (1964) suggested that failure to negotiate transitions from one developmental stage to another plays a role in the development of psychopathology and that personal and social resources are the key to determining how an individual resolves both developmental and situational crises. Caplan also was one of the first theorists to address the concept of homeostasis. According to Caplan, people constantly employ coping strategies to maintain emotional equilibrium, and thus he viewed crisis "as an upset of and an inability to maintain a steady emotional state" (Brock et al., 2001, p. 12). Caplan suggested that crisis overwhelms an individual's normal problem-solving strategies and creates a state of disequilibrium associated with the inability to maintain emotional control.
Erickson's (1963) work concentrated on the typologies of crisis. He contributed much to the field of crisis intervention by demonstrating that crises come in more than one variety and have many sources. According to Erickson, there are two categories of crisis: (1) maturational developmental crises, which involve physical, social, and emotional changes that occur as a result of the natural aging process and (2) accidental situational crises, which involve trauma and/or unexpected loss triggered by an unpredictable situation that taxes an individual's normal coping mechanisms. These categories of crisis also have been referred to as "internal" or "external" crises. Although these categories have been expanded and elaborated, they are still the primary classifications used today.

Quierdo (1968) conducted studies during the 1930s in post-war Amsterdam. He developed a psychiatric first-aid service based on his discovery that intervention in a patient's own environment was therapeutic in itself. Quierdo wrote that, "in this first contact - often in the tense atmosphere of an acute crisis - a picture is unfolded where, I am convinced, never can be obtained in any other way" (p. 299). Quierdo's method, referred to as emergency first aid, was used extensively by the military during the Vietnam, Korean, and Second World wars. According to Hendricks and Thomas (2002), "soldiers suffering from combat fatigue were sent to the rear of the combat zone to receive support. Research indicates that these soldiers were successful in regaining equilibrium within their immediate, albeit threatening, environment" (p. 12). The effectiveness of crisis intervention is directly related to the intervention's proximity in both time and place to the crisis event. Today, Quierdo's method is referred to as psychological first aid and is considered synonymous with crisis intervention.
Caplan (1964) proposed a model of mental health consultation that has become the foundation of school crisis intervention programs and crisis response (Pitcher & Poland, 1992). His model involves a three-part approach to crisis that includes primary, secondary, and tertiary intervention efforts. Primary care, or prevention, focuses on reducing the incidence of crises. Secondary care, or intervention, involves the immediate provision of assistance to individuals experiencing a crisis. Tertiary care, or postvention, reduces the long-term effects experienced by those directly and indirectly impacted by the crisis.

Caplan's three-part approach to crisis intervention and his observation that crises are generated not only by situational factors, such as the Coconut Grove fire, but also by developmental transitions are major contributions to crisis theory. Furthermore, he emphasized community responsibility in facilitating the recovery of those in crisis and he called “for the community and its agencies to work together to assist individuals in need . . . advocates trained in crisis intervention do this by training and networking community programs and by promoting general community welfare through preventative programs and response efforts” (Hendricks & Thomas, 2002, p. 11). Implications for school crisis intervention are particularly significant because of the intensity and frequency of both developmental and situational crises experienced by school age children and the unique social dynamics, capable of either alleviating or exacerbating a crisis, of school communities.

**Scope of the Problem**

Everyday in America, on average, 15 children are killed by firearms, 13 are victims of homicide, and six commit suicide. According to the National School Safety Center, 40 students, teachers, and other school personnel were killed at their schools during the
1997-98 school year alone (Poland & McCormick, 1999, p. 1). According to a National School Board Association survey of 700 schools, violence is worse now than it was five years ago (Pietrzak, Petersen, & Speaker, 1998). Between 1982 and 1991, violent crimes among juveniles increased 40% (Sprague & Walker, 2000). Further, research indicates that the “incidence of teen suicide is rising, that suicide attempts are increasing at an even faster rate than completions, and that children are demonstrating suicidal behavior at increasingly younger ages” (Kalafat, 1993, p. 268).

Among 15 to 19 year-olds, suicide is currently the second leading cause of death (Hayden & Lauer, 2000; King et al., 1999; King et al., 2000; Poland & McCormick, 1999; Popenhagen & Qualley, 1998). It is estimated that 60% of adolescents engage in suicidal ideation and research now indicates that between 10% and 13% of American adolescents have made at least one suicide attempt (Cohen & Fish, 1993; Juhnke, 1996). Cohen and Fish (1993) reported that 1 in every 200 attempters succeed.

Although the suicide rate has remained relatively stable for the general population over the past 40 years, researchers quote a 300% rise in adolescent deaths by suicide, during the same period (Hayden & Lauer, King et al., 2000). In a recent Gallup poll, 60% of teens reported personally knowing someone who had attempted and 15% knew someone who had actually completed suicide (Cohen & Fish, 1993). Unfortunately, those who do not attempt to end their lives are often grievously impacted by those who do and adjustment after a completed suicide is even more problematic because of the atypical nature of the death and the social stigma involved (Clark, 2002; Cohen & Fish).

Widely publicized school-based violence, such as the tragedies in Pearl, Mississippi, Paducah, Kentucky; Jonesboro, Arkansas; and Littleton, Colorado, have
increased awareness of the need for violence prevention programs and crisis intervention services in the schools. However, these events are still relatively rare compared to the number of adolescent suicides, deaths in the school community, accidents, community disasters, and developmental crises, all of which require crisis intervention in the schools on a much more frequent basis. Furthermore, “typical” developmental crises are multiplied and magnified by the increasingly complex issues facing today’s school-age youth and by declining family and community support systems. The impact of societal problems on adolescents is reflected in dramatic increases in substance abuse, suicide, child abuse, teen pregnancy, truancy, school drop out, and random acts of violence (Pitcher & Poland, 1992; Wittmer, 2000). Crisis intervention in schools is necessary for dealing with students who experience situations that overwhelm their ability to cope and have the potential to damage their physical, mental, or emotional functioning or growth.

In Chowchilla, California, in the early 1970s, a busload of school children was kidnapped and buried underground for 27 hours. After their escape, no mental health care or counseling support was provided to the victims. As a result, follow up and review of the incident indicated that, five years later, 100% of the children had clinical symptoms of depression, fear, and anxiety (Terr, 1983). Subsequent reviews of trauma response in the schools demonstrate that children who are able to verbalize their feelings and reactions in a timely manner recover most quickly and are better able to deal with the crisis in the long-term.

A 1990 survey of 1,301 high school students identified school counselors as being the school professional they would feel most comfortable talking to about personal problems (Armacost, 1990). However, 55% reported they would not feel comfortable
seeking out school staff to talk about a personal problem. Because most troubled students will not initiate contact, the importance of recognizing the warning signs and characteristics of at-risk students is critical. These findings also have implications for increasing the efficiency of crisis intervention, improving rapport-building skills, marketing the availability and accessibility of counseling services, and promoting school-wide suicide awareness.

**Definitions of Crisis**

Crisis situations occur periodically throughout the lifespan and may be triggered by either a single catastrophic event or the cumulative effect of successive stressors. Although once viewed as pathological, crisis reactions are now recognized as normal responses to abnormal situations (Brock, 1998). The following characteristics of crisis situations have been identified: (1) the presence of both danger and opportunity, (2) complicated symptomatology and ineffability, (3) seeds of growth and change, (4) the absence of panaceas or quick fixes, (5) necessity of choice and action, (6) time-limited acuteness, (7) universality and idiosyncrasy, and (8) an obstruction of goals and loss of control (Gilliland & James, 1997; Romano, 1990, as cited by Hendricks & Thomas).

According to Caplan (1964), crises challenge coping resources, jeopardize an individual's sense of emotional balance and stability, create psychological distress, and cause individuals to feel trapped (i.e., unable to escape or effectively deal with the problem at hand).

The crisis state "results in significant upset, discomfort, anxiety, disorganization, and/or disequilibrium. This distress is associated with an inability to cope with or adapt to the crisis circumstances" (Brock et al., 2001, p. 15). The emotional experience of a crisis may range from intense pain to numbness, but is typically characterized by confusion,
vulnerability, disorganization, helplessness, and disequilibrium (Cohen & Fish, 1993). Personality characteristics of individuals in crisis include a lowered span of attention, an inability to discriminate between stimuli, introspection, uncontrolled emotional responses, impulsivity, limited perspective, and subtle and/or overt help-seeking behaviors (Hendricks & Thomas, 2002). Crisis is a subjective reaction to a stressful life experience; it is an individual's perception of and reaction to an event that shapes a crisis, not the situation itself (Roberts, 1990). In other words, "the term crisis refers to a person's feelings of fear, shock, and distress about the disruption, not to the disruption itself" (Brammer, as cited by Gilliland & James, 1997, p. 3). Crisis is essentially a relational phenomenon and cannot be understood, prevented, or resolved without attending to the contexts and structures surrounding a distressed individual. According to Hendricks and Thomas (2002), "the interpersonal experience of the individual in response to the event that in some way involves others in the interpersonal environment is the foundation for understanding the dynamics of crisis formation." (p. 7). Therefore, an individual's perceptions, skills, experiences, and abilities cannot be viewed in isolation (Palmatier, 1998).

Burgess and Baldwin (1981) outlined an expanded taxonomy of crises that includes six major classifications of crisis: (1) dispositional; (2) anticipated life transitions; (3) maturational/developmental crises; (4) traumatic stress; (5) crises reflecting psychopathology; and (6) psychiatric emergencies (Hendricks & Thomas, 2002; Pitcher & Poland, 1992). However, most crises typically can be classified as either developmental or situational (Caplan, 1964). Developmental crisis refers to the stress and anxiety associated with transitioning from one developmental stage to another and often
relates to meeting the demands and resolving the tensions of the new stage. For example, the transition from middle to high school comes at a time when many students are worrying about their values and personal identities. This transition period frequently leads to crises when personal decisions cause conflict between family and/or cultural values and the values of their peers or social groups. The frequency, intensity, and duration of developmental crises vary depending on the individual’s combination of personal, social, and environmental resources. Situational crises are triggered either by a single, specific occurrence or a compounded series of events. For example, natural or manmade disaster, mugging, illness, abuse, divorce, loss of a job, moving, war, and gang violence have been cited frequently as precipitators of situational crises (Palmatier, 1998). Typically, these occurrences are universally recognized as crises.

School Crises

Schools are one of the major socializing institutions affecting children’s lives and are therefore the context within which they experience frequent crises (of varying degrees and impact) and also where they learn how to resolve their crises and cope with the associated and causal factors (Cohen & Fish, 1993). A school crisis may be defined as an incident occurring either at school or in the community that negatively impacts students, staff, and/or other members of the school community (Trump, 2000). The simplest criterion for an incident to be considered a crisis is an implied threat to the health, safety, or welfare of students. Every crisis situation creates unique circumstances and evokes associated feelings and reactions. According to Johnson (2000), school crisis “brings chaos” that “undermines the safety and stability of the entire school” (p. 18). Similarly, situations that create, or have the potential to create, a disruption of the educational process or normal school operations may be considered crises.
Situational school crises typically fall into one of the following three categories: (1) purposeful, human-caused disasters, such as violent crimes, shootings, bombings, hostage taking, teacher victimization, assault, suicide, or murder; (2) accidental disasters, such as transportation accidents, gas leaks, chemical spills, fires, or faulty equipment; and (3) natural disasters, such as hurricanes, tornadoes, floods, or earthquakes (Hill & Hill, 1994). Rising incidences of depression, suicide, and physical, sexual, and psychological abuse/neglect also are frequent causes of crises among children and adolescents (Pitcher & Poland, 1992). According to Pitcher and Poland, these types of traumatic stress, which result from unpredictable and uncontrollable losses, are the most common crises experienced in schools. However, given that crises are shaped by individual perceptions, it is important to realize that developmental crises, such as social isolation or interpersonal conflict (although less consensually traumatic) can evoke feelings that create a crisis state solely for the individual experiencing them.

Literature supports the belief that the absence of effective intervention causes the crisis victim/survivor to reach a physical and psychological breaking point and increases the likelihood of permanent or long-term damage (Brock, 1998; Hendricks & Thomas, 2002; Palmatier, 1998; Poland & McCormick, 2000; Terr, 1983; Terr, 1992; Weinberg, 1993). According to Johnson, Casey, Ertl, Everly, and Mitchell (1999), crises that are ignored or resolved ineffectively create post-traumatic stress responses that compromise the achievement of the goals of education in the following ways: (1) creating adverse reactions that affect learning; (2) reducing the ability to concentrate; (3) disrupting attention; (4) interfering with socialization; (5) causing difficulties in memory retention and retrieval; (6) becoming preoccupied with the traumatic experience; (7) regressing to
earlier levels of coping, and (8) heightening physiological arousal and startle reflexes. Johnson et al. suggest that school personnel often misinterpret many of these problems and associated crisis-related behaviors as discipline issues, and thus students are frequently punished as opposed to receiving appropriate intervention services. Students who are experiencing crisis reactions that are not recognized or validated have a more difficult time restoring equilibrium and assimilating the experience (Wellman, 1984).

Regardless of the nature of the crisis, schools should be prepared to provide students with a sense of hope, stability, security, and optimism. According to Hendricks and Thomas (2002), “a common crisis-producing event is the feeling that ‘I have failed to cope adequately’” (p. 5). In the midst of a crisis, feelings of failure and guilt increase the likelihood that another crisis will occur. Therefore, any event that elicits a crisis response, from even the smallest portion of the collective student population, should be dealt with from a proactive crisis intervention standpoint, particularly because children in crisis are often too afraid or confused to seek help on their own.

Although the method and magnitude of response may be different, every crisis should be treated with the utmost care and concern for those experiencing it. Incidents such as student or teacher deaths, school violence, suicide attempts or completions, and car accidents can impact a significant portion of the student body. These crisis situations expose students to “threat, loss, and traumatic stimulus” and undermine their “security and sense of power” (Johnson, 2000, p. 3). School counselors should be prepared to respond to any situation that causes students to experience crisis reactions because efficient intervention minimizes the likelihood that the crisis will escalate and/or cause long-term damage. Furthermore, Fink’s definition of crisis as “a perceived threat that
overwhelms the individual’s coping abilities” (as cited by Palmatier, 1998, p. 59) suggests the possibility of not only intervening and resolving a crisis, but also of taking preventative actions to deal with future crisis by improving coping skills.

Crisis in the context of schools has “unique features because of the school’s social structure and sense of community” (Allen, Jerome, et al., 2002, p. 427). Any crisis, no matter what size, can provide valuable opportunities to communicate and model care and concern to the students and staff. An efficiently managed crisis can be used to unite students and staff and form a sense of understanding, trust, and cohesiveness. However, minimizing and denying the effects of crisis sends the message that the trauma was not significant enough for staff to acknowledge an individual’s distress and also may suggest that the crisis was so overwhelming that school staff were not able to deal with it directly. The sense of community that comes from sharing an emotionally charged experience will not be realized if schools choose to maintain a “business as usual” approach to crisis situations or personal tragedies.

**Suicide**

A youth commits suicide every 90 minutes in the United States (Bolton, 1993). Females are three times more likely than males to attempt suicide, males are five times more likely than females to complete suicide, and gays/lesbians are three times more likely than heterosexual youth to engage in suicidal behavior (King et al., 2000). Fortunately, there are far more suicidal attempts and gestures than actual completed suicides, averaging approximately 14 completions for every 65 suicide attempts each day (Studer, 2000). One epidemiological study estimated that there were 23 suicidal gestures and attempts for every completed suicide (Watkins, n.d.), but other researchers quote as many as 50 to 100 attempts for every completion (e.g., Ayyash-Abdo, 2002, National
Center for Health Statistics, 1992). Watkins cautions that it is important to pay close attention to those who make attempts because 10% of those who attempt suicide will eventually complete suicide. Studies indicate between 60% and 80% of adolescents who attempt suicide give some sort of verbal warning or threat prior to their attempt (Bolton, 1993; Popenhagen & Qualley, 1998).

Suicidal behavior is the end result of a complex interaction of psychological, emotional, social, and environmental factors. As a result, the motivations behind suicide are complex and confusing. Despite the multiple reasons individuals use for committing suicide, an understanding of the commonalities of suicide is the first step towards identifying risk factors and predisposing variables, reducing suicidal intention, and intervening effectively (Clark, 2002). Shneidman (1985) identified the following commonalities of suicide: (1) the common stimulus is unendurable psychological pain, (2) the common stressor is frustrated psychological needs, (3) the common purpose is to seek a solution, (4) the common goal is cessation of consciousness, (5) the common emotion is hopelessness-helplessness, (6) the common internal attitude toward suicide is ambivalence, (7) the common cognitive state is constriction or "tunnel vision", (8) the common interpersonal act is communication of intent, (9) the common action is aggression, and (10) the common consistency relates to life-long coping patterns. Although an understanding of these general commonalities provides a sound foundation for suicide intervention, it is important to explore the nature of adolescent suicide more specifically.

Jobes (2000) asserted, "Suicidality is essentially a relational phenomenon. Specifically, the presence and/or absence of certain key relationships can paradoxically
be both suicide causing and suicide preventive” (p. 8). For example, repeated disruptions of family life, such as parental discord, separation, caretaker changes, and physical or sexual abuse, have been linked to suicidal behavior, and 52% of adolescent suicide attempters revealed having problems with their parents (Studer, 2000). Similarly, Allberg and Chu (1990) found isolation and impaired interpersonal contacts to be correlated with youth suicide and Maris (1981) reported that 50% of the suicide completers he researched had no close friends (as cited by Juhnke, 1996). According to Studer, “because individuals experiencing a crisis are often difficult to be around (Aguilera, 1998), the real or imagined distance created between the suicidal individual and significant others may result in greater isolation, loneliness, and loss of a support system” (p. 270). These findings have implications for the importance of school counselors being able to build rapport and convey empathy to suicidal students quickly and efficiently.

There is considerable agreement that the following risks factors are associated with adolescent suicide: impulsivity, angry or aggressive behavior, cognitive rigidity, isolation, alienation, lack of meaningful attachments, helplessness, hopelessness, problem-solving deficits, poor coping skills, loss of identity or status, and high levels of chronic stress (APA, n.d.; Ayyash-Abdo, 2002; Beautrais, Joyce, and Mulder, 1999; United Way of Connecticut, 1999). It is generally agreed that “biological, emotional, intellectual, and social variables operate together to create conditions conducive to suicidal behavior” (Bolton, 1993, p. 274). Adolescents frequently report the following causes for suicidal behavior: relationship problems, home/family stressors, depression, social problems with peers, low self-esteem, and feelings of rejection (Cohen & Fish, 1993). Furthermore, Petersen and Straub (1992) cited the following environmental factors
in schools that increase the risk of suicide: transitions and restrictions imposed by "the system," lack of specialized programs and services, a social climate with strong cliques and factions, and the alienation and rejection of certain types and/or groups of students.

Kalafat (1993) cited the following triggering events as commonly associated with suicide: "trouble with authority and fear of consequences, disappointment and rejection, a stressful life transition, the anniversary of the death of a loved one, and knowing someone who tried or succeeded in killing him[her]self" (p. 268). According to a study by Shaffer (1988), 41% of male and 33% of female suicide victims had a close relative who had made a suicide attempt or completion (as cited by Studer, 2000). Major life transitions and loss are key themes in the experience of a crisis and suicidality (Bolton, 1993). In addition, separation, divorce, and death have all been linked with adolescent suicide. Thus, as exemplified in a study by Morano et al. (1993), half of adolescent suicide attempters reported losing a significant other prior to their suicide attempt (as cited by Studer, 2000).

A link has been found among the subjective experience of problem irresolvability, the sense of loss of control, and suicidal behavior (Jacobs, as cited by Orbach, Mikulincer, Blumenson, Mester, & Stein, 1999), all of which are essential issues to be addressed in any comprehensive crisis intervention program. As problem-solving skills and coping abilities become overwhelmed, a crisis gains momentum, personality fragmentation occurs, and the crisis victim/survivor moves toward specific patterns of maladaptive behavior (Hendricks & Thomas, 2002). According to Bolton, violence and drug abuse are common correlates of suicide, and substance abuse is reported to be associated with two-thirds of all suicides. In particular, aggressive behavior, alcohol, and
drug use have been found to be strongly associated with suicidal behavior in adolescents, and researchers have suggested that poor impulse control may be the common link that influences the co-occurrence of these behaviors (Simon & Crosby, 2000). An accumulation of negative life events and experiences in conjunction with inadequate problem-solving skills has a major impact on the frequency and intensity of anger experienced at school (Fryxell and Smith, 2000) and also contributes to feelings of hopelessness and suicidal ideation (Ayyash-Abdo, 2002; Bolton, 1993; Simonds, McMahon, & Armstrong, 1991). Suicide and aggressive behavior both represent ineffective means of coping or resolving crises.

There is support for the idea that suicide attempts often occur in crisis situations in which isolated teens see no other option (APA; Beautrais, Joyce, and Mulder, 1999; Bolton, 1993; Hazler & Carney, 2000; Kalafat, 1993). That is, adolescents often perceive that there are no solutions to their problems and turn to suicide or violence as the means to reduce their pain and torment or to cope with their out-of-control emotions (APA, n.d.; Hazler & Carney, 2000). Violence towards oneself or others is frequently used by youth to release pent up feelings of anger or frustration. A suicidal individual sees only two options: pain or escape (Bolton, 1993). Instead of lashing out at others, some teens choose to direct violence toward themselves, with the most final and devastating expression of this kind of violence being suicide. In an early study of aggression and suicide, Nelson (1979) concluded that:

Aggressive behavior, whether it be explosively violent or more subtly manipulative, is directed at effecting change in one's social environment and is seen as potentially rewarding or experienced as stress reducing. Although seeking freedom from internal stress, the suicidal person generally feels that his [her] situation is hopeless and that he [she] is powerless to effect change in his [her] external environment beyond anticipating the effects of his [her] death. (p. 168)
Suicidal ideation is communicated rather consistently through affective and behavioral changes (American Academy of Child and Adolescent Psychiatry, 1994; Wellman, 1984). Warning signs of suicide are generally agreed upon to include verbalized or written expression of death themes or intent or wish to die; dramatic changes in personality, physical appearance, or behavior (e.g., acting out, running away, major drug use, or risk-taking); making plans or final preparations, such as giving away possessions or saying good-bye; poor concentration; extreme self-criticism or verbal self-denigration; feelings of hopelessness, guilt, sadness, anxiety, anger, moodiness, or restlessness; changes in eating habits or sleep patterns; social isolation or withdrawal; academic failure; sudden elevation in mood or absence of depression; suicide-related statements; gestures, such as self-mutilation, cutting wrists or other self-destructive behaviors; a previous attempt, depression; frequent complaints about physical symptoms that are often related to emotions (e.g., stomachaches, headaches, or fatigue); and loss of interest in once-pleasurable activities or relationships (American Academy of Child and Adolescent Psychiatry, 1994; Bolton, 1993; Davis, Sandoval, & Wilson, 1993; Kalafat, 1993; Popenhagen & Qualley, 1998; Wellman, 1984).

According to Wellman (1984), when repeated attempts to communicate suicidal intent through overt gestures and "cries for help" are not responded to, a lull (or latency period) often occurs. Frequently, it is during this period when help is no longer being sought, that individuals become resolved to end their lives and make a lethal attempt. School counselors need to be aware of these signs in order to identify at-risk students more reliably and to intervene more quickly and efficiently. The school counselor's overall knowledge regarding adolescent suicide may directly determine the likelihood
that at-risk students will successfully be identified and given the proper help (King et. al., 2000; Smaby, Peterson, Bergmann, Zentner-Bacig, & Swearington, 1990).

**Crisis Intervention**

Crisis intervention is a process by which trained crisis workers identify, assess, and intervene with distressed individuals so as to restore balance and reduce the negative effects of crisis in their lives. Although the term “crisis intervention” emerged in the late 1970s (Hendricks & Thomas, 2002), the origin of crisis intervention work has been traced to the nation’s first suicide prevention center, which was established in 1906 in New York City (Brown, 2002; Roberts, 1990). The establishment of New York’s suicide prevention center confirmed that effectively resolving a crisis frequently requires the provision of support and resources external to the individual experiencing the crisis. According to Brown, “this notable beginning epitomizes the nature and intent of crisis intervention, because to contemplate suicide suggests a reaction to a crisis event(s) that is beyond a person’s adaptive capabilities” (2002, p.33). Intervention becomes necessary when individuals have exhausted their skills for coping and feel hopeless and overwhelmed by their current situation.

According to Hoff and Adamowski (1998), “A truism about the human condition is the community’s recognition that most individual members cannot manage stressful or traumatic life events alone if they are to avoid potential pathologies or fatal outcomes” (p. 5). Timely, efficient intervention frequently determines whether the resolution of a crisis will be positive. Thus, in order to minimize the likelihood of future physical or emotional deterioration, prompt, skillful support is imperative. Crisis intervention involves an immediate response to and resolution of an urgent problem, focusing particularly on
stabilizing emotional functioning and minimizing the long-term ramifications of the crisis (Hoff & Adamowski, 1998).

Crisis intervention provides the opportunity and means for relief to those who are experiencing acute distress and psychological disequilibrium. Crisis intervention is related to but differs from psychotherapy in that psychotherapy tends to be longer-term and directed towards changing a person’s maladaptive patterns of thinking, feeling, and behaving. Typically, the goal of psychotherapy is personal growth, and the therapeutic relationship is not characterized by the same sense of urgency and immediacy necessary for effective crisis intervention (Pitcher & Poland, 1992). Furthermore, crisis intervention has been referred to as “emotional first aid” or “psychological triage” (Brock, Sandoval & Lewis, 2001; Myer, 2001). Because of its emphasis on immediate pain relief and stabilization, crisis intervention is often likened to procedures in a hospital emergency room (ER). For example, patients must frequently be stabilized in the ER before it is possible to ascertain the extent of their injuries or determine additional treatment needs. The immediacy and efficacy with which ER patients are treated has a significant impact on their long-term prognosis, and, certainly, hospital ER staff are trained quite differently than surgeons or general practitioners because their goals and the needs of their patients are very different.

Similarly, it is a mistake to assume that individuals trained as school counselors have the necessary skills and knowledge for effective crisis intervention. Crisis intervention is a specific helping activity, with its own unique set of theories, skills, attitudes, and knowledge. Hoff and Adamowski (1998) stated, “Crisis intervention is not merely a ‘Band-Aid’ version of psychotherapy. It is an organized approach to helping
distressed people that can be mastered by professionals and laypeople through a
systematic education and training program” (p. 13).

Crisis assessment involves determining a person’s vulnerability to and resources
for managing traumatic life situations, including the recognized standard of explicitly
ascertaining current and past victimization trauma and risk of suicide (Hoff &
Adamowski, 1998). Hoff (1995) proposed a model of assessment that involves two
levels: (1) safety, which would include an exploration of the presence of imminent threat
or harm as well as suicidal or homicidal intent, and (2) the ability to function, which
involves consideration of an individual’s personal and social characteristics and
resources. Hoff’s model has been described as a “vulnerability model” because crisis
workers are able to assess an individual’s overall vulnerability to a maladaptive crisis
response by considering the nature of the hazardous event (an event that, in terms of
timing and/or severity, stretches a person’s ability to cope and increases susceptibility to
a full-blown crisis response), the precipitating factor, and the person’s reactions to the
event (Myer, 2001). According to Hoff, assessing a person’s reactions to crisis includes
examining the following distress signals: difficulty managing feelings, suicidal and/or
homicidal behaviors, alcohol or substance abuse, trouble with the law, and an inability to
utilize available assistance. Gathering information on a person’s assets and liabilities with
respect to family and social resources is essential both in terms of understanding family
and social factors that may be exacerbating a crisis and identifying possible resources and
support that can be mobilized to help with the crisis.

Once an individual is determined to be in a state of crisis, there is agreement among
crisis intervention scholars and practitioners that sound crisis intervention requires “a
combination of effective interpersonal communication, an ability to focus the client on the crisis and crisis-producing event, and the intervener's skill in guiding the person experiencing the crisis through the process of recovery" (Hendricks & Thomas, 2002, p. 13). The process includes but is not limited to debriefing, which is often referred to as Critical Incident Stress Debriefing (CISD). There are various, specific debriefing models, but the common goal is to allow a semi-structured format for traumatized individuals to discuss the details of the traumatic event they have experienced. This detailed processing of a crisis event is most frequently conducted in small groups, and, since most of the principles are the same, the process can be viewed as "group crisis intervention."

Debriefing should be initiated as soon as possible after a critical event occurs and typically involves "listening, catharsis, emotional support, psychoeducation about normal crisis response, and linkage to follow-up crisis counseling or psychiatric services based on assessed needs" (Hoff & Adamowski, 1998, p. 10).

Crisis intervention programs stress the need to listen actively, openly name and discuss the taboo subject (e.g., suicide, rape, or divorce) as soon as it becomes apparent, demonstrate empathy, and remain nonjudgmental. A skilled interventionist uses these behaviors to build rapport and lesson an individual's anxiety, thus allowing for the expression of vulnerabilities in a climate of safety, understanding, and acceptance. In addition, crisis workers should be prepared to provide those impacted by the crisis with information concerning the affective, cognitive, behavioral, physiological, interpersonal (Gilliland & James, 1997), and psychological responses to traumatic events.

Slaikeu (1990) characterized the crisis intervention process as involving the following steps: (1) Making psychological contact through empathy, warmth, and
respect; (2) Exploring dimensions of the problem, including direct inquiries about the immediate past (crisis precursors), the present (the crisis story), and the immediate future (crisis-related problems); (3) Examining possible solutions by asking about the coping strategies already used, facilitating an exploration of additional coping techniques, and proposing other problem-solving options; (4) Taking concrete action by facilitating implementation of solutions to crisis problems (if lethality is high, crisis intervener should assume greater responsibility for assuring that direct action is taken); and (5) Establishing a plan to follow-up with the crisis victim. Trained crisis counselors should be able to anticipate and explain the common emotional, physical, and cognitive reactions associated with crisis and grief as well as empathize with and validate the wide range of emotions experienced (Cohen & Fish, 1993). Kalafat (1993) recommended that schools, specifically, set the following crisis intervention objectives:

To identify at-risk students; to help students in crisis develop options, to provide supports, and to push for their use; to provide students, parents, and staff with the knowledge and methods to respond to the teen, have professional help on hand, and communicate a message to use it; to respond to attempters and to victim-survivors after a [suicide] completion. (p. 268)

**Suicide Intervention**

Statistics on adolescent suicide "require the school practitioner to develop skills to intervene with suicidal students and to develop primary prevention strategies for the school" (Davis, Sandoval, & Wilson, 1993, p. 265). School counselors must be prepared to assist students contemplating suicide appropriately and effectively. Individuals may often be suicidal for short periods of time, and, if prevented from killing themselves, are able to be stabilized, cease suicidal ideations and/or behaviors, and acquire new coping skills in the process (Bolton, 1993). Suicidal risk is assessed by balancing empathy,
rapport building, and emotional support with an exploration of the following topics/questions:

(1) recent loss or trauma; other background information such as academic performance, substance abuse, loss of interest; (2) whether the student is considering suicide (to be asked directly); (3) previous suicidal thoughts or attempts; (4) knowing someone who has committed suicide; (5) suicidal plans—how lethal (fast acting), how realistic, how detailed, chosen method; (6) supports and resources available; for example, parents, former therapist. (Breland et al., 1993, p. 278)

Once suicide risk has been assessed, it is important for school counselors to remain calm and listen attentively to students, validating their emotional responses without judgment or false reassurance. The following guidelines have been accepted as standard practice for assisting potentially suicidal individuals: (1) Stay calm and listen attentively, allow the individual sufficient time to vent painful thoughts and emotions and be validated, (2) Don’t ignore or minimize the warning signs, take every threat seriously, (3) Let the person know you have gotten the message, understand the gravity of the situation, and are concerned for his or her well-being, (4) Explain the short-term nature of crisis versus the irreversible nature of suicide; suicide is a permanent solution to a temporary problem; (5) Normalize the pain and hopelessness that causes a person to consider suicide and explain the reality that many people contemplate suicide but never attempt it; (6) Discuss the suicide plan, including the timeframe, method, feasibility, and steps; and (7) Utilize available referral and treatment resources (Bolton, 1993; Brock, Sandoval & Lewis, 2001; Pitcher & Poland, 1992).

School counselors should never commit to secrecy. In fact, when the decision is made to inform additional parties, rapport is best maintained by openly discussing this with the person being counseled and, if possible, calling with the counselee present (Bolton, 1993). It is important to understand the ethical obligation to interfere with
suicidal individuals while also being aware of the realistic boundaries of personal responsibility. A counselor can help someone look at alternatives but is not responsible for that individual’s life; he/she can’t force someone to live. Furthermore, although it is rare, some youth take their lives without warning; no one can stop someone who is determined to commit suicide.

Prevention

Primary prevention, in the form of education, training, consultation, and crisis intervention, is designed to reduce the occurrence of mental distress, reduce exposure to hazardous situations, and reduce vulnerability to crises by increasing coping ability (Hoff, 1995). The goal is to promote growth, development, and crisis resistance in both individuals and the community. Therefore, prevention refers to proactive attempts by school leaders to teach students new and/or improved coping skills before difficult or traumatic events occur or immediately after a crisis in order to minimize long-term effects. The professional objective for educators, counselors, and human service workers is to establish prevention programs that are so effective that crisis intervention will seldom be needed. However, despite evidence to the contrary, many school personnel erroneously believe that a crisis can’t happen in their school. As a result, they function in a reactive mode, minimizing the importance of prevention efforts, and unconsciously detaching themselves from crisis training and preparation.

Poland and Pitcher (1992) recommended that prevention efforts begin with programs that address the major causes of death for children: accidents, homicides, and suicides. Because suicide is so widespread among school-age children and because it can be more readily recognized, assessed, and prevented, most prevention programs contain components targeted at the reduction of suicidal ideation and behavior. Further, suicidal
thoughts and behaviors are so closely linked to the crisis experience (e.g., suicide can lead to a school crisis and a school crisis can lead to suicide) that suicide prevention efforts parallel crisis prevention. In response to the lack of current prevention and intervention programs, the *Youth Suicide Prevention Plan for Washington State* recommended “comprehensive education and prevention programs for youth, screening students for suicide ideation, training teachers as gatekeepers, and helping high-risk youth with support groups, drug programs, and life-skills training” (as cited by Hayden & Lauer, 2000, p. 239). Indeed, a multifaceted approach to suicide prevention, involving both students and staff and including curriculum-based and staff in-service programs has been consistently recommended in the literature (Dwyer, Osher, & Hoffman, 2000; Garland, Shaffer & Whittle, 1993; Hayden & Lauer, 2000; Miller, Eckert, DuPaul, & White, 1999).

A survey of existing suicide prevention programs yielded 115 school-based curriculum programs for adolescents, with the following indications: nine of ten trained school staff, seven of ten included a parent program, the average program length was four hours, and 66% of the programs included a standard manual and/or descriptive literature (Garland, Shaffer, & Whittle, 1993). The most commonly included topics were suicide facts and warning signs, death/dying education, signs of emotional disturbance, psychological development in adolescents, accessing community resources, confidentiality issues, stress reduction/coping strategies, and interviews with suicide survivors and attempters. Garland, Shaffer, and Whittle recommended program components that sensitize and train school staff to have better understanding of the
factors that increase the likelihood of crisis and the risk of suicide, and that teach participants to identify more reliably and provide resources for high-risk youth.

It is important to understand that crises can and do happen in all types of school communities. Thus, even with the most diligent prevention efforts, it is highly likely that a school counselor will, at some point, need to provide crisis intervention services. However, although school counselors have knowledge of a broad range of adolescent developmental issues, they need to acquire specific skills in developing and implementing prevention programs as well as the competence to intervene and respond to various crisis scenarios, including suicide (Smaby et al., 1990). Effective prevention and intervention become unrealistic expectations when school counselors are not competent, capable, or adequately prepared to understand and handle a wide array of crisis situations. Given the increasing number and variety of crises impacting schools, a thorough understanding of the crisis intervention process and training in crisis intervention skills, with a specific emphasis on suicide intervention, are essential for school counselors.

Postvention

Postvention, or tertiary prevention, involves the provision of services (including debriefing activities) designed to reduce the long-term effects experienced by those directly and indirectly impacted by crises. According to Weinberg (1993), “postvention is in reality a form of prevention, designed to block the occurrence of new tragedies in response to the triggering event, whether suicide, violent crime, or other misfortune.” (p. 277). As noted, crisis presents the opportunity for both self-growth and self-realization, as well as the development of improved coping skills. The recovery process includes, not only re-stabilization, but also learning new ways of coping with stress through positive crisis resolution (Hoff, 1995). Crisis resolution involves cognitive mastery of the
situation, the restoration of equilibrium, and the development of new coping strategies. According to Roberts (1990), "an effective crisis resolution removes vulnerabilities from the individual's past and bolsters the individual with an increased repertoire of new coping skills that serve as a buffer against future similar situations" (p. 330).

Breland et al. (1993) indicated that students are more likely to be responsive to additional evaluation, treatment, and postvention efforts when the counselor has worked to build sufficient rapport and trust by demonstrating empathy and utilizing timely crisis intervention skills. According to Trump (2000), "school and community officials need to realize that some of the most painful and stressful aspects of crisis management will continue after the initial incident itself has passed" (p. 123). In fact, post-crisis experiences can often be much worse than the original crisis event in terms of length, intensity, and strain. What occurs during the immediate aftermath of the crisis event determines whether the person is able to assimilate the experience effectively and, thus, prevent the occurrence of chronic, long-term symptoms.

According to Terr (1992), "if a traumatic response does not have the chance to become entrenched, it will become only a small scar on a very large life" (p. 77). Moreover, if appropriate intervention and postvention activities are not carried out, Gilliland and James (1997) suggest that "although the original crisis event may be submerged below awareness and the individual may believe the problem has been resolved, appearance of new stressors may bring the individual to the crisis state again" (p. 6). Well-resolved crises can provide the opportunity for the development of improved coping strategies and, in the future, "[similar] crises actually can be prevented by
working with and developing new perceptions and coping skills to create a significant increase in a person’s strength and resistance to stress" (Palmatier, 1998, p. 59).

Postvention activities reduce the damage among those impacted by the suicide or crisis of another (Weinberg, 1993). Postvention activities should focus on helping students achieve a reality-based understanding of the trauma, including common themes and experiences as well as common psychological and behavioral symptoms. It is also important to reinforce and praise students for their courage in the face of trauma and to help them regain a sense of control and confidence in their ability to deal with crises in the future. Students need to understand that, although their memory of a crisis may remain, with time, the pain lessons and symptoms disappear. After the immediate crisis subsides, school personnel should follow-up with the individual, make appropriate referrals, and connect him/her with additional resources in order to provide ongoing support and reinforce positive changes.

**Suicide Contagion**

The contagion issue causes many schools to be hesitant about initiating comprehensive programs to address suicide and engaging in appropriate postvention activities because the conditions under which students will imitate suicidal behavior are not clearly understood. Bolton (1993) contended that, “not all counselors are willing to state categorically that raising the issue of suicide will not trigger an act” (p. 275).

Suicide literature clearly stresses the therapeutic importance of being able to discuss suicidal thoughts and behaviors openly, both in terms of understanding the person’s own suicidality and that of others. The issue then appears to be not whether suicide should be discussed, but rather how it should be addressed.
Intervention after a completed suicide should attempt to reestablish immediate coping with survivors in a way that minimizes identification with and glorification of the victim (Brock, Sandoval & Lewis, 2001). It is a mistake to mystify the suicide or categorize it as unexplainable. For example, instead of saying, “It doesn’t make any sense, she had everything going for her,” say instead, “There were obviously serious things troubling her that we may never know about” (Rouf & Harris, 1988 as cited by Brock et al.).

According to Carter and Brooks (1990), “Contagion in the form of distress may occur among survivors, increasing the risk of suicidal behavior. However, postvention can be a counteracting process, allowing potentially self-destructive feelings to be expressed, tolerated, and thus diminished” (p. 381). Postvention-as-prevention is successful when survivors are encouraged to express their personal reactions to and struggles dealing with a suicide death; supported and helped to feel hopeful about the future; and engaged in open, honest discussions that address their confusion and concerns and dispel myths associated with suicide, thus reducing the likelihood of their becoming suicidal (Bolton, 1993; Leenaars & Wenckstern, 1998; Poland & McCormick, 2000). Davis, Sandoval, and Wilson (1993) wrote, “Research suggests that contagion is more likely when suicidal behavior is modeled without discussion. Discussion may reduce the contagion effect” (p. 267). Counselors must address the question of contagion and dispel myths that talking about suicide will glorify the behavior and cause it to happen (Bolton, 1993; Cohen & Fish, 1993; Davis, Sandoval, & Wilson; Kalafat, 1993).

Cohen and Fish (1993) cited only one suicide prevention training manual (Appel, 1984) that specifically addresses procedures for assisting students who return to school
after a suicide attempt. Although the information presented seems valuable at an organizational level (specifically, collaboration efforts between teachers, parents, outside therapists, and pupil service staff), there are no suggestions for how to intervene directly with the returning student or those close to the student. The personal significance of the crisis is minimized by suggesting, “the youth should be treated like any other absent student returning to school and should resume normal activities” (Cohen & Fish, p. 280). However, research supports the improbability of adolescents being able to integrate traumatic experiences adequately, including suicide attempts or completions, without appropriate intervention and postvention efforts (Brock, 1998; Gilliland & James, 1997; Palmatier, 1998; Poland, 1994; Poland & McCormick, 2000; Terr, 1983; Weinberg, 1993).

Research on the contagion hypothesis suggests that teens closest to a suicide victim may be at increased suicidal risk for suicide attempts (Brent et al., 1989; Carter & Brooks, 1990). Screening exposed students, particularly those who were friends of the victim, for suicide risk is advocated, and it is recommended that counselors pursue the survivors as opposed to waiting for them to seek help (Brent et al.; Carter & Brooks). Small group counseling, large group assemblies, dispelling rumors, and comprehensive debriefings are recommended following a student death (Cohen & Fish, 1993). Debriefings after a completed suicide should address the following: guilt and anger, the nature of grief, validation of common reactions, the individuality of experienced grief and the recovery process, opportunities for the expression of thoughts and feelings, and provision of additional resources and support services (Bolton, 1993).
Youth Suicide Prevention Services at Albert Einstein Medical Center in Philadelphia offers school-based post-suicide crisis intervention services. They recommend the following interventions for survivors of completed suicide: (1) Use a proactive approach to act quickly and alleviate fear; (2) Assess students' needs and provide immediate support; (3) Discuss themes of permanent and reversible loss, death, emotional honesty, and problem solving; (4) Plan for and establish a short-term support system; (5) Utilize support groups; and (6) Provide additional resources and access to more in-depth evaluation or therapy (Carter & Brooks, 1990).

Counselor Responsibilities

According to Decker (1997), "school authorities have both a moral obligation and a legal responsibility to provide for protection of public property and the life, health, and property of students, faculty, and staff in emergencies" (p. 4). This responsibility extends to the emotional health and psychological well-being of the entire school community. School personnel frequently fail to recognize or downplay the significance of problem situations, which left unattended to, can eventually instigate crisis events or worsen existing crises.

School crisis plans "highlight the importance of leaders taking charge by assessing the situation, making decisions, giving directions to others, and supervising activities" (Cornell & Sheras, 1998, p. 297). Crisis intervention is not officially listed on anyone's job description and, in fact, there are often no personnel specifically trained to intervene, territorial issues exist about whose job it should be (McIntyre and Reid as cited by Poland, 1994). Literature on professional counseling consistently identifies three counselor roles: counseling, consulting, and coordination, all of which are aimed at enhancing the personal and academic success of all students, with the ultimate goal of
helping students learn more effectively (ASCA, 1999; Ballard & Murgatroyd, 1999; Schmidt, 1999). Crisis intervention, which can be viewed as a form of brief, intensive counseling, seems most ideally matched with the job responsibilities of school counselors.

Professional literature is consistent in stating that school counselors should play a vital role in preventing adolescent suicide by advocating and providing leadership for suicide prevention and crisis intervention efforts (King et al., 2000; Remley & Sparkman, 1993; Smaby et al., 1990). Counselors must strive to formulate and adhere to visions that foster the physical safety, and emotional, as well as intellectual, growth of all children. Territorial issues can be circumvented if adequately trained and educated school counselors accept accountability and share their vision and knowledge with other school personnel.

According to Cornell and Sheras (1998), weaknesses in leadership, problems in teamwork, and failings in responsibility often precipitate or exacerbate crisis situations in schools. School leadership contributes to the morale of students and faculty and influences the nature of the school climate. A survey of school staff perceptions of student support services, rated crisis intervention roles, including serving on a crisis team and providing direct intervention services during crises, as very important (Watkins, Crosby, & Pearson, 2001). If counselors intend to be proactive advocates for their students, they must be instilled with a vision for leadership that allows them to campaign for the prioritization of crisis intervention activities in their school communities.

Bennis and Nanus describe effective leaders as “capable of achieving attention through vision, meaning through communication, trust through positioning, and
[possessing] a willingness to self-deploy and empower others’" (as cited by Hill & Hill, 1994, p.28). The creation and maintenance of safe, orderly, growth-oriented climates in which students can thrive, requires commitment, collaboration, vision, ownership, and comprehensive preparation.

Unfortunately, many school counselors are never exposed to information regarding crisis intervention, which makes cultivating a vision of its importance unlikely. Most students have a limited ability to recognize and discuss their feelings, particularly in times of crisis. Counselors can be of little help to students and staff if they are unable to recognize crisis behaviors and feelings and accurately convey this understanding to others. (Long, Wood, & Fecser, 2001).

School counselors have an ethical, and, in many cases legal, responsibility for knowing the risk factors of adolescent suicide, recognizing potential lethality, and taking appropriate steps to effectively intervene with suicidal students (Kalafat, 1990; Popenhagen & Qualley, 1998, Remley & Sparkman, 1993). Most school counselors feel that it is their role to identify and intervene with students at suicidal risk and that doing so would reduce the chances that the student would commit suicide (King et al., 1999). School counselors should work to actively dispel the following myths associated with suicide: (1) most suicides occur without warning, (2) those who attempt suicide are fully intent on dying, (3) those who talk about suicide do not attempt suicide, (4) openly discussing suicide causes it to happen, and (5) validating and empathizing with suicidal feelings condones suicide (Bolton, 1993; Davis, Sandoval, & Wilson, 1993; King et al., 1999).
School Counselors are the "experts" regarding student mental health issues, such as suicide, and should be responsible for educating school personnel and helping them effectively deal with these concerns (King et al., 1999). Counselors have a responsibility to teach parents, school personnel and peers to identify at-risk students. Collaboration, consultation, and the provision of in-service programs can help counselors generate gatekeepers among the entire school community. The burden of suicide prevention should not have to fall solely on the counselors' shoulders if they take a leadership role in developing a comprehensive crisis intervention program and promoting the vision of suicide awareness and prevention in their schools.

Education topics should include warning signs, listening skills, and ways to get help. The goal is to "provide information about suicide, bolster skills, strengthen confidence, and reduce fears about confronting the issue" (Davis, Sandoval, & Wilson, 1993, p. 266). Counselors cannot be effective in increasing knowledge of suicide, dispelling myths related to youth suicide, increasing coping skills, or promoting expectancies for engaging in help-seeking behaviors if they do not have the relevant knowledge and skills themselves. Therefore, it is imperative that school counselors be adequately prepared to identify, understand, and respond to crises in the school community.

Counselor Preparedness

Many schools are ill-prepared to prevent, intervene with, and follow-up with suicidal students. For example, in a survey of 163 school districts in Washington State, Hayden and Lauer (2000) found that the majority of districts did not have suicide programs, policies or procedures, and they were not actively involved in suicide prevention or intervention efforts. Their research indicated that the largest perceived
roadblock to implementing suicide programs was insufficient staff and the greatest perceived need was additional information and training. According to Oates (1988), the most common reaction to a crisis is to ignore it due to lack of training and awareness or fear that a response will worsen the situation and result in criticism (Klicker, 2000; Poland, 1994).

Surveys conducted by the Gallup Organization in 1991 and 1994 indicated that adolescents “in 1994 were significantly less likely than respondents in 1991 to report that their school and community were doing anything about adolescent suicide” (Brener, Krug, & Simon, 2000, p.311). This reluctance is frequently linked to costs, to the stigma involved, to the logistics of putting on a program, and to a lack of understanding of the associated mental health issues (Simmons, Comstock, & Franklin, 1989; Tierney, Ramsey, Tanney, & Lang, 1990).

Crisis intervention activities are often neglected due to lack of knowledge, overreaction, denial, or “paralysis by analysis”. Misconceptions of the problem and ineffective strategies inhibit crisis prevention and intervention efforts (Trump, 1998). While educating the entire community may be the long-term goal, the first goal should be training those professionals who are most immediately in contact with the students throughout the school day. Although many agree that school counselors should provide leadership and guidance in the development and implementation of prevention and postvention programs, there is growing concern that school counselors are either unprepared or ill equipped to respond effectively to crisis situations, especially adolescent suicide. A national study of school counselors found that only 47% of counselors worked
at schools which provided school faculty training to detect suicide warning signs (Malley, Kush, & Bogo, 1994).

A study by King et al. (1999) indicated that less than two thirds of school counselors were aware of the warning signs of adolescent suicide and only 38% believed that they could recognize a student at risk for suicide. Furthermore, although King et al. found that 74% of the counselors reported that a student from their school had attempted suicide and 89% reported that a student had expressed suicidal thoughts to them, only 1 in 2 respondents reported receiving some special training on adolescent suicide. Additionally, only 1 in 5 reported working at a school that had implemented a suicide prevention or intervention program.

Although research has shown that school counselors are knowledgeable about risk factors, they still do not feel confident in their ability to recognize at-risk students and have indicated a need for more effective strategies for intervening with suicidal youth (Coder et al., 1991; King et al., 1999; King et al., 2000). King et al. suggest further studies to determine whether suicide knowledge translates into significant levels of confidence and skill in identifying and intervening with students at risk for suicide.

Counselor Education

A U.S. national survey conducted by Berman (1983) revealed that few professional schools, including programs for health and other human service professionals, included formal coursework on crisis theory and practice (Hoff & Adamowski, 1998). Hoff and Adamowski believe every person working in human services, including school counselors, “should understand the basic concepts and practices of the crisis model.” (p. 13). Although feedback from school counselors suggests that recent graduates are receiving more preparation for crisis intervention than in the past, almost one-third of
school counselors continue to enter the profession with no formal course work or supervised experiences (Allen, Burt, et al., 2002).

Research assessing future school administrators’ perceptions of the school counselor’s role, indicated that responding to crisis and working with teachers in crisis situations were of primary importance (Fitch et al., 2001). Counselor educators can use this information in preparing school counselors to better fulfill the expectations of their positions. Since school administrators view crisis management as an essential task for counselors, “new counselors may want to receive additional training in crisis management. In addition, school counselors should be trained to educate the school administrators that crisis management is a group effort: as such, proactive planning is paramount” (Fitch et al., p. 97).

In a study by Coder, Nelson, and Aylward (1991), 63% of counselors reported that they had some special training in the area of adolescent suicide. However, results indicated that additional training on suicide was one of their top three self-reported needs for additional assistance. A similar study examining the type and extent of school counselors’ preparation for dealing with suicide found that 57% reported receiving some information on adolescent suicide in college classes, 84% indicated professional workshops and conferences as major sources of information, and 81% received the majority of their information from professional journals (King, et. al., 2000).

Furthermore, fifteen years of research on the suicide intervention skills of a crisis-line staff, alcohol and drug counselors, medical students, and counselors has yielded the following conclusions: (1) meager to nonexistent preparation in suicide assessment and intervention is provided by training programs in a variety of relevant “helping”
disciplines, and (2) competence in working with suicidal people is far from uniform among helping professionals (Neimeyer & Pfeiffer, 1994). According to King et al. (2000), “additional time in school counselor preparation programs may be needed to be spent on helping counselors develop the actual skills to identify adolescents at risk for suicide” (p.262). King et al. recommend that school counselor preparation programs increase the coverage of practical information pertaining to adolescent suicide and utilize role play scenarios to provide valuable skill-building experiences.

**Crisis Intervention Training**

Outside consultants and trained crisis workers are often brought in because school staff and members of the school community feel intimidated and ineffective at responding to youth in crisis. Inexperience and discomfort are typical of crisis intervention teams that are composed of various school personnel who have had little or no training in crisis intervention, and consultants can best serve a school and its students by teaching school-based practitioners the skills with which to manage these events, rather than directly intervening with the students themselves (Weinberg, 1993). Weinberg emphasizes that training practitioners as crisis counselors allows those most familiar with the home school, and its students, to provide leadership and support during crises. Poland and McCormick (2000) suggest, in the midst of turmoil, thorough training helps counselors respond with confidence, enables them to give their full attention to those in need of their assistance, and minimizes chaos, confusion, and conflict, allowing for more timely, efficient intervention.

Core crisis content falls into three categories that lay the foundation for objectives that demonstrate acceptable knowledge, attitudinal, and skill outcomes (Hoff & Adamowski, 1998). Hoff and Adamowski provide the following example: a student
should be able to “identify the steps of the crisis management process (knowledge),
demonstrate a nonjudgmental attitude in role play, and apply the techniques of assessing
suicide risk or victimization trauma in a real or simulated case situation (skill).” (p. 77).
The elements of core content for crisis training curriculum were derived from the
collective experience and knowledge of nationally and internationally recognized crisis
specialists, suicidologists, and crisis organizations, including the National Institute of
Mental Health (NIMH), the National Organization for Victim Assistance (NOVA), the
American Association of Suicidology (AAS), and the Life Crisis Institute (LCI).

Knowledge

The knowledge component of core crisis content is the easiest for students to
master because there are extensive resources available for self-learning, including books,
audiovisual materials, and Internet resources. Essential concepts that should be mastered
by crisis workers include the following list adapted from Hoff and Adamowski (1998,
p.79):

• Crisis theory and principles of crisis management
  o Origins and development of crisis
  o Crisis prevention (through public education and emotional first aid such as
    traumatic stress debriefing)
  o Manifestations of crisis, including effective and ineffective coping skills
  o Steps of the crisis management process: assessment, planning,
    implementation, and evaluation

• Suicidology, including principles and techniques of assessment and suicide
  prevention
• Victimology, including assessment of victimization trauma and crisis intervention with victim-survivors
• Death, dying, and grief work
• Principles of communication
• Identification and use of community resources
  o Voluntary and involuntary hospitalization criteria
• Ethical and legal issues regarding suicide, crime, and victimization
  o Principles and structures for record keeping
• Team relationships and self-care in crisis work
  o The consultation process and its application in crisis work

Familiarization with definitions, types, and characteristics of crisis should be at the core of effective crisis training strategies. Essential content that counselors should be trained on include: crisis definition and theory, types of school crises, developmental reactions to crisis and grief, warning signs and characteristics of suicide, assessment of suicidal risk, crisis intervention/grief counseling strategies, and factors that affect both the severity of the crisis experience and the resolution of crisis responses (Breland, Brody, Hunter-Ebeling, O'Shea, & Ronk, 1993; Cohen & Fish, 1993; Davis, Sandoval, & Wilson, 1993; Weinberg, 1993).

According to Cohen & Fish (1993), specific areas of knowledge related to suicide include: prevention and postvention activities, warning signs, coping techniques, crisis intervention, handling the returning suicidal student, dealing with the friends of suicide attempters or completers, the contagion hypothesis, and managing the aftermath of a teacher, famous pop-culture idol, or parent/family member suicide attempt or completion.
Breland, et al., (1993) believe that issues of denial and preventability, the emotional impact of suicide, steps to take when facing a suicidal student, how to identify and talk to a depressed or suicidal person, and postvention plans for responding to the aftermath of a suicide are also key elements. According to Davis, Sandoval, and Wilson (1993), “learning how to talk to students about suicide may reduce adult fears about such discussions, while training in listening skills and available school and community resources may allow staff to fulfill their roles more effectively” (p.265).

The SOAR program (Suicide: Options, Awareness, Relief) implemented in schools in Dallas, Texas provides intensive training for counselors, teachers, and other school professionals. Each counselor receives 6 hours of training on crisis theory, the dynamics of suicide, how to identify adolescents at risk for suicidal behavior, and the importance of active listening and empathic understanding. The program has shown increases in counselor and staff awareness and understanding of adolescent suicide (King et al., 2000).

Attitudes

Core crisis content includes the following attitudinal outcomes for training, adapted from Hoff and Adamowski (1998, p.81):

- Acceptance of and nonjudgmental response to persons different from oneself and toward controversial, emotional and/or value-laden issues (for example, not discussing the moral rightness or wrongness of suicide or abortion)
- A balanced, realistic attitude toward oneself in the provider role (for example, not expecting to “rescue” or “save” all potentially suicidal people or solve all the problems of the distressed person)
• A realistic and humane approach to death, dying, self-destructive behavior, victimization, and other human issues (for example, not implying to a rape victim that he/she is at fault for having hitchhiked)

• Coming to terms with one’s own feelings about death, dying, and the potential for violence, insofar as these feelings might deter one from helping others

• Activating with conviction one’s advocacy role in client empowerment

Helping people in distress is not a value-free endeavor, and counselors must be aware of personal attitudes and beliefs that may present barriers to impartial and compassionate crisis response. According to Hoff and Adamowski (1998), “it is important to note that rejection of problematic or challenging clients or value-laden responses to them may arise from insufficient knowledge of the dynamics and ramifications of some psychosocial and crisis situations” (p. 83). The authors recognize that some practitioner attitudes may remain fixed, but suggest that new knowledge often leads to the kind of empathy and flexibility necessary to intervene with distressed persons.

**Skills**

Knowledge of crisis concepts and nonjudgmental attitudes are insufficient, without the *ability* to systematically and effectively intervene with distressed individuals. Skilled intervention involves guiding each person toward “problem solving, empowerment, and crisis resolution consistent with the individual’s values and meaning system . . . [and helping] distressed people avoid negative crisis outcomes such as violence, alcohol and other drug abuse, or chronic emotional or mental disability” (p. 84). The skills necessary
to work effectively with people in crisis include the following list adapted from Hoff and Adamowski (1998, p. 84):

- Applying the techniques for formal crisis management—assessment, planning, implementation, and evaluation (including assessment of victimization trauma and risk of suicide or violence toward others).
- Communicating well—listening actively, questioning discretely, responding empathically, and giving appropriate information and direction
- Mobilizing community resources efficiently and effectively
  - Collaborating with mental health professionals or law enforcement, as necessary
  - Making appropriate referral for follow-up counseling or therapy
  - Implementing procedures for voluntary and involuntary hospitalization when indicated
- Implementing agency policy and keeping records accurately and efficiently
  - Ensure consistency and satisfy legal/ethical requirements
- Using the consultative process—knowing whom to call under what circumstances and then doing it
- Carrying out these crisis management steps while withholding judgment on controversial behaviors and not imposing values on the distressed person and his or her family
- Prioritizing to ensure an organized, systematic intervention process that focuses on the most critical problem first and maximizes clinical support where needed while minimizing the possibility of further escalating the problem
A knowledgeable, well-trained counselor should be able to perform the following crisis intervention tasks: receive referrals from staff, build rapport and actively intervene with the immediate emotional crisis, assess the level of risk for the student, contact parents, as appropriate, provide additional resources and referrals to community-based services, when necessary, and follow up on any action taken (Breland, Brody, Hunter-Ebeling, O'Shea, & Ronk, 1993).

Training Activities

According to Hoff and Adamowski (1998), there is a differentiation between training and teaching, and “the design of crisis training programs is a highly specialized area of practice, involving small group skills, effective communication style, and other strategies that are not easily mastered in didactic (classroom-based) instruction” (p. 99). Education and training in crisis intervention are best accomplished through the use of a variety of modalities of instruction: lecture, readings, role-plays, modeled role plays, small group exercises, audiovisual resources, Internet sites, survivor stories, simulated interviews with suicidal students, and observations of experienced trainees by their less-experienced colleagues (Hoff & Adamowski; Weinberg, 1993). Lecture is typically viewed as the method of last resort because trainees can absorb essential written content through training manuals, handouts, and recommended readings or websites. Limited training time is more effectively spent on experiential training.

Role playing crisis intervention scenarios is an essential component of a thorough training program and is emphasized as a central aspect of training by every certified crisis or distress center (Gilliland and James, 1997; Hoff & Adamowski, 1998; King et al., 2000). Role-play provides valuable opportunities to develop familiarity with various situations, practice crisis intervention skills, learn creative ways to deal with unexpected
contingencies, and evaluate the efficiency of the response. Honest, constructive feedback is crucial to the process because it provides the opportunity to examine blocks to rapport, identify overlooked elements to the interaction (such as missed suicidal clues), and allows for objective interpretation of skills. According to Gilliland and James:

A critical component of training is not just talking about problems but practicing the skills of handling them as well. Talking about a problem is fine, but attempting to handle a live situation enables the trainee to get involved in the business of calming, managing, controlling, and motivating clients. Role play gives human services workers the chance to find out what works and does not work for them in the safety of a training situation and affords their fellow students and trainees an opportunity to give them valuable feedback. (p.ix)

Hoff and Adamowski (1998) highlight the importance of helping trainees understand the structure and value of the role-play process, including the use of appropriate content and the responsibility of fellow trainees for providing useful feedback. The authors also suggest that trainers model a brief role-play, containing both strengths and weaknesses, in order to illustrate the format and provide helpful feedback for the group. In particular, Hoff and Adamowski advocate modeling a role-play requiring a lethality assessment because "trainees with little or no experience in addressing the issue of suicide find it helpful to hear an experienced person ask directly about the client's self-destructive thoughts and behaviors or emotional pain from abuse" (p. 111).

In order to determine the common limitations of helping professionals in responding to distressed and self-injurious clients, Neimeyer and Pfeiffer (1994) analyzed participants' responses to the items on the Suicide Intervention Response Inventory (SIRI). According to Neimeyer and Pfeiffer, 10-40% of the interventionists in their study committed significant errors in the treatment of potentially self-destructive clients. The goal of their study was to identify common themes underlying various frequently
occurring errors and less-than-desirable responses, in the hopes that identification of such common themes might be used to focus professional education in a way to redresses these weaknesses. Thus, categories of suboptimal responses were identified in relation to the following themes: (1) superficial reassurance; (2) avoidance of strong feelings; (3) professionalism; (4) inadequate assessment of suicidal intent; (5) failure to identify the precipitating event; (6) passivity; (7) insufficient directiveness; (8) advice giving; (9) stereotypic responses; and (10) defensiveness. Neimeyer and Pfeiffer state, “the frequency with which these errors occurred in our sample is as much an indictment of professional education...as it is a statement about the skill deficits of these generally well-intentioned helpers” (p. 218). It is believed that thorough discussion, examples, and role play of these common errors (including both desirable and undesirable responses) will provide valuable opportunities to correct deficiencies in these previously identified areas of weakness.

Although there is heightened emphasis on crisis response in the schools, education and training have not kept pace with the mounting need for the application of crisis intervention skills in the schools (Johnson, 2000; Klicker, 2000; Pitcher & Poland, 1992). As a result, many school counselors feel they have inadequate training for the crisis intervener role (Allen, Jerome, et al., 2002; Brock et al., 2001; King et al., 2000) and have need for more effective preparation in both crisis response and suicide intervention (Coder, Nelson, & Aylward, 1991; Fitch et al., 2001; King et al., 1999; King et al., 2000).

The growing need for crisis preparedness and trauma response has highlighted the need for programs designed to provide educators with specialized crisis and suicide
intervention skills. According to Hoff and Adamowski (1998) crisis intervention requires
the acquisition and application of specific knowledge, attitudes, and skills in order to
intervene effectively in acute crisis episodes. Appropriate crisis/suicide training should
include the following: (1) knowledge of the nature of crisis and crisis responses,
assumptions and logic necessary for dealing with a crisis, (2) a general model and
practical guidelines to prepare schools for crisis situations, (3) information on
implementing a crisis plan; and (4) preparation activities, including role plays and crisis
drills. Furthermore, school counselors should be knowledgeable about the nature and
extent of adolescent suicide; the warning signs and risk factors for adolescent suicide;
student-at-risk profiles, appropriate prevention, intervention, and postvention techniques;
and the available mental health resources in the community (Kalafat, 1990; King et al.,
2000; Remley & Sparkman, 1993).
CHAPTER 3
METHODOLOGY

The purpose of this experimental study was to determine the effectiveness of an experiential training module to increase the crisis intervention and suicide prevention knowledge and skill level of students in counselor preparation (counselor education) programs. The following topics are addressed in this chapter: (1) variables, (2) population, (3) sampling procedures (4) resultant sample, (5) instrumentation, (6) research procedures, (7) data analysis, and (8) methodological limitations.

Variables

The independent variable for this study was a two-hour crisis intervention training module. Data were collected for the following demographic variables: (1) gender, (2) age, (3) race/ethnicity, (4) number of semester hours completed by the end of the previous academic term, (5) academic major/program (i.e., counseling specialization) (6) previous training, preparation and/or experience for crisis intervention (counseling), and (7) relevant professional preparation activities (e.g., coursework in basic counseling skills and/or counseling theories). Data also were collected for counselor education students’ self-ratings of competence in response to the following:

1. Skill at responding to individuals in crisis.

2. Knowledge of crisis intervention and suicide prevention theory, concepts, and techniques.

3. Feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with individuals who are in crisis and/or suicidal
Population

The population for this study encompassed students enrolled in counselor preparation programs in institutions of higher education in the United States, and in particular those accredited by the Council for the Accreditation of Counseling and Related Educational programs. There are in excess of 500 (so-called) counselor preparation programs in the United States. However, according to the 2004 Directory of Accredited programs (CACREP, 2004), only 153 institutions have a counselor preparation program accredited by CACREP. The scope of accreditation and the number of accredited programs in each area are shown in Figure 3-1 (CACREP, 2004).

<table>
<thead>
<tr>
<th>Description of Entry-level Master's Degree Programs</th>
<th>Number of Programs</th>
<th>Minimum Semester Hours</th>
</tr>
</thead>
<tbody>
<tr>
<td>School Counseling</td>
<td>153</td>
<td>48</td>
</tr>
<tr>
<td>Community Counseling</td>
<td>133</td>
<td>48</td>
</tr>
<tr>
<td>Student Affairs Practice in Higher Education- College Counseling (1994 Standards)</td>
<td>33</td>
<td>48</td>
</tr>
<tr>
<td>Mental Health Counseling</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Marital, Couple, and Family Counseling/Therapy</td>
<td>26</td>
<td>60</td>
</tr>
<tr>
<td>Student Affairs Practice in Higher Education- Professional Practice (1994 Standards)</td>
<td>11</td>
<td>48</td>
</tr>
<tr>
<td>Career Counseling</td>
<td>6</td>
<td>48</td>
</tr>
<tr>
<td>College Counseling (2001 Standards)</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td>Gerontological Counseling</td>
<td>2</td>
<td>48</td>
</tr>
<tr>
<td>Student Affairs (2001 Standards)</td>
<td>1</td>
<td>48</td>
</tr>
</tbody>
</table>

Figure 3-1. 2004 Directory of Accredited Programs
School counselor preparation programs constitute the largest proportion of those programs. Created in 1981 as a corporate affiliate of the American Counseling Association (ACA), CACREP is an independent agency responsible for implementing preparation standards for the counseling profession's graduate-level degree programs (Hollis & Dodson, 2000). CACREP's mission coincides with that of the ACA, specifically, to promote the advancement of quality educational program offerings in the counseling and closely related professions. Its primary purpose is to assist institutions offering graduate-level programs in counseling and related educational fields to achieve accreditation. It does this primarily by assisting counselor preparation programs to meet its standards of preparation.

The goal application of the CACREP standards is to ensure that students obtain and achieve the knowledge and skills necessary for effective practice, develop an identity as a professional counselor, and possess at least the minimum competence for careers in counseling practice, education, and/or research. It is important to note that CACREP-accreditation is program and specialty specific as opposed to accreditation of a counseling program in general. However, consistent with the ACA's philosophical position, CACREP's first priority is the preparation of individuals as counselors and second as counseling specialists. In effect, CACREP's goal is to ensure that accredited-program graduates have at least minimal professional competence as professional counseling "generalists." To that end, CACREP-accredited programs require supervised practica and internship experiences for all students and include additional, specialized coursework necessary for practice in a variety of work settings. These preparation experiences are designed to encompass knowledge of the work setting and provide
students with hands-on learning and skills, and to have sufficient duration to ensure optimum (initial) professional development. According to the 2001 accreditation standards (CACREP, 2001), students are required to demonstrate knowledge in the following eight core areas regardless of intended counseling specialty: human growth and development, career and lifestyle development, social and cultural foundations, appraisal, helping relationships, group work, professional orientation, and research.

Sampling Procedures

CACREP-accredited programs exist in a wide variety of institutions, including so-called Research I (i.e., typically large, comprehensive institutions offering doctoral degrees in a broad array of academic disciplines), so-called Research II (i.e., relatively large and relatively comprehensive institutions, but offering a relatively limited number of doctoral programs), and so-call Regional/Comprehensive (i.e., often comprehensive in regard to academic preparation programs, but not offering doctoral programs) institutions. In order to represent the different types of institutions in which CACREP-accredited programs are found, three counselor preparation programs were identified as representative of the various types: (1) University of Florida (Research I), (2) University of Central Florida (Research II), and (3) University of North Florida (Regional/Comprehensive). Faculty members in the counselor preparation program at each of these universities were contacted to solicit assistance for conduct of the study. Specifically, they were asked to allow the researcher to conduct the training module in one or more of their classes and/or to identify other faculty members in their respective departments who would allow the training to be conducted in their classes. At least one representative from each of the institutions/programs contacted agreed to assist with implementation of the study.
Students in the classes for which faculty cooperation had been obtained were given the opportunity to participate in the training. Informed consent was obtained from all participating students in each of the classes (see Appendix A); participation was voluntary and no compensation was provided for participation.

A pretest-posttest control group design was used. Students who agreed to participate were randomly assigned to either the experimental or the control group condition. Students assigned to the experimental condition completed the assessments for the study prior to receiving the training. Students assigned to the control condition completed the same assessments after having received the training.

**Resultant Sample**

The resultant sample consisted of 69 students enrolled in a graduate-level counselor preparation program. It was anticipated that approximately 20 students would participate at each institution, with half of each group at each institution assigned to the experimental or control conditions. Participants were at various stages of completion of their degree programs and had varying levels of experience and/or training in crisis intervention. Based on demographic data from Hollis and Dodson (2000), a proportionately low male enrollment in counselor preparation programs was expected; therefore, the sample was expected to be comprised primarily of females.

**Instrumentation**

A personal data sheet (Appendix B) was distributed to gather demographic information from the participants. Two other questionnaires also were administered. Skills level was measured by the revised Suicide Intervention Response Inventory (SIRI-2) (Appendix C), which was selected based on its technical adequacy and appropriateness in relation to the objectives of the training that the participants received. Knowledge of
crisis intervention and suicide prevention theory, concepts, and application as well as self-reported feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with individuals who are in crisis and/or suicidal was measured by scores on the Crisis Intervention and Suicide Prevention Questionnaire (CISP) (Appendix D), which was modified from its original version for the purposes of this study.

**Personal Data Sheet**

A personal data sheet was distributed to all participants to gather demographic information. Participants were asked to provide their gender, age, race/ethnicity, degree track, number of semester hours completed, previous type and amount of crisis intervention experience and/or training, and relevant professional preparation activities (e.g. coursework in basic counseling skills, counseling theories) on the data sheet.

**Suicide Intervention Response Inventory-2**

Neimeyer and MacInnes developed the Suicide Intervention Response Inventory (SIRI) in 1981 in response to the widely acknowledged need to evaluate the clinical skills of counselors engaged in suicide intervention (Neimeyer & Hartley, 1986). The SIRI is a 25-item, self-report instrument that assesses competence in selecting appropriate responses to hypothetical scenarios involving potentially suicidal individuals. A factor analysis of the SIRI yielded four basic skill dimensions: (1) elaboration of the complaint, (2) exploration of suicidality, (3) involvement, and (4) reflection of negative feelings (Neimeyer & Hartley, 1986). Research by Neimeyer and Hartley (1986) suggested that this "identification of various factor scores on the SIRI could permit programs to determine whether training is satisfactorily addressing all four skill domains" and "could provide an empirical basis for improving training programs in crisis counseling" (p. 442).
Several studies support the reliability and validity of the SIRI as an effective assessment of suicide intervention skills, both in telephone counseling and in face-to-face treatment settings (Neimeyer & Pfeiffer, 1994). The SIRI is considered a relevant measure of both crisis and suicide intervention skills because suicide is defined as a specific type of crisis. Although an individual in crisis may not necessarily be suicidal, a suicidal individual is, by definition, in crisis. Furthermore, intervening in both crisis and suicide situations requires the use of many of the same skills, including establishing rapport (e.g., paraphrasing and expressing empathy), clarifying the problem, naming taboos (e.g., suicide), and assessing danger.

According to Neimeyer and Hartley (1986), "the SIRI has been incorporated into counselor education and program evaluation efforts in over 100 crisis intervention, medical, and academic settings in the United States and abroad" (p. 434). Its usefulness as a measure of crisis intervention training and competence has been demonstrated with many different types of individuals who have various levels of knowledge and skill, and engage in helper behaviors in a wide variety of settings including counselor education programs, volunteer crisis centers, and paraprofessional training programs. Various studies have established the instrument's high construct validity and internal consistency and have demonstrated the effectiveness of the SIRI in both discriminating between the skill levels of novice and advanced respondents and detecting sensitivity to improvements in counselor's skills resulting from focused training (Cotton & Range, 1992; Neimeyer & Diamond, 1983; Neimeyer & Oppenheimer, 1983; Neimeyer & Pfeiffer, 1994). A related study by Neimeyer and Oppenheimer determined that the SIRI correlated significantly \( r = .60, p < .0001 \) with the Counseling Skills Evaluation (CSE),
an established measure of therapeutic skills. However, the SIRI results were distinguishable from more generalized assessments of counseling skill, indicating that it assesses a domain-specific competency. Additional research by Inman, Bascue, Kahn, and Shaw (1984) demonstrated that abstract knowledge of the psychosocial factors associated with heightened crisis and imminent suicide risk is a separate competency area, unrelated to the specific response skills measured by the SIRI (as cited by Neimeyer & Pfeiffer, 1994).

The revised Suicide Intervention Response Inventory (SIRI-2) also was developed to combat ceiling effects by delineating more effectively the precise skill level of crisis interventionists (e.g., intermediate vs. expert). The original SIRI required respondents to choose the more empathic of two helper responses to a client’s statement. Scores range from 0 to 25, with larger scores representing greater degrees of competency. In contrast, the SIRI-2 requires respondents to assign a value (ranging from −3 to +3) to each of the two responses provided. As a result, scores represent degrees of variation from a hypothetically ideal score, and span a much larger range (Neimeyer & Pfeiffer, 1994). Larger scores represent less, not more, skill in recognizing facilitative responses to a suicidal client.

Neimeyer and Bonnelle (1997) compared the reliability and validity of the SIRI and the SIRI-2. Internal consistency of the SIRI was found to have coefficient alphas of .78 during pre-test and .85 during post-test, whereas analysis of internal consistency for the SIRI-2 yielded coefficient alphas of .90 and .93 during pre- and post-testing, respectively. Pearson correlations were computed to determine the test-retest reliability of
both instruments. A test-retest reliability coefficient of .79 (p<.001) was calculated for
the original SIRI and a coefficient of .92 (p<.001) was calculated for the SIRI-2.

Crisis Intervention and Suicide Prevention Questionnaire

The Crisis Intervention and Suicide Prevention Questionnaire (CISP) was used to
assess knowledge of crisis intervention/suicide prevention theories, concepts, and
application as well as self-reported feelings of adequacy, comfort level, and confidence in
personal ability to identify and respond to individuals who are in crisis and/or are
suicidal. The instrument is a modified form of a questionnaire developed by the Suicide
Prevention Center at the Didi Hirsh Community Mental Health Center in Culver City,
California and was distributed at the American Association of Suicidology conference in
April 2003. The training team and staff at the Alachua County Crisis Center reviewed the
modifications and provided feedback and suggestions for final revisions to the
questionnaire.

The CISP is a 21-question instrument consisting of three scales: (1) fifteen
True/False questions (TF), (2) three open-ended questions requiring participants to
generate appropriate responses identifying important factors for assessing suicide
lethality, recognizing warning signs for suicide, and naming risk factors that increase the
likelihood an individual will attempt suicide (FWR), and (3) three Likert-type questions
requiring participants to assess their feelings of comfort, preparation, and confidence in
recognizing, assessing, and intervening with suicidal individuals (CPC). Scores for the
TF scale range from 0 to 15, with higher scores indicating greater knowledge. Higher
scores on the FWR and CPC scales indicate a greater degree of knowledge of crisis
intervention/suicide prevention theories, concepts, and practices and greater feelings of
comfort, preparation, and confidence, respectively.
Research Procedures

Students were randomly assigned to either an experimental or control group condition and given a packet containing an informed consent form, a demographic data sheet, and the two assessment instruments. Completion of all forms, questionnaires, and assessments required approximately 30 minutes (15 minutes was allotted both before and after the training intervention for completing the instruments). In order to maximize use of the limited amount of time available, half of the participants completed the demographic data sheet and the CISP prior to training (instruments B & D) and completed the SIRI-2 (instrument C) after training. The other half of the participants completed the SIRI-2 prior to training and completed the demographic data sheet and the CISP after training. These assessment conditions are presented in Figure 3-2.

<table>
<thead>
<tr>
<th></th>
<th>Experimental</th>
<th>Control</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pretest</td>
<td>Instruments B &amp; D</td>
<td>Instrument C</td>
</tr>
<tr>
<td>Treatment</td>
<td><em>Training</em></td>
<td><em>Training</em></td>
</tr>
<tr>
<td>Posttest</td>
<td>Instrument C</td>
<td>Instruments B &amp; D</td>
</tr>
</tbody>
</table>

Figure 3-2. Treatment Conditions

The research design was such that the participants who served as the experimental group for the skill measure served as the control group for the knowledge measure, and *vice versa.* These procedures were a variation of a post-test only control group design. The design for the study is shown in Figure 3-3. Regardless of which group they were assigned to, all participants received the two-hour crisis intervention training.
Random Assignment to Treatment Groups | Dependent Variable/Measure | Independent Variable/Treatment | Dependent Variable/Measure
--- | --- | --- | ---
Experimental Group Condition | Two-hour crisis intervention and suicide prevention training module | Posttest | 
Control Group Condition | Posttest | Two-hour crisis intervention and suicide prevention training module | 

Figure 3-3. Research Model

Training Module

The crisis intervention training program consisted of a combination of brief lectures/discussion, role-play activities, and large-group processing. Didactic instruction focused on crisis and suicide theory, concepts, and application. The training program was based, in part, on the 40-hour training provided by the Alachua County Crisis Center (ACCC), which is certified by the American Association of Suicidology and is designed to teach crisis and suicide intervention theory and skills to laypeople from a wide variety of backgrounds and experiences. The original 40-hour training was modified and condensed to a two-hour training module based on the assumption that students enrolled in counselor preparation programs would already possess fundamental skills needed to interview clients and establish rapport with them. Also, information specific to the ACCC history, policies, procedures, clientele, and paperwork was not included in the revised training module.

The training program also relied heavily on discussion and role-plays of the ten most common errors committed by suicide interventionists (Neimeyer & Pfeiffer, 1994). In order to determine the common limitations of helping professionals in responding to distressed and self-injurious clients, Neimeyer and Pfeiffer analyzed participants’ responses to the items on the Suicide Intervention Response Inventory (SIRI). The goal of their study was to identify common themes underlying various frequently occurring
errors and suboptimal responses, in the hopes that identification of such common themes might be used to focus professional education in a way to redress these weaknesses. It was believed that thorough discussion, examples, and role play of these common errors (including both desirable and undesirable responses) would provide valuable opportunities to correct deficiencies in these previously identified areas of weakness.

The training module was developed and provided by the researcher, who had more than eight years of experience providing crisis counseling to clients and three years of experience providing training to volunteers with the ACCC. The four main topics covered were directly relevant to the provision of more efficient crisis intervention services by counselors: crisis intervention theory and practice, personalizing crisis, paraphrasing (naming intense emotions and taboo subjects), and common errors committed by suicide interventionists. The primary focus of the training module was on suicide prevention and intervention because of the widespread incidence of suicidal thoughts and behaviors in response to both situational and developmental crises. The crisis intervention skills taught focused on responding to a variety of emotional crises by utilizing advanced empathy to connect with the client's (psychological/emotional) pain, recognizing and assessing suicidal lethality, and stabilizing individuals in crisis. Participants were given the opportunity to practice skill application with a variety of role play scenarios as well as receive feedback and refine their technique.

The learning objectives of the training were to:

1. Learn basic crisis theory and concepts.
2. Learn characteristics of individuals in crisis.
3. Learn possible outcomes of crisis.
4. Learn crisis intervention techniques.
5. Learn to identify and acknowledge taboo issues.
7. Learn suicide intervention techniques.
8. Learn the ten most common errors of suicide interventionists.
9. Practice crisis and suicide intervention techniques with role-play activities.

Data Analyses

With respect to the 5 hypotheses, the following statistical analyses were used:

Hypothesis 1: The primary analysis conducted to determine if a difference existed between the groups was a 2 (Group) x 4 (Factors) Multivariate Analysis of Variance (MANOVA) utilizing the Wilks Lambda test statistic. The independent variable is training with two levels, a pre-test or a post-test condition. The dependent variables are scores on the SIRI-2 and the T/F, FWR, and CCP scales of the CISP. A criterion p-value of .05 was used to determine the overall significance of the test.

Hypotheses 1a – 1d: Provided a significant multivariate test, univariate t-tests were performed on each of the four dependent variables in order to determine where differences between the groups existed. A Bonferroni technique was applied across the four univariate t-tests utilizing a criterion p-value of .0125 for each test.

Hypothesis 2 – 5: A second area of interest in the analysis was to determine the extent to which prior experience significantly predicted the outcome on the four dependent variables. Variables presumed to be indicative of greater experience included age, number of credit hours, prior crisis intervention training, and prior crisis intervention experience.
Standard multiple regression analyses (MRAs) were used to determine the relationship between each dependent variable (SIRI-2, TF, FWR, and CCF) and the independent variables of training group, age, number of credit hours, crisis intervention training, and crisis intervention experience.

**Methodological Limitations**

Inclusion of an "additional" training experience into a counselor preparation program is difficult at best. Faculty members are reluctant to give over class time to research activities. Therefore, the training module and the assessments associated with it had to be designed to be incorporated into a single (instructional) class period. In addition, the activities in the training module may be similar to those that some students have experienced and radically different from the educational experiences of others. Therefore, the nature of the opportunities for conduct of the study influenced the design of the intervention. However, this was not a significant limitation because the activities in the training module are similar to those applied in many counselor preparation courses. In addition, the training module and its implementation are similar to many other professional development activities for professional counselors.

The administration of some of the assessments to participants before the training module is presented and to the remaining students after the training module is presented might seem to raise the prospect of several threats to the internal validity of experimental research. However, the students not taking the study's assessments prior to implementation of the training module completed questionnaires during the time when the others were completing the study's assessments, and the situation was reversed for the post-training measurements. Therefore, the extant threats to internal validity of experimental research were minimized.
Presentation of the training module by the researcher gave rise to the possibility of researcher bias. However, the researcher had a vested interest in having the training be successful, was better qualified to administer it, and had more control of learning activities than others who could have been trained to conduct it. Therefore, since the nature of the design was such that it was desirable to have all of the participants improve, the researcher was the person best suited and qualified to present the training module.
The purpose of this study was to determine the effectiveness of a crisis intervention training module for improving the crisis intervention knowledge and skill levels of school counseling students in graduate counselor education preparation programs. This experimental study examined the impact of a two-hour crisis intervention training module on the school counseling students' knowledge of crisis intervention/suicide prevention theory, concepts, and techniques as well as their skill at responding to individuals in a variety of crisis scenarios. The students' feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with individuals who are in crisis and/or suicidal, were also explored.

A pre-test-post-test control group design was used. Students who agreed to participate were randomly assigned to one of two group conditions. Data were collected from a survey that included a demographic data sheet and two instruments used to assess the effects of the study's intervention: the revised Suicide Intervention Response Inventory (SIRI-2) and the Crisis Intervention and Suicide Prevention Questionnaire (CISP). All participants completed the demographic data sheet and received the crisis intervention training. Students in the one group condition took the SIRI-2 as a pre-test and the CISP as a post-test, while students in the second group condition took the CISP as a pre-test and the SIRI-2 as a post-test.

To score the SIRI-2, absolute values between the respondents' ratings for each particular item and the mean ratings assigned by the criterion group of experts were
computed. The total score on the SIRI-2 represents the (total) discrepancy between the individual and expert consensus across all items. Thus, scores on the SIRI-2 represented degrees of variation from a hypothetically ideal score. Therefore, larger scores represented less competence in recognizing facilitative responses to a suicidal individual. In validation studies, item 14 of the original SIRI proved to be psychometrically ambiguous because of panelists' inability to distinguish clearly between the theoretically more and less facilitative responses (Neimeyer & Pfeiffer, 1994). Neimeyer and Pfeiffer recommend its exclusion from the SIRI-2, and thus item 14 was discarded from data analyses in this study.

The CISP consisted of three scales: (1) fifteen True/False questions (TF), (2) three open-ended questions requiring participants to generate appropriate responses identifying important factors for assessing suicide lethality, recognizing warning signs for suicide, and naming risk factors that increase the likelihood an individual will attempt suicide (FWR), and (3) three Likert-type questions requiring participants to assess their feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with suicidal individuals (CPC). Each scale constituted a dependent measure that was quantified by summing the responses of the items associated with each specific scale and obtaining a total score. Higher scores on the TF and FWR scales indicated a greater degree of knowledge of crisis intervention/suicide prevention theories, concepts, and practices. Higher scores on the CPC scale indicated greater feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with suicidal individuals.
An examination of the individual True/False items indicated that several questions were not providing adequate differential information between groups. Therefore, items that were correctly answered by over 90% of the sample were excluded from data analyses: question numbers 4, 6, 7, 9, 14, and 15 were disregarded.

**Descriptive Statistics**

Frequencies for demographic information, program-applicable semester hours, types of coursework, amount and type of crisis intervention training received, and the number of hours of direct crisis intervention experience are presented in Table 4-1. The sample included 69 graduate students enrolled in school counselor preparation programs at three different universities: 17 participants (25%) at the University of Florida, 25 participants (36%) at the University of North Florida, and 27 participants (39%) at the University of Central Florida. There were a total of 34 SIRI-2 Pre-test-group participants and 35 CISP Pre-test-group participants.

As expected, the proportionately low male enrollment in counselor preparation programs (Hollis & Dodson, 2000) resulted in a gender-biased sample comprised of 61 (88%) females and 8 (12%) males. The average age of participants was 28.7 years (SD = 7.5) and the average number of program-applicable semester credit hours earned at the end of the previous academic term was 26.9 (SD = 17.8). Questions regarding types of coursework taken yielded the following: 59 participants (86%) had taken a course in counseling skills, 58 (84%) had taken a course in counseling theories, and 16 (23%) had taken a course in crisis intervention.
Table 4-1. Frequencies of the Measured Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>Response</th>
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<tbody>
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<tr>
<td></td>
<td>Females</td>
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<td>Race</td>
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<td>Asian/Pacific Islander</td>
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<td>46-55 years old</td>
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<td>School</td>
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<td>24.6%</td>
</tr>
<tr>
<td></td>
<td>University of North Florida</td>
<td>25</td>
<td>36.2%</td>
</tr>
<tr>
<td></td>
<td>University of Central Florida</td>
<td>27</td>
<td>39.1</td>
</tr>
<tr>
<td>Number of program-applicable semester hours completed at the end of the previous academic term</td>
<td>0-20 hours</td>
<td>32</td>
<td>46.3%</td>
</tr>
<tr>
<td></td>
<td>20-40 hours</td>
<td>20</td>
<td>29.0%</td>
</tr>
<tr>
<td></td>
<td>40-60 hours</td>
<td>12</td>
<td>17.4%</td>
</tr>
<tr>
<td></td>
<td>60-80 hours</td>
<td>2</td>
<td>2.9%</td>
</tr>
<tr>
<td>In which of the following areas have you had formal coursework?</td>
<td>Basic Counseling Skills</td>
<td>Yes</td>
<td>59</td>
</tr>
<tr>
<td></td>
<td>Counseling Theories</td>
<td>Yes</td>
<td>58</td>
</tr>
<tr>
<td></td>
<td>Crisis Intervention</td>
<td>Yes</td>
<td>16</td>
</tr>
<tr>
<td>How many hours of “formal” (i.e., classroom or workshop) crisis training have you received?</td>
<td>None</td>
<td>35</td>
<td>50.7%</td>
</tr>
<tr>
<td></td>
<td>10 hours or less</td>
<td>26</td>
<td>37.7%</td>
</tr>
<tr>
<td></td>
<td>More than 10 hours</td>
<td>8</td>
<td>11.6%</td>
</tr>
<tr>
<td>Which of the following best describes the type of crisis intervention training you received?</td>
<td>None</td>
<td>35</td>
<td>50.7%</td>
</tr>
<tr>
<td></td>
<td>Lecture/didactic</td>
<td>16</td>
<td>23.2%</td>
</tr>
<tr>
<td></td>
<td>Experiential/role-play</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td></td>
<td>Combined lecture/experiential</td>
<td>18</td>
<td>26.1%</td>
</tr>
<tr>
<td>Which of the following best describes the context in which you received crisis training?</td>
<td>Volunteer training program</td>
<td>3</td>
<td>4.3%</td>
</tr>
<tr>
<td></td>
<td>Incorporated into another class curriculum</td>
<td>29</td>
<td>42.0%</td>
</tr>
<tr>
<td></td>
<td>Mandatory C.E. program component</td>
<td>7</td>
<td>10.1%</td>
</tr>
<tr>
<td></td>
<td>Required by practicum/internship or job</td>
<td>10</td>
<td>14.5%</td>
</tr>
<tr>
<td></td>
<td>Other</td>
<td>6</td>
<td>8.7%</td>
</tr>
<tr>
<td>How many hours of direct crisis intervention experience have you had (i.e., actively intervening)?</td>
<td>None</td>
<td>51</td>
<td>73.9%</td>
</tr>
<tr>
<td></td>
<td>20 hours or less</td>
<td>15</td>
<td>21.7%</td>
</tr>
<tr>
<td></td>
<td>More than 20 hours</td>
<td>3</td>
<td>4.3%</td>
</tr>
</tbody>
</table>
The mean number of “formal” crisis intervention training hours was 4.54 (SD = 9.0). Thirty-five participants (51%) reported having no prior training in crisis intervention. 34 participants (49%) reported having 10 hours or more of formal crisis training, and, of those who had received crisis training, 29 (42%) indicated that the topic had been incorporated into the curriculum of another course. In terms of information delivery, 16 (23%) indicated the training was lecture/didactic instruction and 18 (26%) indicated the training was a combined lecture/experiential (i.e., role-play) format. The average number of hours of direct crisis intervention experience was 5.95 (SD = 18.5). Fifty-one participants (74%) reported having no prior experience actively intervening in a crisis situation.

**Data Analyses**

**Multivariate Analyses**

The primary analysis conducted to determine the significance of differences between the groups was a 2 (Group) x 4 (Factors) Multivariate Analysis of Variance (MANOVA) utilizing the Wilks Lambda test statistic. A p-value of .05 was set as the criterion for statistical significance. Provided a significant multivariate test, univariate t-tests were performed on each of the four dependent variables to determine where significant differences between the groups existed. A Bonferroni technique was applied across the four univariate t-tests, therefore establishing a criterion p-value of .0125 for each test.

The results of the MANOVA test yielded a Wilks Lambda = .3828 [F(4, 64) = 25.8, p< .0001], which is shown in Table 4-2.
Table 4-2. Multivariate Analysis of Variance

<table>
<thead>
<tr>
<th>Effect</th>
<th>Wilks Lambda</th>
<th>Effect df</th>
<th>Error df</th>
<th>F-Value</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>.010648</td>
<td>4</td>
<td>64</td>
<td>1486.645</td>
<td>&lt; .0001</td>
</tr>
<tr>
<td>Group</td>
<td>.382788</td>
<td>4</td>
<td>64</td>
<td>25.799</td>
<td>&lt; .0001</td>
</tr>
</tbody>
</table>

Note: bold-faced type indicates difference is significant

H<sub>0</sub>: There is no difference in counselor education students’ mean scores on the Suicide Intervention Response Intervention (SIRI-2) and the Crisis Intervention and Suicide Prevention Questionnaire (CISP) based on participation in the training.

This null hypothesis was rejected because a statistically significant difference existed.

The group mean differences between each pre-test and post-test group are provided in Tables 4-3, 4-4, 4-5, and 4-6.

Table 4-3. SIRI-2 Group Means and Distributions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Valid N</th>
<th>Std. Dev.</th>
<th>-95.00%</th>
<th>+95.00%</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIRI-2 Pre-test</td>
<td>46.24706</td>
<td>34</td>
<td>13.96441</td>
<td>41.37465</td>
<td>51.11947</td>
<td>.275</td>
</tr>
<tr>
<td>SIRI-2 Post-test</td>
<td>42.76171</td>
<td>35</td>
<td>11.34063</td>
<td>38.96607</td>
<td>46.65736</td>
<td></td>
</tr>
</tbody>
</table>

Table 4-4. True/False Test Group Means and Distributions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Valid N</th>
<th>Std. Dev.</th>
<th>-95.00%</th>
<th>+95.00%</th>
<th>Cohen’s d</th>
</tr>
</thead>
<tbody>
<tr>
<td>TF Pre-test</td>
<td>5.685714</td>
<td>35</td>
<td>1.300937</td>
<td>5.238827</td>
<td>6.132602</td>
<td>1.47</td>
</tr>
<tr>
<td>TF Post-test</td>
<td>8.147059</td>
<td>34</td>
<td>9.25476</td>
<td>7.824145</td>
<td>8.469973</td>
<td></td>
</tr>
</tbody>
</table>

Key: TF is the True/False portion of the CISP
Table 4-5. FWR Group Means and Distributions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Valid N</th>
<th>Std. Dev.</th>
<th>-95.00%</th>
<th>+95.00%</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td>FWR Pre-test</td>
<td>6.714286</td>
<td>35</td>
<td>2.243572</td>
<td>5.943592</td>
<td>7.484980</td>
<td>.316</td>
</tr>
<tr>
<td>FWR Post-test</td>
<td>7.352941</td>
<td>34</td>
<td>1.756069</td>
<td>6.740220</td>
<td>7.965663</td>
<td></td>
</tr>
</tbody>
</table>

Key: FWR is the open-ended response scale on the CISP

Table 4-6. CPC Group Means and Distributions

<table>
<thead>
<tr>
<th>Variable</th>
<th>Mean</th>
<th>Valid N</th>
<th>Std. Dev.</th>
<th>-95.00%</th>
<th>+95.00%</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td>CPC Pre-test</td>
<td>7.371429</td>
<td>35</td>
<td>1.832480</td>
<td>6.741950</td>
<td>8.000907</td>
<td>.871</td>
</tr>
<tr>
<td>CPC Post-test</td>
<td>8.794118</td>
<td>34</td>
<td>1.008431</td>
<td>8.442259</td>
<td>9.145976</td>
<td></td>
</tr>
</tbody>
</table>

Key: CPC is the comfort-preparation-confidence scale on the CISP

Univariate Analyses

Given the statistically significant result of the multivariate test, each dependent variable was analyzed using a univariate t-test to determine on which of the four dependent variables the groups differed significantly. Table 4-7 shows the univariate t-test values and results for each of the four variables.

Table 4-7. Univariate t-tests on Dependent Variables

<table>
<thead>
<tr>
<th>Variable</th>
<th>df</th>
<th>t-value</th>
<th>p-value</th>
<th>Cohen's d</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIRI-2</td>
<td>67</td>
<td>-1.14</td>
<td>0.259</td>
<td>.275</td>
</tr>
<tr>
<td>TF</td>
<td>67</td>
<td>-9.03</td>
<td>&lt; .0001*</td>
<td>1.47</td>
</tr>
<tr>
<td>FWR</td>
<td>67</td>
<td>-1.31</td>
<td>0.193</td>
<td>.316</td>
</tr>
<tr>
<td>CPC</td>
<td>67</td>
<td>-3.98</td>
<td>&lt; .0002*</td>
<td>.871</td>
</tr>
</tbody>
</table>

Note: * = Difference is significant at the p < .0125 level.

H₀₁: There is no difference in counselor education students’ mean scores on the revised Suicide Intervention Response Intervention (SIRI-2) based on participation in the training.
This null hypothesis was not rejected.

\( H_{0b} \): There is no difference in counselor education students' mean scores on the True/False portion of the Crisis Intervention and Suicide Prevention Questionnaire (CISP) based on participation in the training.

This null hypothesis was rejected.

\( H_{0c} \): There is no difference in counselor education students' ability to generate appropriate responses identifying important factors for assessing suicide lethality, recognizing warning signs for suicide, and naming risk factors that increase the likelihood an individual will attempt suicide (as measured by the FWR scale of the CISP) based on participation in the training.

This null hypothesis was not rejected.

\( H_{0d} \): There is no difference in counselor education students' feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with individuals who are in crisis and/or suicidal (as measured by the CPC scale of the CISP) based on participation in the training.

This null hypothesis was rejected.

The univariate tests for each of the four dependent variables yielded no significant differences for the SIRI-2 and FWR scales, but significant differences were found for the TF scale \( [F (1, 67)= 81.58, \ p< .0001] \) and on the CPC scores \( [F (1, 67)= 15.83, \ p< .0002] \).

**Multiple Regression Analyses**

A second area of interest in the analyses was to determine the extent to which prior experience significantly predicted outcome on the four dependent variables. Variables presumed to be indicative of greater experience included age, number of semester credit
hours completed, prior crisis intervention training, and prior crisis intervention experience.

Standard multiple regression analyses (MRAs) were used to determine the relationships among each dependent variable (SIRI-2, TF, FWR, and CPC) and the predictor variables indicative of experience. For the purpose of these analyses, age and number of semester credit hours were treated as continuous variables. However, in reporting prior crisis intervention training and experience, the estimates of the number of hours engaged in each activity appeared to be poor measures. Combined with the fact that many participants had no prior crisis intervention training or experience, a seemingly more reasonable approach was to create categorical variables that were only concerned with whether a participant actually had prior crisis intervention training (Y/N) or crisis intervention experience (Y/N). Because the combination of didactic training and role play also was thought to be an important element in crisis training, those having prior training were further divided into groups having had only lecture/didactic training (Y/N) and groups having had a combined didactic/experiential (Y/N) training.

There are four assumptions made in order to use the standard MRA: (1) the scores for a subject are independent of scores for other subjects, (2) the scores on the dependent variable are normally distributed, (3) the variances of the dependent variables are equal, and (4) the relationship between the dependent variable and the independent variable is linear when all other independent variables are constant (Shavelson, 1996).

The primary purpose of the multiple regression analysis was to determine if enough information was provided from the set of independent variables \((x_1, x_2, z_1, z_2, z_3, z_4)\) to allow for the reasonable prediction of the dependent variable. A secondary purpose of the
Multiple regression analysis was to determine which of the independent variables included in the model significantly contributed to prediction of the dependent variable.

For this study, the following (standard) MRA equation was used:

\[ y = \alpha + \beta_1 x_1 + \beta_2 x_2 + \sigma_1 z_1 + \sigma_2 z_2 + \sigma_3 z_3 + \sigma_4 z_4 + \varepsilon, \]

where:

- \( y \) = dependant variable (SIRI-2, TF, FWR, CPC)
- \( \alpha \) = y-intercept
- \( \beta_1 \) = partial regression coefficient for Age
- \( x_1 = \) Age
- \( \beta_2 \) = partial regression coefficient for Credit Hours
- \( x_2 = \) Credit Hours
- \( \sigma_1 \) = partial regression coefficient for Pre-Post test
- \( z_1 = \) Pre or Post test where:
  - \( z_1 = 0 \) for SIRI-2 post-test
  - \( z_1 = 1 \) for SIRI-2 pre-test
- \( \sigma_2 \) = partial regression coefficient for Didactic Training
- \( z_2 = \) Category of Training where \( z_2 = 1 \) for Didactic Training, otherwise \( z_2 = 0 \)
- \( \sigma_3 \) = partial regression coefficient for Combined Training
- \( z_3 = \) Category of Training where \( z_3 = 1 \) for Combined Training, otherwise \( z_3 = 0 \)
- \( \sigma_4 \) = partial regression coefficient for Crisis Intervention Experience (CIE)
- \( z_4 = \) Category of Experience where \( z_4 = 1 \) for CIE, otherwise \( z_4 = 0 \)
- \( \varepsilon \) = error term

In the event of a significant full-model, a backwards step-wise regression test was to be conducted to confirm the full-model results. A backwards step-wise regression approach sequentially removes independent variables by determining which variable explained the least overall variance in the model. Independent variables were removed until the model was left with only the independent variables contributing significantly to the prediction of the dependent variable.

**Multiple regression analyses for the SIRI-2**

A summary of the regression model, including variance components accounted for in the backwards step-wise model, is provided in Table 4-8.
The MRA computed for the SIRI-2 revealed that the full model was not significant \[ F(6, 62) = .45482, \ p = .8385, R^2 = .042 \]. This result was consistent with the univariate test performed on the SIRI-2, confirming that the training did not impact the SIRI-2 scores. Further, none of the experience variables was found to explain performance on the SIRI-2 significantly. Overall, only 4.2\% of the overall variance in the SIRI-2 was explained by the variables included in the model.

As a follow-up to the primary analysis, reduced models that eliminated the training group variable were conducted separately on the SIRI-2 pre-test and SIRI-2 post-test groups. The SIRI-2 pre-test proved not to be significant \[ F(5, 28) = 1.059, \ p = .4037, R^2 = .0088 \]. The SIRI-2 post-test also proved not to be significant \[ F(5, 29) = .6287, \ p = .6792, R^2 = .0978 \]. These reduced models provided further support for the conclusion that none of the experience variables examined predicted performance on the SIRI-2 significantly. Summaries of the reduced regression models are provided in Tables 4-9 and 4-10.
Table 4-9. Reduced Model: SIRI-2 Pre-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>$B$</th>
<th>$t(28)$</th>
<th>$p$</th>
<th>Variance ($R^2$) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>33.69</td>
<td>3.333</td>
<td>.0024</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.370</td>
<td>1.180</td>
<td>0.247</td>
<td>0.0313</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>0.046</td>
<td>0.377</td>
<td>0.708</td>
<td>0.0042</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>-15.74</td>
<td>-1.924</td>
<td>0.064</td>
<td>0.0575</td>
</tr>
<tr>
<td>Combined Training</td>
<td>-7.22</td>
<td>-1.389</td>
<td>0.175</td>
<td>0.0353</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>4.82</td>
<td>0.891</td>
<td>0.380</td>
<td>0.0304</td>
</tr>
</tbody>
</table>

$N = 34; \quad R^2 = .1590; \quad F(5,28) = 1.059; \quad p = 0.4037$

Table 4-10. Reduced Model: SIRI-2 Post-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>$B$</th>
<th>$t(29)$</th>
<th>$p$</th>
<th>Variance ($R^2$) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>49.02</td>
<td>4.485</td>
<td>&lt;.0002</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.01</td>
<td>0.023</td>
<td>0.981</td>
<td>&lt; 0.0001</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>-0.20</td>
<td>-1.285</td>
<td>0.209</td>
<td>0.0559</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>0.39</td>
<td>0.071</td>
<td>0.944</td>
<td>&lt; 0.0002</td>
</tr>
<tr>
<td>Combined Training</td>
<td>6.32</td>
<td>1.025</td>
<td>0.314</td>
<td>0.0417</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.15</td>
<td>0.025</td>
<td>0.980</td>
<td>&lt; 0.0001</td>
</tr>
</tbody>
</table>

$N = 35; \quad R^2 = .0977; \quad F(5,29) = 0.6287; \quad p = .6792$

$H_{02}$: There is no significant relationship between experience factors (as measured by training group, age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the Suicide Intervention Response Intervention (SIRI-2).

This null hypothesis was not rejected.
Multiple regression analyses for the True/False test

The MRA computed for the True/False test revealed that the full model was significant \[ F(6, 62) = 15.04, p < .0001, R^2 = .5927 \]. In particular, the pre-post test group variable was found to be significant \[ t(62) = 8.67, p < .0001 \]. This result is consistent with the univariate test performed on the True/False test, confirming that the training impacted scores on the True/False test. A summary of the regression model, including variance components accounted for in the backwards step-wise model, is provided in Table 4-11.

Table 4-11. True/False Full Model

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>t(62)</th>
<th>p</th>
<th>Variance (R^2) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Interception</td>
<td>5.087</td>
<td>8.196</td>
<td>&lt;.0001</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.023</td>
<td>1.188</td>
<td>0.240</td>
<td>0.0096</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>0.001</td>
<td>0.080</td>
<td>0.937</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Pre-Post Test Group</td>
<td>2.409</td>
<td>8.680</td>
<td>&lt;.0001</td>
<td>0.5490</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>-0.625</td>
<td>-1.798</td>
<td>0.077</td>
<td>0.0197</td>
</tr>
<tr>
<td>Combined Training</td>
<td>-0.034</td>
<td>-0.010</td>
<td>0.921</td>
<td>&lt;.0001</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.393</td>
<td>1.173</td>
<td>0.245</td>
<td>0.0142</td>
</tr>
</tbody>
</table>

\[ N = 69; \quad R^2 = 0.5927; \quad F(6,62) = 15.040; \quad p = <.0001 \]

None of the experience variables were found to explain performance on the True/False test significantly. Overall, 59.27% of the total variance in the True/False test was explained by the variables included in the model. The backwards stepwise regression confirmed that the pre-post test group was the only significant predictor variable in the model; it explained 54.9% of the total variance in the True/False test scores.
As a follow-up to the primary analysis, reduced models that eliminated the training group variables were conducted separately on the True/False pre-test and True/False post-test groups. The True/False pre-test was not significant [\( F(5,29) = 2.377, p = .0634, R^2 = .2906 \)]. The True/False post-test also was not significant [\( F(5,28) = 2.5066, p = .0537, R^2 = .3092 \)]. These reduced model tests further supported the conclusion that none of the experience variables examined predicted performance on the True/False test significantly. Summaries of the reduced regression models are provided in Tables 4-12 and 4-13.

Table 4-12. Reduced Model: True/False Pre-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>( \beta )</th>
<th>t(29)</th>
<th>p</th>
<th>Variance (( R^2 )) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>3.895</td>
<td>3.042</td>
<td>0.005</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.120</td>
<td>2.969</td>
<td>0.006</td>
<td>0.2151</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>-0.026</td>
<td>-1.425</td>
<td>0.165</td>
<td>0.0429</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>-0.289</td>
<td>-0.451</td>
<td>0.655</td>
<td>0.0050</td>
</tr>
<tr>
<td>Combined Training</td>
<td>0.441</td>
<td>0.611</td>
<td>0.545</td>
<td>0.0217</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.358</td>
<td>0.528</td>
<td>0.601</td>
<td>0.0058</td>
</tr>
</tbody>
</table>

\( N = 35; \ R^2 = 0.2906; \ F(5, 29) = 2.377; \ p = 0.0634 \)

\( H_{03} \): There is no significant relationship between experience factors (as measured by training group, age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the True/False portion of the CISP.

This null hypothesis was rejected. However, none of the experiential variables were found to be significant predictors.
Table 4-13. Reduced Model: True/False Post-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>t(28)</th>
<th>p</th>
<th>Variance (R^2) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intercept</strong></td>
<td><strong>8.085</strong></td>
<td><strong>6.852</strong></td>
<td><strong>&lt; .0001</strong></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-0.053</td>
<td>-1.451</td>
<td>0.158</td>
<td>0.0803</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>0.018</td>
<td>1.254</td>
<td>0.220</td>
<td>0.0297</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>-1.099</td>
<td>-1.150</td>
<td>0.259</td>
<td>0.0384</td>
</tr>
<tr>
<td>Combined Training</td>
<td>1.250</td>
<td>2.050</td>
<td>0.048</td>
<td>0.1446</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>-0.510</td>
<td>-0.807</td>
<td>0.426</td>
<td>0.0161</td>
</tr>
</tbody>
</table>

N = 34; R^2 = 0.3092; F(5,28) = 2.507; p = 0.0537

Multiple regression analyses for the FWR

The standard MRA computed for the FWR revealed that the full model was not significant [F (6, 62) = .7016, p = .6493, R^2 = .064]. This result is consistent with the univariate tests performed on the FWR, confirming that the training did not impact scores on the FWR. A summary of the full regression model is provided in Table 4-14.

Table 4-14. FWR Full Model

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>t(62)</th>
<th>p</th>
<th>Variance (R^2) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Intercept</strong></td>
<td><strong>6.90</strong></td>
<td><strong>6.05</strong></td>
<td><strong>&lt; .0001</strong></td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-0.022</td>
<td>-0.642</td>
<td>0.523</td>
<td>0.0081</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>0.005</td>
<td>0.381</td>
<td>0.705</td>
<td>0.0021</td>
</tr>
<tr>
<td>Pre-Post Test Group</td>
<td>0.639</td>
<td>1.251</td>
<td>0.215</td>
<td>0.0251</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>0.290</td>
<td>0.454</td>
<td>0.651</td>
<td>0.0038</td>
</tr>
<tr>
<td>Combined Training</td>
<td>0.313</td>
<td>0.503</td>
<td>0.617</td>
<td>0.0023</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.588</td>
<td>0.953</td>
<td>0.344</td>
<td>0.0220</td>
</tr>
</tbody>
</table>

N = 69; R^2 = 0.0635; F(6,62) = 0.702; p = 0.6493
Further, none of the experience variables were found to explain performance on the FWR significantly. Overall, only 6.4% of the overall variance in the FWR was explained by the variables included in the model. As a follow-up to the primary analysis, reduced models that eliminated the training group variables were conducted separately on the FWR pre-test and FWR post-test groups. The FWR pre-test was not significant \( F(5,28) = .6413, p = .6700, R^2 = .099 \). The FWR post-test also was not significant \( F(5,28) = .9439, p = .4683, R^2 = .144 \). These reduced model tests further support the conclusion that none of the experience variables examined predicted performance on the FWR significantly. Summaries of the regression models are provided in Tables 4-15 and 4-16.

\( H_{44} \): There is no significant relationship between experience factors (as measured by age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the FWR scale of the CISP.

This null hypothesis was not rejected.

Table 4-15. Reduced Model: FWR Pre-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>( \beta )</th>
<th>( t(29) )</th>
<th>( p )</th>
<th>Variance ( (R^2) ) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>7.73</td>
<td>4.50</td>
<td>.0001</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-0.025</td>
<td>-0.458</td>
<td>0.650</td>
<td>0.0065</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>-0.025</td>
<td>-0.959</td>
<td>0.345</td>
<td>0.0297</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>0.772</td>
<td>0.895</td>
<td>0.377</td>
<td>0.0180</td>
</tr>
<tr>
<td>Combined Training</td>
<td>0.569</td>
<td>0.587</td>
<td>0.561</td>
<td>0.0173</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>1.160</td>
<td>1.275</td>
<td>0.212</td>
<td>0.0278</td>
</tr>
</tbody>
</table>

\( N = 35; \quad R^2 = 0.0996; \quad F(5,29) = 0.641; \quad p = 0.6700 \)
Table 4-16. Reduced Model: FWR Post-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>t(28)</th>
<th>p</th>
<th>Variance (R^2) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>5.725</td>
<td>3.455</td>
<td>0.002</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.013</td>
<td>0.248</td>
<td>0.805</td>
<td>0.0019</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>0.033</td>
<td>1.657</td>
<td>0.109</td>
<td>0.0908</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>-1.471</td>
<td>-1.096</td>
<td>0.282</td>
<td>0.0425</td>
</tr>
<tr>
<td>Combined Training</td>
<td>0.308</td>
<td>0.362</td>
<td>0.720</td>
<td>0.0070</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.236</td>
<td>0.266</td>
<td>0.792</td>
<td>0.0021</td>
</tr>
</tbody>
</table>

N = 34; \( R^2 = 0.1442; \) \( F(5,28) = 0.9438; \) \( p = 0.4683 \)

Multiple regression analyses for the CPC

The standard MRA computed for the CPC scale revealed that the full model was significant \( F(6, 62) = 8.98, p < .0001, R^2 = .4651 \). The pre-post test group variable was found to be significant \( t(62) = 3.88, p < .0003 \). A summary of the full regression model is provided in Table 4-17.

Table 4-17. CPC Full Model

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>t(62)</th>
<th>p</th>
<th>Variance (R^2) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>7.745</td>
<td>11.113</td>
<td>&lt; .0001</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-0.042</td>
<td>-1.969</td>
<td>0.053</td>
<td>0.0366</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>0.011</td>
<td>1.208</td>
<td>0.231</td>
<td>0.0150</td>
</tr>
<tr>
<td>Pre-Post Test Group</td>
<td>1.211</td>
<td>3.886</td>
<td>&lt; .0003</td>
<td>0.1162</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>0.365</td>
<td>0.937</td>
<td>0.352</td>
<td>0.0076</td>
</tr>
<tr>
<td>Combined Training</td>
<td>1.515</td>
<td>3.987</td>
<td>&lt; .0002</td>
<td>0.2509</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.641</td>
<td>1.702</td>
<td>0.094</td>
<td>0.0386</td>
</tr>
</tbody>
</table>

N = 69; \( R^2 = 0.4651; \) \( F(6,62) = 8.986; \) \( p = < .0001 \)
This result is consistent with the univariate tests performed on the CPC scale, confirming that the scores on the CPC scale were impacted by the training. The combined type (didactic/experiential) of crisis intervention training variable also was found to explain performance on the CPC scale significantly \( t (62) = 3.98, p < .0002 \). Overall, 46.51% of the total variance in the CPC scale was explained by the variables included in the model. The backwards stepwise regression confirmed that the pre-post test group and combined type of crisis intervention training were the only significant predictor variables in the model and explained 36.7% of the total variance in the CPC scale scores. The combined type of crisis intervention training variable was the strongest predictor and explained 25.1% of overall variance (pre-post group explained an additional 11.6%).

As a follow-up to the primary analysis, reduced models that eliminated the training group variables were conducted separately on the CPC pre-test and CPC post-test groups. The CPC pre-test was significant \( F (5,29) = 2.622, p = .044, R^2 = .3113 \). The combined type of crisis intervention training experience variable was found to explain performance on the CPC scale significantly \( t (29) = 3.31, p < .003 \). Overall, 31.13% of the total variance in the CPC scale was explained by the variables included in the model. The backwards stepwise regression confirmed that the combined type of crisis intervention training was the only significant predictor variable in the model, it explained 21.9% of the total variance in the CPC scale scores.

The CPC scale post-test also was significant \( F (5,28) = 6.178, p = .0006, R^2 = .5245 \). The combined type of crisis intervention training experience variable was found to explain performance on the CPC scale significantly \( t (28) = 3.61, p < .0012 \). Additionally, age was found to be significant \( t (28) = -2.99, p < .0057 \). Overall, 52.45%
of the total variance in the CPC scale was explained by the variables included in the model. Summaries of the regression models are provided in Tables 4-18 and 4-19.

Table 4-18. Reduced Model: CPC Pre-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>t(29)</th>
<th>p</th>
<th>Variance (R²) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>6.559</td>
<td>5.978</td>
<td>&lt; .0001</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>0.030</td>
<td>0.880</td>
<td>0.386</td>
<td>0.0152</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>-0.008</td>
<td>-0.481</td>
<td>0.634</td>
<td>0.0054</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>0.598</td>
<td>1.086</td>
<td>0.286</td>
<td>0.0191</td>
</tr>
<tr>
<td>Combined Training</td>
<td>2.048</td>
<td>3.310</td>
<td>0.003</td>
<td>0.2193</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.687</td>
<td>1.183</td>
<td>0.246</td>
<td>0.0521</td>
</tr>
</tbody>
</table>

N = 35; R² = 0.3113; F(5,29) = 2.622; p = .0449

Table 4-19. Reduced Model: CPC Post-test

<table>
<thead>
<tr>
<th>Independent Variable</th>
<th>B</th>
<th>t(28)</th>
<th>p</th>
<th>Variance (R²) Component</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intercept</td>
<td>9.815</td>
<td>8.986</td>
<td>&lt; .0001</td>
<td></td>
</tr>
<tr>
<td>Age</td>
<td>-0.101</td>
<td>-2.994</td>
<td>0.006</td>
<td>0.1872</td>
</tr>
<tr>
<td>Credit Hours</td>
<td>0.020</td>
<td>1.552</td>
<td>0.132</td>
<td>0.0510</td>
</tr>
<tr>
<td>Didactic Training</td>
<td>0.148</td>
<td>0.167</td>
<td>0.868</td>
<td>0.0004</td>
</tr>
<tr>
<td>Combined Training</td>
<td>2.030</td>
<td>3.613</td>
<td>0.002</td>
<td>0.2848</td>
</tr>
<tr>
<td>Crisis Intervention Experience</td>
<td>0.103</td>
<td>0.176</td>
<td>0.862</td>
<td>0.0009</td>
</tr>
</tbody>
</table>

N = 34; R² = 0.5245; F(5,28) = 6.178; p = 0.0006

The backwards stepwise regression confirmed that the combined type of crisis intervention training and age were the only significant predictor variables in the model; these explained 47.2% of the total variance in the CPC scale scores. Combined type of
crisis intervention training was the strongest predictor, accounting for 28.5% of total variance, followed by age, which accounted for 18.7% of overall variance.

$H_0$: There is no significant relationship between experience factors (as measured by age, number of credit hours, crisis intervention training, and crisis intervention experience) and performance on the CPC scale of the CISP.

This null hypothesis was rejected. Further, the post-test condition age was found to be a significant predictor of CPC responses. Discussions of the conclusions, implications, limitations, and recommendations related to the results presented in this chapter are presented in Chapter 5.
CHAPTER 5
DISCUSSION

This chapter includes a discussion of the findings for each hypothesis as well as additional conclusions and interpretations resulting from analyses of the data. The implications and limitations of the study also are presented. Recommendations for future research and a summary of the results and findings conclude the chapter.

In order to address current concerns in the literature that school counselors do not feel adequately prepared to respond to individuals in crisis, the goal of this research was to examine strategies for increasing the crisis intervention knowledge, skill, and confidence levels of school counseling students. Specifically, this study was designed to determine the impact of a two-hour crisis intervention training module on school counselor education students' knowledge of crisis intervention and suicide prevention theories and concepts and their skills for responding to individuals in a variety of crisis scenarios. The relationship between knowledge and skill levels and the students' feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with suicidal individuals also was examined.

Conclusions

The outcomes of the study were mixed in that some of the variables had a significant impact while others did not. The training module was not effective in increasing school counseling students' crisis intervention skills significantly. However, significant differences were found in students' knowledge of crisis intervention/suicide
prevention concepts and their self-reported feelings of comfort, preparation, and confidence. These conclusions are explored further in relation to each of the hypotheses.

**Hypothesis 1**

It was determined that the pre- and post-test groups’ scores on the Suicide Intervention Response Intervention (SIRI-2) and the Crisis Intervention and Suicide Prevention Questionnaire (CISP) differed based on participation in the training. As a result, each dependent variable was examined to determine on which of the four dependent variables the groups differed significantly.

In particular, participation in the training did not significantly increase competence in recognizing facilitative responses to a suicidal individual. Therefore, the training did not have a significant impact on school counseling students’ skill level. There was a significant difference in pre- and post-test scores on the TF scale. Therefore, counselor education students’ knowledge of crisis intervention/suicide prevention theories, concepts, and practices improved as a result of participating in the training.

No significant difference was found in counselor education students’ ability to identify factors for assessing suicide lethality, warning signs for suicide, and risk factors that increase the likelihood an individual will attempt suicide. Finally, participation in the training did increase students’ feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with suicidal individuals.

**Hypothesis 2**

Counselor education students’ competence in recognizing facilitative responses to a suicidal individual was not influenced by the training or participants’ age, number of semester credit hours completed, prior crisis intervention training, or prior crisis
intervention experience. Therefore, none of the experience variables was found to explain performance on the SIRI-2 significantly.

**Hypothesis 3**

The training did impact scores on the knowledge portion of the CISP. However, none of the experience variables explained performance significantly. Therefore, participation in the training significantly improved performance on the TF scale, regardless of participants' age, number of semester credit hours completed, prior crisis intervention training, or prior crisis intervention experience.

**Hypothesis 4**

None of the experience variables explained performance on the FWR. Thus, counselor education students' ability to identify factors for assessing suicide lethality, warning signs for suicide, and risk factors that increase the likelihood an individual will attempt suicide was not influenced by the training or participants' age, number of semester credit hours completed, prior crisis intervention training, or prior crisis intervention experience.

**Hypothesis 5**

Participation in the training did increase students' feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with suicidal individuals. Further, the combined (didactic/experiential) type of crisis intervention training was a significant predictor of performance, while didactic training alone had no impact. Additionally, age was found to be a significant predictor of comfort, preparation, and confidence levels in the post-test group condition.
Implications

School counselor education students' knowledge of crisis intervention theories and concepts improved significantly as a result of participation in the training. However, there was no concomitant improvement in skills. This finding is consistent with other findings in the literature that suggested knowledge of crisis intervention does not necessarily translate into intervention skill (Coder et al., 1991; King et al., 1999; King et al., 2000). Although more than half of the participants reported feeling more confident in their ability to recognize an individual at-risk for suicide, more than half also indicated that they did not feel adequately prepared to intervene with individuals in crisis, further demonstrating the discrepancy between “knowing” and “doing,” and lending support for the need for more skill-based training. Similarly, although self-perceptions of confidence, comfort level, and preparation increased, skill measures indicated that students’ ability to produce the most facilitative responses to individuals in crisis did not change significantly. Thus, increases in knowledge and self-efficacy were not translated into significant skill improvement.

Those students who had combined (didactic/experiential) crisis intervention training prior to the study indicated higher levels of comfort, preparation, and confidence. Since the combined type of crisis intervention training proved to be a significant predictor of performance on the CPC, while didactic training alone had no impact, there are implications for the inclusion of experiential/role-play activities in future training modules. This is consistent with recommendations in the literature that suggest that limited training time is spent more efficiently on experiential/role-play activities because trainees can absorb essential knowledge content in written form (such as training
manuals, handouts, and recommended readings or websites) (Gilliland and James, 1997; Hoff & Adamowski, 1998; King et al., 2000).

In regard to inclusion of specific knowledge content in future training modules, the TF scale provided valuable information concerning the knowledge that individuals already possess, regardless of whether they participated in the training. For example, the following statements were excluded from data analyses because over 90% of respondents in the overall sample were able to respond to them correctly: (1) discussing the details of a suicide plan encourages morbid thinking and implies acceptance of the choice (False); (2) most deaths by suicide cannot be prevented (False); (3) if someone tells you he/she is thinking of suicide and asks you not to tell anyone, you should not violate his/her trust by revealing the “secret” to others (False); (4) knowing someone who has committed suicide decreases the likelihood that individuals will attempt suicide themselves (False); (5) any suicidal gesture, no matter how “harmless” it seems, demands immediate attention (True); and (6) substance abuse is strongly associated with suicidal behavior in adolescents (True).

Because knowledge of these particular concepts was consistently high, suicide education efforts would be spent more effectively on topics that proved more ambiguous. For example, questions such as, “It is important to remind suicidal individuals of all the things they have to live for”; “Suicidal people are almost always ambivalent about their decision to kill themselves”; and “Offering hope, rather than solutions, is more helpful to a suicidal person,” were answered incorrectly by a substantial number of respondents. It is likely that these questions require more detailed explanation and/or discussion in order for students to understand the nuances of their practical applications, whereas the six
questions that were consistently answered correctly are more factual in nature and could be conveyed more easily in written form.

**Limitations**

There apparently was not sufficient time for demonstrating and practicing the concepts presented thoroughly. While the training was effective in increasing school counseling students' knowledge and self-efficacy, the condensed format may have been a factor in restricting opportunities for skill mastery. However, concluding that two hours is not enough time to impact skill acquisition and development may not be appropriate; the issue may be structure and time management since a significant portion of the training was devoted to lecture and discussion and role-play activities were confined to a large-group format.

The training module was specifically designed for incorporation into a single (instructional) class period because counselor education faculty members typically are reluctant to “sacrifice” class time for research activities. Thus, the training was controlled by length of time allotted as opposed to time needed for presentation of content. Some variability is inherent in the conduct of experiential training. In other words, consistency was difficult to achieve because of the flexibility necessitated by large-group role-play activities and discussion. Frequently, as questions were asked and tangential issues arose, training time was spent redirecting focus to the specific training content. Participant motivation and investment in the training was variable and may have impacted attentiveness to the training as well as thoroughness in completing the assessment instruments.

Self-reports of the number of hours of previous training and direct experience in crisis intervention are by definition subjective and may have impacted results. A related
limitation was the absence of comparative baseline data for the SIRI-2. Although results were interpreted based on pre- and post-test measures of skill, where participants scored in relation to "average" pre-test measures is unknown. If participants had higher baseline levels of skill prior to training, a ceiling effect might have skewed the data.

The use of a single trainer as opposed to a team of trainers or individuals trained to facilitate small-group activities also may have influenced the results. Role-playing crisis intervention scenarios is an essential component of a thorough training program and is emphasized as a central aspect of training by every certified crisis or distress center (Gilliland & James, 1997; Hoff & Adamowski, 1998; King et al., 2000). While the large-group role-play seemed to be productive and efficient, it may have inhibited both risk-taking and the exchange of honest, constructive feedback. Thus, time and structure restrictions may have limited opportunities to examine specific blocks to rapport and to identify subtle overtones and overlooked elements of the interaction (such as missed suicidal clues). The size of the classes, which was more suited to didactic instruction, proved to be an additional challenge to the experiential format.

**Recommendations**

Since knowledge acquisition may be accomplished through other methods (e.g., reading), it is recommended that future crisis intervention trainings focus primarily on experiential activities (with content learning as a prerequisite). Lecture is typically viewed as a limited method because trainees apparently can absorb essential written content through training manuals, handouts, and recommended readings or websites. Further, skill acquisition seems to be a more pressing need. Therefore, it is recommended that handouts/supplemental readings be used to convey relevant knowledge-based information and that the majority of available training time be allotted to
experiential/role-play activities. It is important to differentiate between training and teaching, and limited training time is more effectively spent on experiential training.

It is recommended that considerable time be dedicated to role-playing (including both desirable and undesirable responses) and subsequent discussion and processing of the ten most common errors of suicide interventionists (Neimeyer & Pfeiffer, 1994). This would maximize opportunities to correct deficiencies in previously identified areas of weakness in the treatment of potentially self-destructive clients. Participants in this study responded positively to discussion and brief role-play of the material. Therefore, more in-depth exposure would have a better impact on skill application. Although further studies should be conducted to determine whether suicide knowledge translates into significant levels of confidence and skill in identifying and intervening with students at risk for suicide, it appears that demonstrating the validity of relevant concepts experientially is more likely to influence both self-efficacy and skill acquisition and development most strongly.

It also is recommended that training be conducted with a team of trainers as opposed to a single trainer. In order to maximize the potential of role-play activities, training that utilizes a small-group format, with each trainer responsible for facilitating small group discussion and ensuring that participants get practice handling in-depth role-play scenarios, would provide a more personalized training experience. Ideally, groups of four to six people would allow each individual to practice the relevant techniques and receive appropriately specific feedback.

Because the activities in the training module are similar to those that many school counseling students experience, effort should be made to offer time-restricted training to
individuals with minimum levels of knowledge and skill (i.e., interviewing, rapport-building, and advanced empathy). Assumptions can be made about the knowledge and skill level of students who have completed graduate coursework in counseling skills and counseling theories. Therefore, it is recommended that future training target cohorts of students with at least these basic prerequisites.

**Summary**

Despite the increasing demand for school counselors to provide crisis intervention services within the school setting, education and training have not kept pace with this growing need. This discrepancy has highlighted the need for counselor preparation programs to provide school counselors with more specialized skills in crisis and suicide intervention. Further, since additional training on suicide is one of counselors’ top three self-reported needs for additional training, the preparation of school counselors for crisis intervention continues to be important.

In order to address the current concerns in the literature that school counselors are not adequately prepared to respond to individuals in crisis, this research provided a basis from which to initiate strategies for increasing the crisis intervention knowledge, skill, and confidence levels of school counselor education students. As the needs of the school community become increasingly complex, it is imperative that counselor preparation programs and school counselors find practical ways to create more effective school guidance programs and more efficient delivery of services. In an effort to produce school counselors who are competent to intervene effectively in a wide variety of crisis situations, school counselor preparation programs must increase the coverage of practical information pertaining to crisis intervention and suicide prevention by utilizing
experiential activities and role-play scenarios to provide valuable skill-building experiences.

The results of this study yield qualified support for the use of a crisis intervention training module for increasing school counseling students’ knowledge of crisis intervention/suicide prevention theories, concepts, and techniques and their feelings of comfort, preparation, and confidence in recognizing, assessing, and intervening with individuals who are in crisis and/or suicidal. However, a need still exists for more comprehensive training to increase skill at responding to individuals who are in crisis and/or suicidal.
APPENDIX A
INFORMED CONSENT
INFORMED CONSENT

Project Title: The effect of a training module on the crisis intervention knowledge and skill level of students in school counselor preparation programs

Principal Investigator: Michelle Murphy, Doctoral Candidate
Univ. of Florida, Counselor Educ. Dept.
Phone: (352) 375-4223; mmurphy@ufl.edu

Faculty Supervisor: Larry Loesch, Ph.D.
Univ. of Florida, Counselor Educ. Dept.
Phone: (352) 392-0731 ext.225; lloesch@coe.ufl.edu

Description: The purpose of this study is to examine the effects of crisis intervention training on the knowledge and skill level of graduate students enrolled in school counseling preparation programs. Volunteers will be given the opportunity to participate in a two-hour crisis intervention training, consisting of brief lectures, small group exercises, and role-plays. In addition, you will be asked to respond to the following questionnaires, which will require approximately 30 minutes: (1) a demographic data sheet requesting information such as race, gender, major/track, and previous professional preparation experiences; (2) a 25-question inventory involving the evaluation of the appropriateness of helpers’ responses to a series of excerpts from counseling sessions; and (3) a 21-question instrument designed to measure knowledge of crisis intervention/suicide prevention theories, concepts, and application. You do not have to answer any question you do not wish to answer.

This study is designed to directly benefit participants by increasing their crisis intervention knowledge and skill level. Indirectly, the study will benefit counselor educators by providing valuable information for improving the effectiveness of counselor preparation in crisis intervention/suicide prevention. This research does not involve any known risks to you as a participant. Your participation is completely voluntary and you may choose to stop or not respond at any time. You will not be asked to identify yourself by name in this study and no compensation will be awarded for your participation. Your identity will be kept confidential to the extent provided by law.

Authorization: I have read the above description. I have the right to refuse to participate and my right to withdraw from participation at any time during the study will be respected with no coercion or prejudice. My signature below indicates my agreement to participate in the study and acknowledgement that I have received a copy of this description.

If you have any questions regarding this study, please contact the Principal Investigator or Faculty Supervisor at the contact information listed above. If you have any questions or concerns about your rights as a research participant, please contact: UFIRB office, Box 112250, University of Florida, Gainesville, FL 32611-2250, phone: (352) 392-0433.

Participant’s Signature:____________________________________  Date:________________
PERSONAL DATA SHEET

The following questions are intended to gather demographic information about the students participating in this research study. You will not be asked to identify yourself by name. Your responses will be reported only in general terms as they relate to relevant variables of interest. Thank you for your participation!

1. Gender: ______ M ______ F   2. Race (check one): ______ African American
   ______ Asian/Pacific Islander
   ______ Caucasian
   ______ Hispanic
   ______ Native American
   ______ Mixed/Other

3. Age: ______

4. School: ______ University of Florida
   ______ University of North Florida
   ______ University of Central Florida

5. Counselor education degree program: ______ School Counseling
   ______ Community/Mental Health Counseling
   ______ Marriage and Family Counseling
   ______ Other

6. Number of program-applicable semester hours you had completed
   at the end of the previous academic term: ______

7. In which of the following areas have you had formal coursework? (check all that apply):
   ______ Basic Counseling Skills
   ______ Counseling Theories
   ______ Crisis Intervention

8. How many hours of “formal” (i.e., classroom or workshop) training in crisis intervention
   have you received? ______

9. Which of the following best describes the type of crisis intervention training you received? (circle one)
   None Lecture/didactic instruction Experiential/role-play Combined lecture/experiential

10. Which of the following best describes the context in which you received this training:
    ______ Volunteer training program (e.g. crisis hotline or abuse shelter)
    ______ Incorporated into another course’s curriculum
    ______ Mandatory Counselor Education program component (e.g. required workshop)
    ______ Required by practicum, internship, or employment site
    ______ Other. Please describe: _________________________________________________

11. How many hours of direct crisis intervention experience have you had (i.e., actively intervening
    in a crisis situation)? ______
Suicide Intervention Response Inventory (Form 2)

The following items represent a series of excerpts from counseling sessions. Each excerpt begins with an expression by the client concerning some aspect of the situation he or she faces, followed by two possible helper responses to the client’s remark.

You are to rate each response in terms of how appropriate or inappropriate you feel the reply is to the client’s comment. In the blank, you should record a rating from –3 to +3, corresponding to the chart below. Be sure to respond to each item and try not to leave any blanks.

+3: Highly appropriate response
+2: Appropriate response
+1: Marginally appropriate response
0: Neither appropriate nor inappropriate
-1: Marginally inappropriate response
-2: Inappropriate response
-3: Highly inappropriate response

1. Client: I decided to talk to you because I really feel like I might do something to myself… I’ve been thinking about suicide.
   _____ Helper A: You say you’re suicidal, but what is it that’s really bothering you?
   _____ Helper B: Can you tell me more about your suicidal feelings?

2. Client: And now my health is going downhill too, on top of all the rest. Without my family around to care for me anymore, it just seems like the end of the world.
   _____ Helper A: Try not to worry so much about it. Everything will be alright
   _____ Helper B: You must feel pretty lonely and afraid of what might happen

3. Client: But my thoughts have been so terrible… I could never tell them to anybody.
   _____ Helper A: You can tell me. I’m a professional and have been trained to be objective about these things.
   _____ Helper B: Some of your ideas seem so frightening to you, that you imagine other people would be shocked to know you are thinking such things.

4. Client: No one can understand the kind of pain I’ve been through. Sometimes I just feel like I have to hurt myself, so I cut my wrists.
   _____ Helper A: It seems like you’ve been suffering so much that cutting your wrists is the only way you can make the pain go away.
   _____ Helper B: But you’re so young, you have so much to live for. How can you think of killing yourself?
5. **Client:** What are you anyway? Are you a doctor? How do you know what I’ve been going through? You’ve probably always had it pretty soft.

_____ **Helper A:** So you’re wondering if I can understand how you feel.

_____ **Helper B:** You’re not even giving me a chance. I’ve had a pretty rough life, too; you’re not the only one who’s seen some hard times.

6. **Client:** My life has been worthless ever since my wife, Emma, died four years ago. The kids are grown and married now, and I’ve been retired from my job at the railroad for some time. It just seems that I’d be better off dead.

_____ **Helper A:** But try to think of what Emma would want for you. She’d want you to continue leading a productive life, wouldn’t she?

_____ **Helper B:** It sounds like everything just collapsed around you when Emma died… But what has happened recently to make things even worse, to make you think that dying is the only way out?

7. **Client:** I really need help… It’s just… [voice breaks: silence]

_____ **Helper A:** It must be hard for you to talk about what’s bothering you.

_____ **Helper B:** Go on, I’m here to listen to you talk.

8. **Client:** When you sum up my problem like that, it makes it seem less confusing and not so scary.

_____ **Helper A:** See, it really isn’t so bad after all. It certainly isn’t anything you would think of killing yourself over, is it?

_____ **Helper B:** Sometimes talking about problems does make them a bit clearer. I think you realize how dangerous your suicidal feelings were, that’s why you decided to contact me.

9. **Client:** You were supposed to help me, but you’ve only made things worse.

_____ **Helper A:** I’m sorry. I was only trying to help.

_____ **Helper B:** You sound pretty angry.

10. **Client:** How could you ever help me? Have you ever wanted to kill yourself?

_____ **Helper A:** It sounds like you’re concerned about whether I can understand and help you.

_____ **Helper B:** Sure, I’ve thought about suicide sometimes. But I always found more realistic solutions to my problems.

11. **Client:** I don’t know… this whole thing with my girlfriend really gets to me. [Sobs] I try so hard to keep from crying…

_____ **Helper A:** Do you think that the reason it’s hard for you to cry is because you’re a man?

_____ **Helper B:** With all the hurt you’re feeling, it must be impossible to hold those tears in.
12. Client: How can I believe in God anymore? No God would ever let this happen to me, I’ve never done anything to deserve what’s happened.
   _____ Helper A: Things have gotten so bad, that it’s difficult to see any meaning in the things that have happened to you.
   _____ Helper B: Well, God works in mysterious ways. Maybe this is His way of testing your faith.

13. Client: I don’t know why I’m talking to you. My family is financially well off, and my husband spends plenty of time with me, even though he has a successful law career. Even my kids have been doing well. They get good marks at school and have lots of free time activities with their friends. But nothing seems to interest me. Life is just a bore...
   _____ Helper A: Considering all you have going for you, your problems can’t be all that serious. Try to focus more on the positive aspects of your situation.
   _____ Helper B: So even though things seem to be going well at one level, life still seems pretty depressing, even if it’s hard to say exactly why.

14. Client: I have to leave now. My mother will be home soon and I don’t want her to know I’ve been talking to you.
   _____ Helper A: Okay, but if you keep feeling suicidal, remember you can always come back.
   _____ Helper B: All right, but first I want you to promise me you won’t do anything to hurt yourself, until you come and talk to me. Will you repeat that promise?

15. Client: Is it really true, that many people feel this way? I thought I was the only one who had such dreadful, sinful ideas.
   _____ Helper A: No, there are many people who suffer from mental illness. But with appropriate treatment by a qualified physician, some of these patients can be cured.
   _____ Helper B: It is true. You’re not the only one who has suicidal thoughts. And you can be helped to get through this crisis, just as others have been.

16. Client: I’m so lonely, so tired. [Crying] There just isn’t anywhere left to turn.
   _____ Helper A: You seem so alone, miserable. Have you been feeling suicidal?
   _____ Helper B: Come on now. Things can’t be all that bad.

17. Client: [Over telephone] It’s hard to talk here, with all these people.
   _____ Helper A: Would it help if I asked questions?
   _____ Helper B: Why don’t you call back some other time when you can talk more easily?

18. Client: I have a gun pointed at my head right now, and, if you don’t help me, I’m going to pull the trigger!
   _____ Helper A: You seem to be somewhat upset.
   _____ Helper B: I want you to put down the gun so we can talk.
19. Client: Why should you care about me, anyway?

Helper A: I’ve been trained to care about people. That’s my job.

Helper B: Because I think your death would be a terrible waste, and it concerns me that things are so bad that you are considering suicide. You need help to get through this critical period.

20. Client: I really hate my father! He’s never shown any love for me, just complete disregard.

Helper A: You must really be angry at him for not being there when you need him.

Helper B: You shouldn’t feel that way. After all, he is your father, and he deserves some respect.

21. Client: I don’t think there’s really anyone who cares whether I’m alive or dead.

Helper A: It sounds like you’re feeling pretty isolated.

Helper B: Why do you think that no one cares about you anymore?

22. Client: I’ve tried going to a therapist once before, but it didn’t help…Nothing I do now will change anything.

Helper A: You’ve got to look on the bright side! There must be something you can do to make things better, isn’t there?

Helper B: Okay, so you’re feeling hopeless, like even a therapist couldn’t help you. But has anyone else been helpful before- maybe a friend, relative, teacher, or clergyman?

23. Client: My psychiatrist tells me I have an anxiety neurosis. Do you think that’s what’s wrong with me?

Helper A: I’d like to know what this means to you, in this present situation. How do you feel about your problem?

Helper B: I’m not sure I agree with that diagnosis. Maybe you should seek out some psychological testing, just to be certain.

24. Client: I can’t talk to anybody about my situation. Everyone is against me.

Helper A: That isn’t true. There are probably lots of people who care about you if you’d only give them a chance.

Helper B: It must be difficult to find help when it’s so hard to trust people.

25. Client: [Voice is slurred, unclear over telephone]

Helper A: You sound so tired. Why don’t you get some sleep and call back in the morning?

Helper B: Your voice sounds so sleepy. Have you taken anything?
APPENDIX D
CRISIS INTERVENTION AND SUICIDE PREVENTION QUESTIONNAIRE
Crisis Intervention and Suicide Prevention Questionnaire

Please answer the following questions by checking the box before the letters T (for True) or F (for False) for each question.

☐ T  ☐ F  1. Most adolescent suicide attempts are precipitated by interpersonal conflicts

☐ T  ☐ F  2. People who repeatedly attempt suicide often are at low risk for suicide completion

☐ T  ☐ F  3. Feelings of hopelessness are found to be more predictive of suicide risk than a diagnosis of depression

☐ T  ☐ F  4. Discussing the details of a suicide plan encourages morbid thinking and implies acceptance of the choice

☐ T  ☐ F  5. The vast majority of individuals who are suicidal display clues and warning signs

☐ T  ☐ F  6. Most deaths by suicide cannot be prevented

☐ T  ☐ F  7. If someone tells you he/she is thinking of suicide and asks you not to tell anyone, you should not violate his/her trust by revealing the “secret” to others

☐ T  ☐ F  8. Offering hope, rather than solutions, is more helpful to a suicidal person

☐ T  ☐ F  9. Knowing someone who has committed suicide decreases the likelihood that individuals will attempt suicide themselves

☐ T  ☐ F  10. Suicidal people are almost always ambivalent about their decision to kill themselves

☐ T  ☐ F  11. When an individual is not disclosing suicidal ideation during the interview, directly asking him/her about suicidal thoughts may make things worse

☐ T  ☐ F  12. When someone repeatedly threatens suicide but does not attempt, it is likely that he/she is “only trying to get attention”

☐ T  ☐ F  13. It is important to remind suicidal individuals of all the things they have to live for

☐ T  ☐ F  14. Any suicidal gesture, no matter how “harmless” it seems, demands immediate Attention

☐ T  ☐ F  15. Substance abuse is strongly associated with suicidal behavior in adolescents
Please respond to the following short-answer questions to the best of your ability.

16. In assessing suicidal lethality, what are three important factors?

   (1) ___________________________________________________________________________

   (2) ___________________________________________________________________________

   (3) ___________________________________________________________________________

17. What are three warning signs for suicide?

   (1) ___________________________________________________________________________

   (2) ___________________________________________________________________________

   (3) ___________________________________________________________________________

18. Name three risk factors that increase the likelihood an individual will attempt suicide:

   (1) ___________________________________________________________________________

   (2) ___________________________________________________________________________

   (3) ___________________________________________________________________________

Please read each statement below and determine how accurately these statements reflect your perception of your crisis/suicide intervention skills. Circle the response that most closely applies to you.

19. I feel confident in my ability to recognize when an individual is at-risk for attempting suicide.

   Strongly Agree                      Agree                      Disagree                     Strongly Disagree

20. I feel adequately prepared to intervene with individuals in a wide variety of immediate crises.

   Strongly Agree                      Agree                      Disagree                     Strongly Disagree

21. I feel comfortable asking if an individual is feeling suicidal and assessing lethality, when appropriate.

   Strongly Agree                      Agree                      Disagree                     Strongly Disagree
CRISIS INTERVENTION AND SUICIDE PREVENTION TRAINING FOR
SCHOOL COUNSELORS

I. Overview

C. Scope of the problem

1. Everyday in America, on average, 15 children are killed by firearms, 13 are victims of homicide, and six commit suicide
   - 40 students, teachers & other personnel killed at school during the 1997-1998 school year (National School Safety Center)

2. It is estimated that 60% of adolescents engage in suicidal ideation and research now indicates that between 10% and 13% of American adolescents have made at least one suicide attempt
   - Each year 500,000 attempt & 5,000-6,000 complete suicide
   - On average, 3 students in a typical high school class will attempt suicide

3. Suicide attempts often occur in crisis situations in which isolated teens see no other option: A link has been found among the subjective experience of problem irresolvability, the sense of loss of control, and suicidal behavior

C. Types of crisis

1. Classifications of crisis
   - **Accidental situational crises** (external), which involve trauma and/or unexpected loss triggered by an unpredictable situation
   - **Maturational developmental crises** (internal), which involve physical, social, and emotional changes that occur as a result of the natural aging process

2. What are the types of crises that schools might experience? Ask participants for their ideas before discussing the following. Any not mentioned by the participants should be presented to them:
   - **Purposeful, human caused disasters**: suicide, assault, murder, rape, gang warfare, kidnapping, hostage situations
   - **Accidental disasters**: death of a student or teacher by natural causes, auto accidents, fires, chemical spills,
   - **Natural disasters**: hurricane, earthquake, flood, tornados
   - Any of these could be national, state, or community emergencies
3. The severity of a crisis is relative to the individual who is experiencing it. Some forms of crisis may not be as apparent, but are equally "real" to the individuals experiencing them. Again, ask the participants for their ideas before providing the list to them:

- divorce of parents
- moving away from friends or family
- separation from parents
- unsuccessful relationships
- lack of desired social acceptance
- academic difficulties

II. The nature of crisis

A. Definitions of crisis:

1. Chinese symbol represents danger and opportunity
2. "Balance Beam" model of pressures and assets (P=Pressure, A=Assets)

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3. A challenge that overwhelms an individual’s normal problem-solving strategies
4. "A situation or period in which things are very uncertain, difficult, or painful, especially a time when action must be taken to avoid complete disaster or breakdown."
5. The perception of an event that jeopardizes an individual’s sense of emotional balance and stability, creating psychological distress and disequilibrium

B. Personalizing crisis activity

1. We have all experienced a crisis at some time in our lives; we can use these experiences to empathize with individuals in crisis. Facilitate a discussion that has the following components: how crises occur in everyone’s life, how crisis challenges one’s coping skills and pushes one beyond his/her usual tolerance, and how there are fairly universal ideas of what helps and/or hinders one’s dealing with a crisis.
2. Ask the participants to identify a recent crisis in their lives and to take a minute to think about their feelings during that time. Make clear that the discussion is to focus on the feelings they experienced during the crisis and should not include the actual details of their particular crisis.
3. Major concepts to be discussed will include:
   - What were your feelings during the crisis? *Powerless, hopeless, isolated, desperate*
   - How did you behave during the crisis? What were your actions? How could others tell you were in crisis? *Flight or flight*
   - What did you want from others during the crisis? *Intense emotion scares us and those around us*
   - What helped and what hurt your dealing with the crisis? *Minimizing, advice-giving, judgment, impatience*

4. Emphasize the universality of the crisis response. Reinforce responses that are close to crisis intervention philosophy, while also expanding upon the differences between effective and ineffective modes of response. You should end this discussion by providing a brief summary of what works and why it works (i.e., acknowledging someone’s situation rather than minimizing it, being listened to, not being judged).

C. Characteristics of crisis
   - the presence of both danger and opportunity
   - complicated symptomatology and ineffability: *thus, the power of paraphrasing*
   - seeds of growth and change
   - the absence of panaceas or quick fixes
   - necessity of choice and action
   - time-limited acuteness: *crisis usually lasts no more than 6 weeks*
   - universality and idiosyncrasy
   - an obstruction of goals and loss of control

D. The four courses of crisis resolution
   1. Acquiring new coping skills: *Opportunity*
   2. Using existing coping skills
   3. Regressing to a “primitive” or reduced level of functioning
   4. Attempting/committing suicide: *Danger*

III. Crisis intervention in the schools
   A. Crisis interventionists in the schools have accepted the following concepts as fundamental:
      1. Crisis reactions are considered normal, not pathological.
      2. The focus of intervention is quickly returning an individual to the “pre-crisis” state and re-establishing autonomy. *Restore emotional and behavioral stability*
      3. The problem solving skills of an individual in crisis have been exhausted. For this reason, people in crisis are desperate and more likely to accept outside help.
B. Crisis intervention programs and crisis response in the schools
   1. The role of counselors in crisis intervention
      o Education and training have not kept pace with the growing need
      o less than two thirds of school counselors were aware of the warning signs of adolescent suicide and only 38% believed that they could recognize a student at risk for suicide
      o 74% of counselors have had a student attempt suicide at their school, 89% have had a student express suicidal ideation

C. Caplan’s model involves a three-part approach to crisis management
   1. Primary care, or prevention, focuses on reducing the incidence of crises.
   2. Secondary care, or intervention, involves the immediate provision of assistance to individuals experiencing a crisis.
   3. Tertiary care, or postvention, reduces the long-term effects experienced by those directly and indirectly impacted by the crisis. Chowchilla 1970’s

D. Steps in Crisis Intervention
   1. Establish rapport and maintain contact with the student.
   2. Identify and clarify the student’s central problem.
   3. Evaluate danger.
   4. Assess the student’s strengths and weaknesses.
   5. Mobilize resources

IV. Paraphrasing activity
A. Emphasize how powerful paraphrasing emotion can be to a person in crisis: lets the speaker know what the listener is hearing, encourages person to go on, helps them feel understood, communicates acceptance and concern, and helps them have a clearer understanding of what they are expressing. Then, ask participants to respond to the statements below with a paraphrase of the emotion being expressed. Suggest that they begin their statement with, “It sounds like.” or, “You feel like.” Explore layers of depth for each of the feeling words offered by the participants.
   o “I can’t talk to anybody about my situation. Everyone is against me.”
   o “I’ve tried everything. I don’t know what I should do now.”
   o “You don’t really care about me anyway.”
   o “I’ve been to a counselor before and it didn’t help. This will never work.”
   o “No matter what I do, nothing ever changes.”
   o “I have such terrible thoughts...I could never share them with anyone.”
   o “I’m so lonely, so tired. There just isn’t anywhere left to turn.”
   o “I really hate my father! He’s doesn’t really love me anyway.”
VI. Matching emotional intensity
   A. Empathy vs. Sympathy
      1. Sympathy is feeling sorry for someone and identifying a person's situation as your own. How do you feel when someone is sympathetic to you? Sympathy is a subjective judgment of a person's feelings. The use of sympathy can be demeaning, as if the other person is worse off than you are.
      2. Empathy is the ability to understand what another person is experiencing through their eyes. Empathy is the objective and insightful awareness and acknowledgement of a person's feelings, emotions, and behaviors.
   B. Well Theory
      1. A simple, graphic concept identifying why many interactions may tend to circle or not progress in any discernible fashion. The theory offers the thought that the individual in crisis, like a person in a well, feels isolated. The belief that no one is capable of experiencing his/her fears, pain, loneliness, etc., may be exacerbated when he/she speaks with someone who merely leans over the edge of the well. Being careful to separate empathy from sympathy, the model suggests that the helper must be willing to let the individual understand how "deep" he/she is in the "well". The major premise is that only by having someone willing to risk expressing the depth of feelings being experienced, will the individual in crisis feel understood and supported enough to potentially deal with those feelings and be able to move on to other feelings or actions. This theory focuses directly on using powerful feeling words in paraphrases and avoiding any phrases that diminish the intensity of feelings.
   C. Layer model of emotions (onion theory)
      1. Numerous emotions are experienced during a crisis. This model asks the helper to be aware of which emotion(s) may be most overwhelming or critical to the person in crisis at any given point. If this feeling is not identified and acknowledged, it can be predicted that the individual will be unable to deal effectively with any other feelings. The layer concept states that underlying emotions will more fully surface and be dealt with only after the surface layers of emotions are expressed and responded to.

VII. Naming taboo subjects
   A. Many crises that your students will experience will deal with topics that are not easily discussed in our culture. Such subjects, often called taboo subjects, may include abuse, incest, rape, and suicide. You may be working with students who are afraid to tell anyone what is going on in their lives, their vocabulary may not be sophisticated enough to tell you exactly what is going on, or they may be ashamed to tell you. However, people often will hint around to you about what is going on in their lives.
B. Naming taboo subjects requires you to take a risk and trust your gut. You most likely know what they are referring to, but naming that taboo can be difficult. Most often you will be right and the person you are talking to will be relieved to have the pressure taken away from them. Remind them that the worst thing that can happen is that the student will correct them... people rarely get mad when you are genuinely trying to help them.

C. This activity/discussion will follow the same format as the paraphrasing activity. The trainer will again portray a student and make statements that hint at an underlying taboo subject. Participants will practice naming a variety of taboo topics in response to each statement. It may be helpful for the trainer to respond to each paraphrase, to model how acknowledgement of the taboo subject helps to open up the student for further conversation.

- “I thought I could trust him, but something horrible happened on my date last night.” (rape)
- “My dad doesn’t treat my mom right sometimes. She wears glasses and long sleeve shorts and has to stay away from her friends for a while after it happens.” (spouse abuse)
- “My mom was so angry the other night that she punished me really hard.” (child abuse)
- “I’m concerned about being in the house alone with my uncle. Sometimes he touches me and it makes me feel uncomfortable.” (incest)
- “It scares me, when I drink with my friends I sometimes can’t remember anything that happens for the rest of the night.” (fear of alcoholism)
- “It just isn’t worth it anymore—there’s no point! I can’t go on living like this” (suicide)

VII. Suicide

A. Suicide myths

1. Suicide cannot be prevented: **Awareness & intervention are the keys to prevention**
2. Most suicides occur without warning: **Vast majority display clues**
   a. 23 gestures/ attempts for each completed suicide, 60-80% give verbal warning
3. Those who attempt suicide are fully intent on dying: **Characterized by ambivalence**
4. Those who talk about suicide do not attempt suicide: **Never commit to secrecy**
5. Openly discussing suicide causes it to happen: **Important to discuss details of plan**
6. Validating and empathizing with suicidal feelings condones suicide
7. Repeated threats/attempts are only “cries for help”: **repeated attempts increase risk**
8. Suicidal people just need solutions and/or to be reminded of all they have to live for
   a. Hopelessness is the hallmark. It is more predictive of risk than depression
   b. Offering hope, rather than solutions, is more helpful to a suicidal person
   c. Avoid instinct to offer clichés and/or false reassurance
B. Risk factors

1. Impulsivity, angry or aggressive behavior, cognitive rigidity, isolation, alienation, lack of meaningful attachments, helplessness, hopelessness, problem-solving deficits, poor coping skills, loss of identity or status, and high levels of chronic stress

2. Adolescents frequently report the following causes for suicidal behavior: relationship problems, home/family stressors, depression, social problems with peers, low self-esteem, and feelings of rejection. Most adolescent suicide attempts are precipitated by interpersonal conflicts.

3. Violence and drug abuse are common correlates of suicide. Poor impulse control is believed to be a common link. Substance abuse is strongly associated with suicidal behavior in adolescents; it is reported to be associated with two-thirds of all suicides.

4. Major life transitions and loss are key themes in the experience of a crisis and suicidality. Separation, divorce, and death have all been linked with adolescent suicide. In addition, 41% of male and 33% of female suicide victims had a close relative who had made a suicide attempt or completion. Knowing someone who has committed suicide places an individual at greater risk for a suicide attempt.

C. Warning signs

1. verbalized or written expression of death themes or intent or wish to die; dramatic changes in personality, physical appearance, or behavior (e.g., acting out, running away, major drug use, or risk-taking), making plans or final preparations; poor concentration; extreme self-criticism or verbal self-denigration; feelings of hopelessness, guilt, sadness, anxiety, anger, moodiness, or restlessness; changes in eating habits or sleep patterns; social isolation or withdrawal; academic failure; sudden elevation in mood or absence of depression; suicide-related statements; gestures, such as self-mutilation, cutting wrists or other self-destructive behaviors; a previous attempt, depression; frequent complaints about physical symptoms that are often related to emotions (e.g., stomachaches, headaches, or fatigue); and loss of interest in once-pleasurable activities or relationships

D. The following guidelines have been accepted as standard practice for assisting potentially suicidal individuals:

(1) Stay calm and listen attentively, allow the individual sufficient time to vent painful thoughts and emotions and be validated; (2) Don't ignore or minimize the warning signs; take every threat seriously; (3) Let the person know you have gotten the message, understand the gravity of the situation, and are concerned for his or her well-being; (4) Explain the short-term nature of crisis versus the irreversible nature of suicide; suicide is a permanent solution to a temporary problem; (5) Normalize the
pain and hopelessness that causes a person to consider suicide and explain the reality that many people contemplate suicide but never attempt it; (6) Discuss the suicide plan, including the timeframe, method, feasibility, and steps; and (7) Utilize available referral and treatment resources

E. Suicide prevention steps
1. Listen (identify clues which suggest suicidal ideation/intent)
2. Acknowledge suicide (paraphrase directly)
3. Lethality assessment: how, when, where, who (significant others)
4. Life pacts
5. Hope

IX. The 10 Most Common Errors of Suicide Interventionists
A. Neimeyer and Pfeiffer (1994) analyzed participants’ responses to the items on the Suicide Intervention Response Inventory (SIRI) in order to determine the common limitations of helping professionals in responding to distressed and self-injurious clients.
   o 15 years of research on the suicide intervention skills of a crisis-line staff, alcohol and drug counselors, medical students, and counselors have yielded the following conclusions: (1) meager to nonexistent preparation in suicide assessment and intervention is provided by training programs in a variety of relevant “helping” disciplines, and (2) competence in working with suicidal people is far from uniform among helping professionals.
   o The goal of their study was to identify common themes underlying various frequently occurring errors and suboptimal responses, in the hopes that identification of such common themes might be used to focus professional education in a way to redresses these weaknesses.

B. 10-40% of interventionists committed significant treatment errors in the following areas:
1. Superficial reassurance: trivial responses to clients’ expressions of acute distress and hopelessness can do more harm than good. Rather than reassuring clients, these responses risk alienating them and deepening their feelings of being isolated in their distress.
   o Attempts to emphasize more positive or optimistic aspects of the situation: “But you’re so young and have so much to live for!”
   o Premature offering of a prepackaged meaning for the client’s difficulties: “Well life works in mysterious ways. Maybe this is life’s way of challenging you.”
   o Directly contradicting the client’s protest of anguish: “Things can’t be all that bad.”
2. **Avoidance of strong feelings**: Diverting discussions away from powerful, intense emotion and toward a more abstract or intellectualized exchange. These responses keep interactions on a purely cognitive level and prevent exploration of the more profound feelings of distress, which may hold the key to successful treatment.

- Tears and sobbing are often met with silence of tangential issues instead of putting into words what the client is mutely expressing: “With all the pain you’re feeling, it must be impossible to hold those tears in.”
- “I don’t think anyone really cares whether I live or die.” Helpers often shift to discussing why/asking questions as opposed to reflecting emotional content.

3. **Professionalism**: Insulating or protecting by distancing and detaching from the brutal, exhausting realities of clients’ lives by seeking refuge in the comfortable boundaries of role definition. The exaggerated air of objectivity/disinterest implies a hierarchical relationship, which may disempower the client.

- “My thoughts are so awful I could never tell anyone” is often met with, “You can tell me. I’m a professional.” as opposed to the riskier, empathic reply.

4. **Inadequate assessment of suicidal intent**: Implicit negation of suicide threat by responding to indirect and direct expressions of risk with avoidance or reassurance rather than a prompt assessment of the level of intent, planning, and lethality.

- “There’s no where left to turn” and “I’d be better off dead” should be met with “You sound so miserable. Are you thinking of killing yourself?”

5. **Failure to identify the precipitating event**: Pinpointing the specific occurrence that prompted the client’s decision to seek help can identify and prioritize issues in a way that more quickly restores a client’s sense of balance and equilibrium and facilitates action planning. This should be an extension of basic empathic concern.

- To the life-threatening client who complains at length that “life has been worthless” since the death of his wife, the counselor might respond, “Sounds like your world fell apart when your wife died...What has happened recently to make things worse, to make you think dying is the only way out?”

6. **Passivity**: Failure to join with a client’s distress and taking a nonparticipatory role, even when the client clearly required higher levels of helper involvement.
Client stammers, voice breaks, and silence ensues: “Go on. I’m here to listen” vs. reflecting the client’s distress, “It must be very hard for you to talk about what’s bothering you.”

[Over telephone] “It’s hard to talk here, with all these people.” could be met with “Would it help if I asked questions?” or a paraphrase. “Call back some other time when you can talk more easily” could terminate the connection at a potentially dangerous moment, with no clear plan for follow-up. Try “I understand it’s really awkward for you to talk right now, but I’m really worried about you. Will you promise to call us back?” (variation on a pact when suicide is not discussed)

7. Insufficient directiveness: In dangerous, unpredictable situations, counselors must be attentive to the urgency. Emphasize the importance of continued interaction, or at a minimum, secure a verbal no-suicide contract. Effective crisis intervention often requires directive crisis management, particularly in terms of creating distance between a distressed, impulsive client and means of self-injury.

More than 1/3 responded to caller’s bid to end the call with “OK, but if you keep feeling suicidal, remember you can always call back” instead of pacting.

“I have a gun pointed to my head, and I’m going to pull the trigger if you don’t help me” was met with a weak reflection of “you seem to be somewhat upset” as opposed to securing sufficient control for continued interaction, “I want you to put down the gun so we can talk.”

8. Advice giving: Overly simplistic, rarely effective, and tends to convince the client that the counselor does not appreciate the gravity of the situation nor understand the actual or psychological constraints that prevent the client from following the advice. Action plans are worked out collaboratively, after the particulars of a client’s situation have been explored and assessed.

“Considering all you have going for you, things can’t be that bad”, “Try not to worry about it”, “Look on the bright side”, and “Try to focus on the positive aspects of your situation” are patronizing and ineffective.

“What would be one or two small steps you could take in the next few days to start to deal with this problem?” arouses less resistance and may reveal interventions not envisioned by the counselor.
9. **Stereotypic responses.** Making unwarranted assumptions about the client's personality, pathology, or predicament. Interventionists should focus on clients' individuality and unique emotional experience without trying to fit them into a typology of client problems.

   - [Male sobbing] "I try so hard to keep from crying." The response, "Do you think it's so hard for you to cry because you're a man?" is based on a stereotypic assumption and misses the opportunity for reflection of feelings.

10. **Defensiveness.** Often arises when an angry or rejecting client directly or indirectly rebuffs attempts to help. Reacting personally as opposed to therapeutically erodes whatever level of trust might be established. Join with the client's concern through empathy. The key is not to respond in an automatic, self-protective manner.

   - Responding to, "How could you ever help me? Have you ever wanted to kill yourself?" with "Sure. But I've always found healthier ways to resolve my problem" is condescending. The empathic reply is, "Sounds like you're afraid I won't be able to understand and help you."

   - Outright rejection of client's feelings. Responding to, "I can't talk to anybody. Everyone is against me." with "That isn't true. There are probably lots of people who care about you."

   - "You don't really care about me anyway." can be responded to with a genuine expression of concern, "I think your death would be a terrible waste."

**X. Conclusion**

A. Emphasize the school counselor's responsibility to provide leadership in crisis intervention/suicide prevention activities, both schoolwide and on an individual level, and the necessity of being adequately prepared to fulfill this role. Provide a brief summary of all the information discussed:

   - the nature of crisis/suicide
   - the school counselor's role is in crisis intervention
   - the personalization of crisis
   - steps in crisis intervention
   - paraphrasing
   - naming taboo subjects
   - Suicide prevention/intervention
   - Intervention errors
LIST OF REFERENCES


BIOGRAPHICAL SKETCH

Michelle Lynn Murphy was born in Washington, D.C., on March 26, 1972, the daughter of Paul and Vicki Murphy and younger sister to Paul Murphy, Jr. Michelle completed her undergraduate degree at the University of Central Florida in 1993. She earned a Bachelor of Arts degree in psychology and graduated summa cum laude. Michelle began graduate school in the Department of Counselor Education at the University of Florida in 1996 and earned her Master of Education and Specialist in Education degrees in 1998, with a dual-track specialization in both mental health counseling and school counseling and guidance. She earned her Doctor of Philosophy degree in 2004.

Michelle first became interested in the field of crisis and suicide intervention in 1996, through her involvement with the Alachua County Crisis Center. She completed the crisis and suicide intervention training program offered by the Crisis Center and, for the past eight years, has worked as a volunteer providing phone counseling, consultation, face-to-face counseling, clinical supervision, suicide prevention workshops, and training.

She is a National Board Certified Counselor, a Florida Licensed Mental Health Counselor, and a Florida Certified School Counselor as well as an active member of both the American Counseling Association and the American Association of Suicidology. Prior to beginning her doctoral studies, Michelle worked for two years as a guidance counselor at Gainesville High School, where she served as the designated crisis counselor for the school and as a member of the countywide crisis response team.
While working on her doctorate degree, she had the unique opportunity to work as an adolescent crisis counselor and mental health consultant, collaborating with various schools and youth organizations in Alachua County, to provide individual, group, and crisis counseling to self-referred students and identified at-risk youth. For the past four years, she has held a graduate assistantship in the Counselor Education Department, teaching undergraduate courses in Stress and Anxiety Management and Interpersonal Communication Skills.

Michelle continues her active involvement with the Alachua County Crisis Center and maintains a commitment to community education and outreach activities. Her goal is to continue working to increase awareness of the importance of providing efficient crisis and suicide prevention and intervention services in the schools, while continuing to emphasize the need for professional preparation programs to modify education and training activities to meet the increasing demand for these services.