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Counseling Center Clinicians Experience Providing Assessments of Risk to Self versus Risk to Others

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Abstract

As part of collecting information for the purpose of threat assessment and management regarding a person of concern within an institution of higher education, a threat assessment and management team or another institutional official may request that a campus counseling center conduct a risk assessment of dangerousness-to-others. This study measured counseling center clinicians' training and experience in conducting risk assessments of dangerousness-to-others. Survey data from mental health providers practicing in counseling centers within institutions of higher education revealed that these practitioners had significantly less training and experience in assessing dangerousness-to-others as compared to the training and experience they have in assessing dangerousness-to-self. This lack of training and experience brings into question the appropriateness of counseling center mental health providers conducting these assessments.

Keywords: Violence risk assessment, threat assessment, counseling centers

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Introduction: challenges of assessing threat to others in college contexts

Threat assessment and management teams (TAMTs) have become increasingly prevalent within institutions of higher education. It is common practice for a member of the counseling center staff to serve as a designated member of the TAMT, and this clinician may assist the team in a variety of ways. Periodically, a TAMT might seek the results of a risk assessment of dangerousness-to-others and dangerousness-to-self. This risk assessment may be sought from the campus counseling center. It can be requested for a variety of reasons, including situations in which it is known that the subject of investigation is or has been a client of the counseling center or could be mandated to be seen by the counseling center.

Although risk assessment for both dangerousness-to-self and others is part of a standard clinical intake evaluation, counseling center staff have vastly more experience with assessing dangerousness-to-self over dangerousness-to-others. Because of the prevalence of suicidal ideation and histories of suicidality among the population of students who approach counseling centers, practitioners inescapably must become quite proficient in this area. Of clients seen in counseling centers, 33.2% endorsed having "seriously considered attempting suicide" and 9.3% of all respondents endorsed having a history of at least one attempted suicide (CCMH, 2017, p. 4). Dangerousness-to-others is far less frequently encountered. Among counseling center clientele, 8.8% "considered seriously hurting another person" with 2.5% of the total respondents acknowledging that they "intentionally caused serious injury to another person" (CCMH, 2017, p. 4). Moreover, note that the latter two items do not clearly specify physical harm, while a suicide attempt is, by definition, an effort to kill oneself.

Problematic confusion of risk assessment with forensic interview

Since violence toward others can be associated with externalizing pathology, students at risk of harming others are considered less likely to voluntarily seek help from counseling centers due to their inclination to perceive their life problems as originating from the behavior of others. Nonetheless, counseling centers sometimes see students who are mandated referrals from institution officials (AUCCCD, 2014). Typically, these

students receive a clinical evaluation including a risk assessment of dangerousness-to-self and dangerousness-to-others. These risk assessments should not be confused with forensic evaluations. Additionally, it is important to emphasize that counseling center practitioners seldom possess the skills to conduct forensic evaluations (AUCCCD, 2015). In fact, forensic evaluations, if needed, are best obtained from an off-campus professional due to the administrative and legal consequences that may arise from such an evaluation (Greenberg & Shuman, 1997).

Unfortunately, a counseling center clinician may approach the risk assessment task as though they are accomplishing goals that may only be obtained at best through a forensic assessment. Forensic evaluations are not therapeutically driven, but instead attempt to establish fact in order to inform a third party in making decisions that are either legal or administrative in nature. By contrast, clinical evaluation – including the corresponding risk assessments of dangerousness-to-self and to others – is for the purpose of arriving at diagnostic conceptualization and treatment recommendations for the client. Worse yet, rather than assessing degree of risk in a clinical interview, a counseling center provider may be trying to predict the likelihood of an event, even though it has been demonstrated that accurate prediction of violence is a challenging goal even for forensically trained examiners (Campbell, French, & Gendreau, 2009).

Methodological challenges of threat assessment

How the interview is conducted may be another problematic blurring of the distinction between a risk assessment and forensic evaluation. There are significant differences between these types of assessment in terms of informed consent, confidentiality, and who is considered to be the client (the student being interviewed, or the institution the provider is seeking to protect). These and other differences between a therapeutic role and forensic evaluations have been described as irreconcilable (Greenberg & Shuman, 1997) and have been thoroughly addressed elsewhere (Citation Removed, ; Greenberg & Shuman, 1997; Knapp, Younggren, Vandecreek, Harris, & Martin, 2013).

The major difficulty a counseling center may experience in providing risk assessments of dangerousness-to-others is the experience level of the provider in conducting this specific type of risk assessment. As stated before, the prevalence of this sort of risk assessment is considerably lower than that of those associated with danger to self, especially at the extreme end of severity. Consequently, those conducting

risk assessments on dangerousness-to-others do not have the ready day-to-day familiarity with adjunctive instruments and a large comparison group for frame of reference as they do for dangerousness-to-self. For example, in working with suicidality a mental health provider may use the Beck Hopelessness Scale (BHS; Beck, 1993) as an adjunctive instrument to provide additional information about risk, having observed BHS results for various clients several times a week. This provides a solid long-range view for understanding the nuances of what any particular score means for a specific person and adds a frame of reference for interpreting results. However, if a provider seldom uses an analogous instrument for exploring dangerousness-to-others, such as the Historical, Clinical, and Risk Management Violence Risk Assessment Scheme (HCR-20; Webster, Douglas, Eaves, & Hart, 1997), the provider may lack the knowledge base of familiarity and experience with administering and interpreting the instrument that are ethically required for sound practice (Association for Assessment in Counseling & Education, 2003; American Educational Research Association, American Psychological Association, National Council on Measurement in Education, 2014). There is also the question as to whether such instruments are even appropriate for use in a collegiate environment, given the limited criminal history found within the sample.

Additionally, since students who are the subject of mandated referrals for dangerousness-to-others may not be completely forthcoming, skills and tools to identify and mitigate deception are critical. Use of such skills and instruments are a component of forensic evaluations, whereas counseling center providers likely lack any, let alone sufficient, experience with these tools. Much of the training and consideration that counseling center mental health providers have acquired in the area of dangerousness-to-others resides in the context of their fiduciary responsibility to the needs of the client in question. Specifically, as clinicians seeking to build and preserve rapport to maintain an effective therapeutic relationship, counseling center clinicians tend to have a fine-honed awareness of their state's version of the so-called Tarasoff law (duty to warn or protect) and the decision-making process involved in deciding when to invoke an exception to confidentiality (Knapp et al., 2013). Consequently, the typical provider practicing in a counseling center is not only poorly prepared to thoroughly evaluate dangerousness-to-others, but also far more equipped to be focused on the demands and boundaries of the psychotherapeutic confidentiality of the students they evaluate.

The concerns discussed thus far suggest that when a TAMT seeks a risk assessment for dangerousness-to-others from their campus counseling center, the results may be of questionable utility given the lack of training and experience possessed by counseling center mental health providers in precisely this type of risk assessment.

Present study

The present study tests the hypothesis that the majority of counseling center clinicians have less training and experience working with dangerousness-to-others compared with dangerousness-to-self. Data were collected on training in assessing and managing risk of dangerousness-to-others and dangerousness-to-others received during and after graduate school. Demographic information was collected to assess the generalizability of our findings to counseling center staff across the United States.

Methods

Participants and procedures

Participants were U.S. college counseling center clinicians whose counseling center directors were a part of the Association of University and College Counseling Center Directors (AUCCCD). Upon obtaining approval from George Mason University's Office of Research Integrity and Assurance as well as from the governance of AUCCCD, we submitted an online survey to the AUCCCD e-mail listserv asking all college counseling center directors to forward an online survey to their college counseling center clinical personnel. We received 212 total survey responses. Ninety-five responses included only demographics and the first two survey questions before the participants stopped the survey.¹ An additional 29 responders did not pass attention check items and were therefore excluded. This resulted in a final sample size of 88 participants.

1. We hypothesize that these survey responders initially thought the survey was going to be shorter than it was. Then when they saw the first two questions asking about their clinical training during graduate school practicum, they may have realized the survey was going to ask about each aspect of their clinical training separately. Because of the length of time required to respond to each aspect of their clinical training, they may have decided to stop the survey.

Measures

Participants were first asked general and clinical demographic questions. Next, participants self-reported on their clinical training experience. To increase autobiographical recall accuracy of self-reported clinical experiences, training hours and cases were anchored by three different stages: practicum, externship, and internship. A new page of the survey started for each training stage and began with "Please take a moment to reflect on your time during [insert stage of training]..." At each stage of training, participants reported their:

- (1) hours assessing dangerousness-to-others,
- (2) cases assessing dangerousness-to-others,
- (3) hours managing dangerousness-to-others,
- (4) cases managing dangerousness-to-others,
- (5) hours assessing dangerousness-to-self,
- (6) cases assessing dangerousness-to-self,
- (7) hours managing dangerousness-to-self, and
- (8) cases managing dangerousness-to-self.

Eight separate total scores were computed for each clinical experience by summing responses across the three training stages. Due to *a priori* hypotheses about the ranges of plausible values, we assumed that participants would not report more than 100 hours or 100 cases of a particular type of training during a particular stage of training. We therefore restricted participants to record a maximum value of 100. However, a small minority of participants reported these maximum numbers on the surveys, suggesting they may have received even more clinical training. To discover more about this minority, we explored the demographics of these extremely well-trained counseling center clinicians.

Licensed participants were given single-item measures of their perceived competence around dangerousness-to-others and dangerousness-to-self. One item was for assessment and one for management with each response scale ranging from 1 = "very inadequate" to 6 = "very adequate" without a midpoint. The assessment items read "How adequate are your clinical skills to assess clients' risk factors and means to commit dangerous acts to others/ self?" and the management items read "How adequate are your clinical skills to help clients cope with present and ongoing risk for dangerousness to others/self?" In addition, any training post-licensure (e.g., continued education credits) was recorded by

the number of hours; assessment and management were combined for post-licensure training. The maximum possible value participants could report here was 200.

Results

Demographics and generalizability

The sample demographics of college counseling center clinicians are reported in **Table 1**. The proportion breakdown by gender, ethnicity, degree, discipline, and licensure are reported. To determine whether our sampling method generated a representative sample, we compared our demographic proportions versus those from a nationally representative sample of college counseling center clinicians collected by the Center for

Table 1. Demographics compared to nationally representative sample.

<i>Demographic</i>	<i>Relative Frequency</i>		<i>Absolute Frequency</i>		<i>NHST</i>			
	<i>Current Sample</i>	<i>National Sample</i>	<i>Current Sample</i>	<i>National Sample</i>	χ^2	<i>p-value</i>		
Women	64.8%	67.9%	57	609	0.63	.643		
Men	35.2%	31.9%	31	286				
Non-gender binary	0.0%	0.2%	0	2				
White	80.2%	73.4%	69	651	12.62	.034		
Black	7.0%	8.7%	6	77				
Asian	1.2%	7.6%	1	67				
Latino	2.3%	6.0%	2	53				
Multiracial	5.8%	2.4%	5	21				
Other	3.5%	2.0%	3	18				
PhD	50.0%	42.1%	44	377			18.80	.002
PsyD	20.5%	13.4%	18	120				
MA	19.3%	14.1%	17	126				
MSW	4.5%	7.9%	4	71				
MD	0.0%	3.5%	0	31				
Other	5.7%	19.0%	5	170				
Counseling	39.8%	37.1%	35	329	16.84	.003		
Clinical	50.0%	33.4%	44	296				
Social Work	4.5%	8.5%	4	75				
Psychiatry	0.0%	3.9%	0	35				
Other	5.7%	17.1%	5	152				
Licensed	79.5%	71.3%	70	626	2.92	.098		
In Training	20.5%	28.7%	18	252				

The total sample size for the national sample slightly differs across demographics because the national sample had more categories than our current sample. Only categories in our current sample were compared.

Collegiate Mental Health ($N \sim 900$; Center for Collegiate Mental Health, 2015). We conducted chi-square goodness-of-fit tests to determine whether the demographic breakdown of our sample was equivalent to that of the nationally representative sample. Due to a few small expected cell counts, 10,000 non-parametric Monte Carlo draws were used to estimate empirical sampling distributions and p -values (Haberman, 1988).

The tests revealed no differences by gender or licensure, but significant differences by ethnicity, degree, and discipline (see Table 1). With regard to ethnicity, the current sample had a greater proportion of White clinicians and a smaller proportion of Black, Asian, and Latino clinicians. With regard to degree, the current sample had a greater proportion of PhD, PsyD, and Master's degrees, and a smaller proportion of all other degrees. With regard to discipline, the current sample had a greater proportion of clinical psychology clinicians, about an equal proportion of counseling psychology clinicians, and a smaller proportion of all other disciplines. A one-sample t -test revealed no differences ($t(87) = 0.49, p = .625$) by age from the current sample ($M = 42.72$) and the national sample ($M = 42.06$). Overall, the current sample is slightly less diverse than national demographics and interpretation of findings should be tailored accordingly.

Descriptive statistics

The minimum, 25th percentile, mean, median (i.e., 50th percentile), mode, 75th percentile, and maximum of each clinical experience at each training stage are reported in **Table 2**. Total scores across all training stages are also presented. These descriptive statistics were chosen instead of conventional means and standard deviations because each of the hours and cases scores was very positively skewed and contained statistical outliers. The median is arguably the best measure of central tendency for these data, as it is not as influenced by the extreme values. Every dangerousness-to-others median is lower than its associated dangerousness-to-self median. Interestingly, the mode total number of cases with assessment of dangerousness-to-others was zero while its dangerousness-to-self complement was 20. The large maximum values reflect statistical outliers. Note, the online survey was set up such that the maximum number of hours/cases a participant could report was 100; participants' true values could be larger. Due to the nonconventional distribution of scores, non-parametric rank-based hypothesis tests were used to analyze the data in the R statistical software package (R Core Team, 2017;

Table 2. Descriptive statistics of clinical experience by training stage.

Training	Danger to Others					Danger to Self								
	Min	25th	Mean	Med	Mode	75th	Max	Min	25th	Mean	Med	Mode	75th	Max
Practicum														
Assessment Hours	0	0.75	4.24	2	0	5	100	0	2	10.22	5	10	10	100
Assessment Cases	0	0	8.07	1.5	0	6.5	100	0	3	18.64	8	5	25	100
Management Hours	0	0	3.55	1	0	3	100	0	1	6.90	3	0	8	100
Management Cases	0	0	2.36	1	0	2	30	0	1	9.52	5	0	12.5	50
Externship														
Assessment Hours	0	1	8.76	1.5	1	5	100	0	2	11.28	4.5	2	10	100
Assessment Cases	0	1	14.89	2.5	1	12.5	100	0	2.75	18.67	9	0	21.25	100
Management Hours	0	0	7.64	1	0	3.5	100	0	2	9.19	3	2	5	100
Management Cases	0	0	6.33	1	1	4.25	100	0	1.75	11.44	5	0	10	100
Internship														
Assessment Hours	0	1	7.45	2	1	5	100	0	4	15.54	10	5	15.25	100
Assessment Cases	0	1	15.55	4	0	10	100	0	10	34.58	20	100	50	100
Management Hours	0	0	6.28	2	0	5	100	0	2	13.12	5	5	13.5	100
Management Cases	0	0	4.80	1.5	0	4.75	100	0	5	21.12	10	5	30	100
Total														
Assessment Hours	0	2	14.18	5	2	10	300	0	7	28.25	16	20	30	300
Assessment Cases	0	2	27.24	7	0	20.75	260	0	13.75	55.15	35	20	75.25	260
Management Hours	0	0	8.989	3	0	8	205	0	5	21.76	10	4	23.5	300
Management Cases	0	0	11.94	3	0	8	300	0	7	31.85	17.5	0	40.5	215
Post-Licensure														
CE Credit Hours	0	2	23.08	16	20	25	200	0	10	34.53	20	30	40	200
Assessment Competence	1	4	4.43	4	4	5	6	1	5	5.41	6	6	6	6
Management Competence	1	4	4.21	4	4	5	6	1	5	5.20	5	5	6	6

Due to the way the online survey was set up, the maximum possible value for all hours/cases was 100 and the maximum possible value for CE credit hours was 200. Min = minimum, Med = median, Max = maximum, CE = continued education.

Wilcox, 2012). The Benjamini–Hochberg procedure was conducted to keep the false discovery rate at 5% across the 95 hypothesis tests (Benjamini & Hochberg, 1995).

Dangerousness training differences

The differences between training in dangerousness-to-others compared with dangerousness-to-self were analyzed using Wilcoxon signed-rank tests. Difference scores were calculated by subtracting the dangerousness-to-self scores from the dangerousness-to-others scores. The difference scores were then converted to ranks based on their absolute value and the sums of the ranks for positive versus negative scores were compared. Given that the sample size was greater than 30, the normal approximation with a continuity correction was used to calculate the p -values (Hollander & Wolfe, 1973). The pseudo-median differences and associated confidence intervals were calculated according to Bauer (1972).

Table 3 reports the results for clinical experience at each training stage as well as total training. All confidence intervals included solely negative values, resulting in all but one statistically significant median difference. The results show that clinical training hours and cases for the assessment and management of dangerousness-to-others is between one-fourth to one-half that of dangerousness-to-self. Comparisons of perceived competence suggest counseling center clinicians are on average one Likert response scale lower on dangerousness-to-others than dangerousness-to-self (e.g., the difference between “somewhat adequate” and “adequate”).

Clinical demographic training differences

The differences between training in dangerousness-to-others across the various degrees and disciplines were analyzed using Kruskal–Wallis tests. As there were not any psychiatrists in the sample, that category was excluded from the analyses. The scores were converted to ranks ordered across all degree/discipline categories. Given that the sample size was greater than 30, the chi-square distribution was used to calculate the p -values (Hollander & Wolfe, 1973). Although the total number of hours managing dangerousness-to-others was initially statistically significant for both degree and discipline, it was not after applying the Benjamini–Hochberg correction.

Table 3. Training differences across types of dangerousness.

<i>Training</i>	Δ <i>Median</i>	95% CI		<i>T</i> -statistic	<i>p</i> -value
		<i>Lower</i>	<i>Upper</i>		
Practicum					
Assessment Hours	-5.0	-6.5	-3.5	26.5	< .001
Assessment Cases	-12.0	-17.5	-7.5	21.0	< .001
Management Hours	-3.5	-5.0	-3.0	121.0	< .001
Management Cases	-9.0	-12.0	-5.0	36.0	< .001
Externship					
Assessment Hours	-3.3	-5.0	-1.5	31.5	.001
Assessment Cases	-7.0	-13.0	-2.0	28.0	*.012
Management Hours	-2.0	-3.0	-1.0	53.5	.003
Management Cases	-5.5	-11.5	-2.5	18.5	.001
Internship					
Assessment Hours	-7.5	-10.0	-5.5	17.0	< .001
Assessment Cases	-19.0	-27.5	-13.5	44.5	< .001
Management Hours	-6.0	-8.0	-4.0	2.5	< .001
Management Cases	-14.0	-19.0	-10.0	23.5	< .001
Total					
Assessment Hours	-12.5	-15.5	-10.0	19.0	< .001
Assessment Cases	-30.5	-40.5	-23.0	15.5	< .001
Management Hours	-10.0	-13.5	-6.5	180.0	< .001
Management Cases	-20.0	-26.0	-14.5	198.0	< .001
Post-Licensure					
CE Credit Hours	-11.5	-20.0	-6.5	157.5	< .001
Assessment Competence	-1.5	-1.5	-1.0	47.0	< .001
Management Competence	-1.0	-1.5	-1.0	65.0	< .001

Δ median = pseudo-median difference; T-statistic = Wilcoxon signed rank test statistic; * = nonsignificant difference after applying the Benjamin–Hochberg correction.

After testing main effects, we continued to interaction effects. We tested whether clinical demographics might predict the training discrepancy between dangerousness-to-others and dangerousness-to-self. Unfortunately, there is no standard, non-parametric rank-based hypothesis test comparable to a factorial analysis of variance. Therefore, we collapsed the within-person factor of dangerousness type by using difference scores. We then conducted Kruskal–Wallis tests on the difference scores. In this context, the “main effects” of degree and discipline are interpreted as interaction effects with dangerousness type. No interaction effects were statistically significant; however, this should not be construed as evidence for the null hypothesis because of the low statistical power.

Table 4. Participants very high on dangerous-to-others training.

<i>Row</i>	<i>Gender</i>	<i>Age</i>	<i>Race</i>	<i>Degree</i>	<i>Discipline</i>	<i>Licensure</i>
1	Woman	26	Black	PsyD	Clinical	Not licensed
2	Man	61	Black	MA&MSW	Other	For 22 years

<i>Row</i>	<i>Assess. Hours</i>	<i>Manage. Hours</i>	<i>Assess. Cases</i>	<i>Manage. Cases</i>	<i>Assess. Comp.</i>	<i>Manage. Comp.</i>
1	205	205	205	205	NA	NA
2	300	300	90	90	6	6

NA = Not available; Assess. = Danger to others assessment; Manage. = Danger to others management; Comp. = Competence.

High training participants

We examined the two participants who were outliers on the four dangerousness-to-others total scores, defined as values greater than 150. Both participants were also outliers on the four dangerousness-to-self total scores.² **Table 4** presents their demographic information and total scores. Because the participant in row 1 was not licensed, perceived competence data are not available. However, the participant in row 2 reported feeling “very adequate” at assessment and management of dangerousness-to-others. The main training centers of the two participants were community mental health centers and inpatient psychiatric hospitals.

Discussion

The results confirmed the hypothesis that counseling center mental health providers generally possessed little training and experience in conducting risk assessments of dangerousness toward others. In comparing self-reported training, supervision, and experience across counseling center mental health professionals, it was found that training, supervision, and experience in dealing with dangerousness-to-others resided somewhere between one-third to half that of dangerousness-to-self. There was a small cluster of outliers with a great deal of training and experience and who also came to the counseling center setting from different backgrounds than most counseling center staff. Specifically, these highly trained and experienced providers had previously practiced in

2. There were also three participants who were outliers for only the dangerousness-to-self total scores. Because the focus of the article is on training around dangerousness-to-others, these participants are not examined in detail.

inpatient settings or community mental health centers. However, this cluster of outliers was the exception; most mental health providers who come to counseling centers via the traditional career path for that setting do not have much training or experience in risk assessments of dangerousness-to-others.

The authors recognize that a competent TAMT understands the circumscribed role that clinical risk assessments have in the threat assessment and management enterprise. However, situations in which inadequately trained and inexperienced counseling center clinicians are asked to provide these services present a sizable risk for a tragic outcome – a classic “Black Swan” event. A risk assessment that concludes with a type I error – a false negative wherein an individual is assessed as low in dangerousness-to-others but who subsequently commits an act of violence – has far-reaching ramifications, beginning with the victim(s) and their families. The clinician who provided the assessment would be devastated, as would the reputation of the counseling center. The institution could also be held liable for relying on an evaluation by an inadequately trained clinician.

Based on the results of this study, the primary recommendation for counseling center practice is to compensate for the low frequency of providing risk assessments for dangerousness-to-others with an intensive amount of training in conducting such risk assessments. This may prompt the question: Why should counseling centers invest so much time and money in such training for something that is done so infrequently? The answer to this question is the same that explains why an institution of higher education should have a TAMT and why it should be well trained. Given the situations that either a TAMT or a clinician doing a risk assessment for dangerousness-to-others are trying to understand, the consequences of a bad outcome are so devastating that the time invested in thorough training to do the task well is essential. Having highly trained clinicians conducting risk assessments for dangerousness-to-others benefits both the TAMT and the institution of higher education as a whole through effective risk management.

Limitations

A few primary limitations of the present study are worth noting. First, the current sample does not fully represent the population of interest. It is unclear if the results in the present study would generalize as well to non-White, non-clinical psychology trained counseling center clinicians.

Second, the measurement of clinical training experiences to assess and manage dangerousness-to-others was somewhat limited in the present study. Although the quantity of direct clinical experience was measured, reports about the quality of psychoeducation and supervision provided were not measured. Future studies should incorporate this additional information, potentially through interviews with counseling center clinicians. Third, as in all surveys, the accuracy of participant's self-reported clinical training is susceptible to biases in autobiographical recall. Therefore, there is likely some misestimation of hours and cases, particularly for older participants.

Disclosure No potential conflict of interest is reported by the authors.

Public significance This study measured counseling center clinicians' training and experience in conducting risk assessments of dangerousness-to-others as compared to risk-to-self. The sample practitioners had significantly less training and experience in assessing dangerousness-to-others as compared to the training and experience they have in assessing dangerousness-to-self.

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