

A MULTILEVEL EXAMINATION OF CLIENT SUICIDE IN DOCTORAL TRAINING
PROGRAMS IN PSYCHOLOGY AND ALLIED MENTAL HEALTH FIELDS

A Dissertation

Presented to

The Faculty of the Department of Psychology and Philosophy

Sam Houston State University

In Partial Fulfillment

of the Requirements for the Degree of

Doctor of Philosophy

by

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August, 2020

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DEDICATION

This dissertation is dedicated to the clients I have lost as well as the supervisors who have helped me through those losses, in particular Drs. Conroy, Elliott, Henderson, and Johnson.

ABSTRACT

Yenne, Elise M, *A multilevel examination of client suicide in doctoral training programs in psychology and allied mental health fields*. Doctor of Philosophy (Clinical Psychology), August, 2020, Sam Houston State University, Huntsville, Texas.

Client suicide is associated with a host of consequences for mental health professionals and, in particular, mental health professionals in training. The present study used samples of faculty and students in psychology and allied mental health training programs to develop a set of parallel scales for faculty and students measuring program climate related to preparing trainees for client suicide. The scales both demonstrated adequate reliability and the student scale demonstrated promising convergent and divergent validity. Non-parametric analyses suggest that the distributions of the scales are not significantly different, lending support to their parallel structure. Additionally, the present study provides an update to the literature regarding training in suicide-related matters and exposure to suicide for psychology and allied mental health students. Overall, allied mental health programs reported marginally more formalized training in suicide-related matters available, while psychology programs covered the topic more in supervision. Additionally, psychology students tended to have more exposure to suicide amongst their clients than allied mental health professionals, although this difference was not significant. Exposure to suicide was not related to negative mental health symptoms, skill in responding to suicidal statements, self-efficacy in suicide intervention, or preparedness for client suicide, but was related to self-efficacy in suicide assessment. Implications for suicide-related training are discussed.

KEY WORDS: Suicide risk assessment, Suicide intervention, Suicide postvention, Graduate training, Psychology, Allied mental health

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CHAPTER I

Literature Review

Estimates regarding the prevalence of client suicide consistently predict that between one fourth and one fifth of mental health professionals will lose a client to suicide (Castelli Dransart, Heeb, Dulfi, & Gutjahr, 2015; McAdams & Foster, 2000; Chemtob, Hamata, Bauer, Torigoe, & Kinney, 1988; Wurst, Kunz, Skipper, Wolfersdork, Beine, & Thon, 2011). However, there is more variability in the proportion of graduate students in psychology who will lose a client to suicide with estimates ranging from about 4% (Dexter-Mazza & Freeman, 2003) to 17% (Kleespies, Smith, & Becker, 1990). Experiencing this type of loss often leads to profound personal effects on clinicians including traumatic symptoms, grief, and burnout (Castelli Dransart et al., 2015; Chemtob et al., 1988; Ellis & Patel, 2012). Further, loss of a client to suicide has been associated with changes in professional practice such as increased caution when dealing with suicidal clients (Wurst et al, 2011). These effects are estimated to be exacerbated for student clinicians who may not only call into question their developing clinical skills, but also must situate the experience within a context where their clinical skills are constantly being evaluated (Gill, 2012).

Much of the literature regarding training in matters related to suicide focuses on suicide risk assessment and intervention. Despite the profound personal and professional impacts of experiencing client suicide as a graduate student, the literature surrounding best practices for training programs in mental health fields to respond to client suicide after it occurs (known as postvention), is sparse. Further, the existing literature is one-dimensional, focusing either on self-report data from students or program directors.

Thus, the current study aims to update the literature regarding training program responses to client suicide using a multi-level approach to compare reports of trainee experiences with the stated training expectations set by program training directors, faculty, and supervisors. In addition, much of the current literature is focused specifically on training at the doctoral level in psychology. The current study aims to expand the literature by including master's programs and programs in allied mental health fields.

Personal and Professional Consequences of Client Suicide

Numerous studies have sought to outline the characteristics of mental health practitioners who lose clients to suicide as well as the personal and professional impacts of these losses. The first examination of client suicide with professional psychologists found that while higher levels of training predicted fewer client suicides, years in practice had no effect on the likelihood of client suicide (Chemtob et al., 1988). In a follow up study, Chemtob et al. (1989) suggested that years of training was confounded by practice setting, with psychologists working in institutional settings such as psychiatric hospitals or psychiatric units of general hospitals being more likely than those in private practice or academia to experience client suicide. The likelihood of client suicide was also elevated for practitioners working with clients diagnosed with psychiatric disorders such as schizophrenia or affective disorders or substance abuse disorders (Chemtob et al., 1989). Regardless of amount of experience and practice setting, both studies found evidence of acute personal and professional consequences of client suicide including symptoms of posttraumatic stress such as intrusive thoughts about suicide, anger, and guilt. Additionally, common consequences included increases in vigilance toward suicide,

requests for consultation, attention to documentation, and concern with death (Chemtob et al., 1988; Chemtob et al., 1989).

Researchers have also tried to identify which clinicians may be at risk for more severe reactions to client suicide, with mixed results. Chemtob et al. (1989) identified individuals who spent greater time providing therapy services as more distressed and individuals who treated substance use disorders as less distressed by client suicide than other individuals in their sample. However, in a smaller sample of psychologists, psychiatrists, and social workers, females and trainees were at highest risk for distress (Hendin, Haas, Maltsberger, Szanto, & Rabinowicz, 2004). In this study, distress was characterized as feelings of grief, guilt, inadequacy, anxiety, and depression. Distress was also related to failure to hospitalize suicidal patients, attributing the suicide to treatment decisions made by the therapist, fear of facing a lawsuit, and experiencing negative reactions from the individual's place of employment. Relatedly, Castelli Dransart et al. (2015) found that individuals with less institutional support and those who felt emotionally close to their client faced more negative consequences than those who felt supported by their institution, had additional emotional support, and anticipated the suicide.

As alluded to above, institutional support following client suicide is crucial in recovery from client suicide. Finlayson & Simmonds (2017) investigated the institutional needs of psychologists in Australia following client suicide using a mixed methods approach. They found that approximately 61% of the 47 psychologists willing to discuss institutional culture experienced open communication and support from their institution. However, most of the remaining psychologists felt as though they were unable to discuss

the suicide at work or relied on colleagues as they did not feel safe discussing the suicide with supervisory staff. Two participants indicated they lacked support from their colleagues, while one indicated they were subjected to an investigation after the suicide, which impeded the grieving process. Finally, the four respondents in private practice described the client suicide as an “isolating experience.” When asked what they would have liked to have seen in terms of institutional responses, practitioners indicated they wanted more open communication and acknowledgement of the event from the institution, formal support provided through supervision or the opportunity to debrief, space to grieve, and a review of practices to improve suicide-related procedures (Finlayson & Simmonds, 2017).

The above research is based on information collected from professionals. Research with trainees in mental health fields suggests that the emotional experiences of trainees related to client suicide are similar, but often more intense, than for professionals (Foster & McAdams, 1999; Kleespies et al., 1990, 1999). Gill (2012) posits that one of the reasons for this intensity of reaction is that students in clinical psychology may adopt a “healer” mentality toward their profession and their experiences in graduate training become a large part of their identity. Thus, when a client dies by suicide, the healer mentality is disrupted, which consequently disrupts the student clinician’s identity. Additionally, negative reactions from peers and supervisors may serve as a barrier to adequately processing and coping with the death as these reactions may reify doubts trainees have developed regarding their clinical skills (Knox, Burkard, Jackson, Schaak, & Hess, 2006).

Suicide-Related Training

Ellis and Dickey (1998) identify two primary tasks in graduate training regarding client suicide. The first is to prevent client suicide to the best of the program's ability, and the second is to ensure the trainee's emotional and training needs are met if a suicide occurs. Consistent with the first task, researchers across the literature advocate for comprehensive and thorough graduate training in suicide risk assessment and intervention (Chemtob et al., 1989; Ellis & Dickey, 1998; Kleespies et al., 1990; Osteen, Jacobson, & Sharpe, 2014). Specifically, Chemtob et al. (1989) recommend at least one course during graduate training with content regarding how to respond to suicidal clients, but also recognize the utility of additional experiences such as workshops, focused supervision, and experiential exercises related to suicide. Beyond this, supervision and practical experiences focused on adequately responding to suicidal clients are key in developing the appropriate skills when response is necessary (Westefeld et al., 2000).

Despite these recommendations, graduate training in suicide has been found to be consistently lacking over the past several decades. Early studies reported that over half of doctoral training programs in psychology merely covered suicide as a topic in graduate coursework and lacked formal training in managing suicidal clients (Bongar & Harmatz, 1991). Importantly, the proportion of faculty members who reported losing a client to suicide was almost half of that found in other studies (9.5%), which is consistent with Chemtob et al.'s (1988) finding that psychologists in academic settings experienced a lower incidence of client suicide. Bongar and Harmatz (1991) suggest that this may reduce the perception of the need for training in suicide risk assessment in academic settings. Further, Dexter-Mazza et al. (2003) found only modest increases in training

related to suicide over a decade later as well as a movement toward keeping suicide education in the classroom as opposed to more experiential learning modalities.

Kleespies et al. (1993) found similarly low reported rates of suicide training among predoctoral interns in psychology, despite 97% reporting working with suicidal clients, 30% reporting working with clients who attempted suicide, and 11% reporting experiencing client suicide. More recently, a study of 59 clinical psychology doctoral students found that while approximately three quarters of students reported covering suicide assessment or intervention in a class, only one in five reported covering the topic in supervision (Mackelprang, Karle, Reihl, & Cash, 2014). Further, almost half of the sample reported relying on personal reading for training in suicide-related matters. Regarding topics covered in training, almost half of students reported learning about no-harm contracting, a practice that is not widely supported in clinical practice, and only 22% reported discussing postvention (Mackelprang et al., 2014). Relatedly, a study of masters students in social work found that students' knowledge related to suicide, including risk factors and available resources, was low despite a high number of students working with high-risk clients (Osteen et al., 2014).

In order to help graduate programs better track student progress related to training in suicide-related matters, Cramer, Johnson, McLaughlin, Rausch, & Conroy (2013) developed a set of core competencies for trainees working with suicidal clients. These ten competencies focus primarily on preparing students to competently recognize, assess, and manage suicidal clients and present a framework for using Objective Structured Clinical Experiences (OSCEs; scripted clinical interactions which allow clinicians to be evaluated based on responses to a hypothetical patient) as a standardized method for

assessing competency. However, this method does not address the final competency of engaging and debriefing in self-care, which is the only competency to highlight the potential emotional and professional consequences of losing a client to suicide.

Postvention

While the discussion of suicide risk assessment and intervention is crucial in training mental health professionals, there is a substantial lack of discussion of appropriate procedures related to Ellis and Dickey's (1998) second task of adequately meeting the personal and professional needs of trainees who experience client suicide. Suicide "postvention" refers to "procedures to alleviate the distress of suicidally bereaved individuals, reduce the risk of imitative suicidal behavior, and promote the healthy recovery of the affected community (p. 485)." (Westefeld et al., 2000). This definition specifically includes mental health clinicians affected by client suicide as a population who may necessitate postvention. According to Westefeld et al.'s (2000) synthesis of research regarding postvention procedures as a whole (i.e. not limited to mental health professionals), postvention must occur with speed and flexibility. In particular, they suggest planning responses to suicide in advance. Relatedly, Ellis and Dickey (1998) recommend that training programs develop a written protocol for responding to and reporting suicide risk and suicidal behavior. Such a procedure would include steps for trainees to inform supervisors and clinical directors of a suicide, filing incident reports if necessary along with programs ensuring adequate supervisory support for trainees, and debriefing procedures such as an examination of the interventions used and an analysis of the events leading up to the suicide. Despite this, Ellis & Dickey's (1998) examination of psychology internships and psychiatry residency programs, showed only 38% of

psychology internships provided training in postvention procedures and only 30% documented these procedures in a written manual.

Specific recommendations for program-wide training on client suicide before it occurs include biannual program meetings related to suicide postvention that discuss the prevalence and impact of client suicide and reviews the program policies related to postvention (Veilleux & Bilsky, 2016). Additionally, Lerner, Brooks, McNeil, Cramer, and Haller (2012) developed a curriculum for a large academic residency program which includes the aforementioned topics as well as small group discussions facilitated by clinicians who have previously lost clients to suicide, although this may not be feasible in a graduate program as there may be no facilitators available who have lost clients to suicide. Apart from better equipping student clinicians to cope with client suicide, a primary goal of these types of trainings is to foster a supportive environment for student clinicians in the event of a suicide (Spiegelman & Werth, 2005; Veilleux & Bilsky, 2016).

Veilleux and Bilsky (2016) offer a potential framework for postvention procedures in mental health training programs beginning with ensuring the student, supervisor, and clinic or program director are each informed. An initial meeting between the student, the supervisor, the training director, and an additional “observer” faculty member should then take place for the primary purpose of supporting the student. Also at this initial meeting, plans should be made to address administrative tasks (such as documentation and contact with the client’s family) and disclosure of the suicide to other students and faculty in the program. A second “critical incident review” should be held with the same participants after the student clinician feels ready to discuss the incident

more fully. This meeting should consist of a review of the case including background information about the client, the client's risk factors for suicide, the course of treatment, and potential oversights made by the clinician and the supervisor regarding the case. In particular, this meeting would serve as an opportunity to identify any training needs that should be remediated on the part of the clinician and program policies or practices that should be changed related to working with suicidal clients. Beyond these two postvention meetings, the authors suggest that program faculty and supervisors continue to monitor the student clinician's reaction, particularly if they observe changes in the way student clinicians approach their cases (Veilleux & Bilsky, 2016).

Present Study

The present study aims to update the literature regarding the prevalence of and response to client suicidal behavior in doctoral training programs in psychology and allied mental health fields. Further, existing studies examine either student perspectives or faculty perspectives regarding policies and responses to client suicide, which may limit the field's understanding. Thus, the current study will employ a multi-level approach to compare the experiences of students with the responses of directors of clinical training, clinic directors, and clinical supervisors to determine how the stated policies and practices of programs are translating into actual student experiences. Finally, the present study will explore how exposure to client suicidal behavior and client suicide relates to student clinicians' overall mental health, clinical self-efficacy regarding working with suicidal clients, and skill at responding appropriately to suicidal behavior.

Research Questions

The specific research questions that will be answered by the current study are:

1. How similar are reports between students and faculty of the availability of suicide-related training?
2. What are the types of training available related to suicide risk assessment, intervention, and postvention in mental health training programs? Do the types and amount of training differ between program types (e.g., psychology, counseling, social work, etc.)?
3. How many students and programs have experienced client suicidal behavior and/or suicide? Does exposure to client suicidal behavior or suicide differ between program types?
4. Is exposure to client suicidal behavior and/or suicide related to overall clinician mental health?
5. Is exposure to client suicidal behavior and/or suicide related to clinical self-efficacy related to dealing with suicidal clients?
6. Is exposure to suicidal behavior and/or suicide related to skill in responding to suicidal statements?

In addition to the above questions, the current study aimed to create a set of parallel scales to be used as a measure of preparedness for client suicide. The faculty version of the scale is intended for directors of clinical training, faculty, and supervisors to provide an assessment of their program's climate related training in suicide-related matters. The student version of the scale is intended for students to provide their feedback regarding their perceptions of their program's climate related to training in suicide-related matters.

CHAPTER II

Methods

Stage 1: Construction of the Preparedness for Client Suicide Scale

The Preparedness for Client Suicide Scales (PFCSS) is an author-generated set of measures intended to assess program climate related to readiness for client suicide. Specifically, the measures included one scale for design for faculty to assess the state of training in their program and a parallel scale designed for students to assess the state of training they received. Prior to piloting the measures, a Delphi study (Hsu & Sandford, 2007) was completed in order to ensure the validity of the item content. First, a list of items related to training in preparing for client suicide was generated by the author. The wording of these items was then changed to create a scale for faculty/ supervisor respondents and a scale for student respondents. The proposed items were then sent via the American Association of Suicidology's listserv for feedback from mental health professionals who provide supervision to students related to suicide risk assessment, intervention, and postvention. Additionally, the authors of papers published in peer-reviewed journals related to client suicide for trainees were directly contacted via email. Participants were asked to provide feedback on each individual item of the measures and were given the opportunity to provide holistic feedback about the scales. Five participants responded to the first round of the study and agreed to be contacted again for the second round. Of these, two participants were faculty members at universities who provided direct supervision to doctoral students in clinical psychology, one participant was the director of a university counseling center, and two participants were research

scientists affiliated with universities whose areas of expertise included training mental health professionals in matters related to suicide.

Once responses from the first round of data collection were compiled and the suggested changes were made to the items, the revised scale was sent to participants again. One of the original participants responded (a research scientist) and indicated they did not have any additional feedback related to the revised items. Thus, the scale was deemed fit to be included in data collection for the second stage of the study.

Stage 2: Student and Faculty Questionnaires

Participants. Data was collected using the web-based survey platform, Qualtrics. Participants were recruited through the American Association of Suicidology (AAS) listserv, the Council of University Directors of Clinical Training (CUDCP), Association of Psychology Training Clinics (APTC), the Masters in Psychology and Counseling Accreditation Council (MPCAC), Council on Social Work Education (CSWE), and the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) listservs. Specifically, the recruitment email explained the purpose and scope of the study and asked clinic directors (CD), directors of clinical training (DCT), and/or clinical supervisors to fill out a questionnaire and disseminate a similar student version of the questionnaire to their students. Program staff and students were matched based on the name of their institution. Once this was completed, additional emails were sent to institutions which were missing a match (either student or faculty).

Measures. *Clinic Directors/Directors of Clinical Training/Supervisor Questionnaire.* Information about program type and size, years in existence, and accreditation status was collected from training directors and supervisors. In addition,

information was collected about what the training the program provides regarding suicide risk assessment, intervention, and postvention, as well as postvention procedures.

Program directors were also asked how many client suicide attempts and completions students in their program have experienced within the past five years. Finally, they responded to the faculty version of the Preparedness for Client Suicide Scale.

Student Questionnaire. Students were asked a standard set of demographic questions including how long they have been in training and how long they have been engaged in clinical work. Students were also asked about their program's postvention procedures. They were further asked how many suicidal clients they have worked with as well as the number of clients who have attempted suicide and died by suicide while clients were in services. Students then responded to a student version of the author-developed PFCSS. In addition, students responded to the following measures:

Depression, Anxiety, and Stress Scale. The Depression, Anxiety, and Stress Scales (DASS-21; Lovibond & Lovibond, 1995), a 21-item questionnaire assessing depression, anxiety, and stress, is a measure of overall mental health symptoms. The DASS-21 is composed of three subscales consisting of 7 questions each. The depression scale ($\alpha = .86$) measures common symptoms of depression including anhedonia, hopelessness, and depressed mood. The anxiety scale ($\alpha = .79$) measures common symptoms of anxiety including worry and physiological symptoms such as increased heart rate and shortness of breath. The stress scale ($\alpha = .86$) measures common symptoms of stress including agitation and irritability. Higher scores on each subscale reflect higher severity.

Counselor Suicide Assessment Efficacy Survey. The Counselor Suicide Assessment Efficacy Survey (CSAES; Douglas & Wachter Morris, 2015) is a 25-item questionnaire designed to assess clinician self-efficacy related to suicide assessment and intervention. The CSAES is comprised of four factors. The first factor is related to self-efficacy in matters related to general suicide assessment (8 items; $\alpha = .95$) and asks about the student's ability to effectively assess topics such as suicidal ideation, suicide plans, and level of risk for suicide. The second factor measures self-efficacy related to assessment of personal characteristics related to risk for suicide (9 items; $\alpha = .94$) such as substance use, mental illness, and abuse history. The assessment of suicide history factor measures self-efficacy related to assessment of history of suicidal behaviors (3 items; $\alpha = .94$) including previous attempts and family history. These factors can be further combined into a second-order factor addressing suicide assessment broadly. The final factor is related to self-efficacy related to suicide intervention (5 items; $\alpha = .86$) such as knowing when to break confidentiality and taking action in high risk situations.

Suicide Intervention Response Inventory - 2. The Suicide Intervention Response Inventory – 2 (SIRI-2; Neimeyer & Pfeiffer, 1994) is a 25-item, single factor questionnaire which asks students to rank the appropriateness of various responses to client statements, in order to assess their skill in responding to suicidal clients. Student responses are then compared to a set of exemplar ratings derived from experts in the field of suicidology and total scores are calculated by summing the difference of student responses. Higher scores are indicative of less skill in responding to suicidal clients.

CHAPTER III

Results

Participants

Faculty Participants. A total of 41 faculty supervisors from 34 different institutions responded to the questionnaire. An additional 3 faculty members completed the questionnaire but did not specify their institutional affiliation. Approximately 29.3% of the faculty members were from clinical psychology doctoral programs, 12.2% were from counseling psychology doctoral programs, 17.0% were from marriage and family therapy programs (which were predominately master's level), 4.9% were from school psychology doctoral programs, 24.4% were from social work master's programs, and 7.3% were from other programs (which included clinical mental health counseling and counselor education). Approximately 4.9% of faculty members did not provide information about the type of program or degree type offered at their institution. Table 1 shows the breakdown of faculty affiliation by program type and degree level. Notably, all of the psychology programs (i.e., clinical, counseling, and school psychology) that responded were doctoral level programs while the majority of the respondents from allied mental health fields (i.e., marriage and family therapy, social work, and other) were master's level programs. Because degree type and level were confounded with one another, clinical, counseling and school psychology programs were combined into one category (n=19) and the remaining allied mental health programs (n=20) were combined into a separate category for subsequent analyses.

Faculty in combined allied mental health programs on average reported having more faculty members with specialized training in suicide-related matters (mean = 8,

standard deviation = 9) than psychology programs (mean = 4, standard deviation = 4); however, these differences were not statistically significant, $t(24) = -1.37, p = .18$.

Table 1

Crosstabulation of faculty participants by program type and degree level

Program Type	Degree Level			Total
	Master's	Ph.D.	Psy.D.	
Clinical Psychology	0	9	3	12
Counseling Psychology	0	4	1	5
Marriage & Family Therapy	6	1	0	7
School Psychology	0	2	0	2
Social Work	10	0	0	10
Other	2	1	0	3
Total	18	17	4	39

Student Participants. A total of 61 students from 27 institutions responded to the questionnaire. Although 10 students did not specify their institutional affiliation, all student respondents provided information about their program type and degree level. Approximately 30.8% of student participants were from clinical psychology doctoral programs, 21.5% were from counseling psychology (with more students from doctoral programs than master's programs), 6.2% from marriage and family therapy programs (predominantly master's programs), 1.5% from school psychology programs, and 38.46% from master's programs in social work. As with the faculty data, degree level and type were confounded within the student sample and thus a combined psychology category (n=35) and an allied mental health category (n=30) were created for subsequent analyses. Table 2 displays the breakdown of program type by degree type.

Table 2

Crosstabulation of student participants by program type and degree level

Program Type	Degree Level			Total
	Master's	Ph.D.	Psy.D.	
Clinical Psychology	0	18	2	20
Counseling Psychology	6	4	4	14
Marriage & Family Therapy	3	1	0	4
School Psychology	1	1	0	1
Social Work	25	0	0	25
Total	35	24	6	65

Table 3 displays student participant demographics and training characteristics. The majority of student participants were female (89.2%), below the age of 30 (70.8%), white (70.8%), and in the first four years of their training program (83.1%). The range of time (in years) providing direct clinical services was 0 to 18 with a mean of 3.2 and a standard deviation of 3.6.

Table 3

Student participant demographics

	Variable	N (% of N)
Gender		
	Male	6 (9.2%)
	Female	58 (89.2)
	Other	1 (1.5)
Age		
	22-25	17 (26.2%)
	26-30	29 (44.6)
	31-35	7 (10.8)
	36-40	5 (7.7)
	41-45	1 (1.5)
	46-50	3 (4.6)
	50+	2 (3.1)
	Mean (Std Dev)	30.31 (7.5)
Race/Ethnicity		
	White/Caucasian	46 (70.8%)
	Black/African American	15 (23.1)
	Latino/a	2 (3.1)
	Asian	1 (1.5)
Year in Program		
	1	14 (21.5%)
	2	19 (29.2)
	3	12 (18.5)
	4	9 (13.9)
	5	4 (6.2)
	6	4 (6.2)
	7+	3 (4.6)
Years Providing Direct Services		
	Minimum	0
	Maximum	18
	Mean (Std Dev)	3.2 (3.6)

Stage 1: Construction and Preliminary Validation of the Preparedness for Client**Suicide Scales**

In order to develop the final versions of the Preparedness for Client Suicide (PFCS) scales, the original proposed questions were revised based on the feedback provided by the five experts who responded to the survey. Feedback for each item

generally centered around the need for clarification of terms such as “administration,” “someone,” and “coping.” Broad feedback regarding the entirety of the scales suggested that the faculty items were too difficult to answer because it was unclear as to whether the respondent should answer for one supervisee, a group of supervisees, or the program as a whole. Thus, the wording of the faculty items was changed to focus the items on a broad assessment of program curriculum, training opportunities, and supervisor comfortability with client suicide, rather than responses related to any individual supervisees or groups of supervisees.

Once the items were finalized, they were included in the student and faculty versions of the questionnaires and reliability analyses were conducted for each scale. The list of the original questions as well as the final, revised scales can be found in the appendix.

Faculty Scale. The faculty version of the PFCS scale included 7 items and demonstrated good reliability ($\alpha = 0.89$). Items along with means, standard deviations, and Corrected Item-Total Correlations are reported in Table 4.

Table 4

Item statistics for the PFCS – Faculty

Item Content Summary	Mean	Standard Deviation	Item-Total Correlation
Know how to appropriately support a student	5.54	1.32	.65
Would appropriately support a student	6.00	1.11	.74
Fosters a supportive peer environment	6.19	.91	.75
Fosters open discussion of suicide-related topics	6.11	1.04	.71
Encourages healthy coping	6.16	.93	.81
Adequately addresses the possibility of client suicide	5.22	1.51	.70
Adequately addresses the consequences of client suicide	4.60	1.46	.64
Total Scale	39.81	6.59	

Student Scale. The original, 6-item version of the PFCS student scale did not demonstrate adequate reliability ($\alpha = 0.46$). One item in particular (“I worry about my ability to handle a situation such as the death of a client to suicide”) demonstrated negative correlations with the other items and appears to have contributed to the low reliability. It is possible that the wording of the question (i.e. “handle”) was too ambiguous. Thus, the item was dropped for further analysis. The 5-item version of the student scale demonstrated improved reliability ($\alpha = .66$). The items along with their means, standard deviations, and item-total correlations are reported in Table 5.

Table 5

Item statistics for the PFCS – Student

Item	Mean	Standard Deviation	Item-Total Correlation
Program faculty would know how to support me	5.42	1.60	.67
Feel comfortable telling program faculty what kind of support I need	5.36	1.55	.49
Feel comfortable disclosing client suicide to a supervisor	6.22	1.39	.40
Peers in my program would adequately support me	6.25	1.12	.28
Confident in healthy coping skills	5.0	1.44	.27
Total	28.23	4.68	

Correlations between the total score of the PFCS – Student with participant demographics were run. The PFCS – Student was not significantly correlated with age, year in program, years providing client services, type of program, suicidal clients seen, or number of suicide attempts of active clients, supporting the scale’s discriminant validity. The highest correlation with the PFCS – Student amongst these variables was with the number of suicidal clients seen ($r = .21, p = .14$). Additional discriminant and convergent validity was tested by correlating the total student scale score to the other scales in the

questionnaire. The correlation matrix for the PFCS – Student with the additional student scales is presented in Table 6. The PFCS was significantly correlated with each of the CSAES subscales (largest $r = .53, p < .01$), supporting convergent validity, but not with the SIRI-2 ($r = -.28, p = .06$), which does not support convergent validity. In support of discriminant validity, the PFCS was not significantly correlated with any of the DASS-21 subscales (largest $r = -.25, p = .07$).

Table 6

Correlations among student scales

	1	2	3	4	5	6	7	8	9	10
1. SIRI	—									
2. CSAES-GA	-.16	—								
3. CSAES-PC	.10	.75**	—							
4. CSAES-SH	-.13	.82**	.84**	—						
5. CSAES-Assess	-.09	.92**	.92**	.95**	—					
6. CSAES-Int	-.04	.68**	.75**	.75**	.78**	—				
7. DASS-Stress	.01	-.14	-.08	-.08	-.11	-.19	—			
8. DASS- Anxiety	-.02	-.06	-.01	.01	-.02	-.03	.73**	—		
9. DASS-Depression	-.03	-.03	.14	-.09	-.09	-.20	.57**	.55**	—	
10. PFCS-Student	-.28	.35**	.30*	.53**	.36**	.44**	-.17	.00	-.25	—

Note. * $p < .05$; ** $p < .01$

As a test of the parallel structure of the scales, an independent samples Kolmogorov-Smirnov test ($p = .97$) and an independent samples Mann-Whitney U ($p = .77$) test were run in order to determine whether the distributions of the student and faculty versions of the PFCS were significantly different. Results of both tests support the null hypothesis that the distributions of each scale do not significantly differ from each other, lending support to the parallel structure of the student and faculty scales.

Stage 2: Comparison of Training and Exposure to Suicidal Behavior

Chi-square analyses were run in order to compare the types of training available in suicide risk assessment, intervention, and postvention between program type. As discussed above, due to the confound between degree type and program type, these variables were collapsed into a single variable comprising combined psychology programs and combined allied mental health programs. Table 7 presents the results of the Chi-square analysis for types of training in suicide risk assessment by program type for faculty.

Table 8 presents the results of the Chi-square analysis for types of training in suicide intervention by program type for faculty.

Table 9 presents the Chi-square analysis for types of training in postvention for faculty. Regarding faculty reports of the types of training available, significant differences between program type existed in the number of programs offering suicide risk assessment ($\chi^2 (1, N=37) = 4.03, p = .05$) and postvention ($\chi^2 (1, N=37) = 3.72, p = .05$) training as a topic within a class. Additionally, the programs offering training in suicide intervention as a topic in a course was approaching significance ($\chi^2 (1, N=37) = 3.47, p = .06$). Notably, higher proportions of allied mental health programs offered training in every category of assessment, intervention, and postvention training.

Table 7

Chi-Square of faculty reports of suicide risk assessment training

Program Type	Specialized Coursework	Topic in a Course	Specialized Workshop	Covered in Supervision
Combined Psychology (N=17)	1 (5.8%)	12 (70.5%)	7 (41.2%)	14 (82.4%)
Allied Mental Health (N=20)	5 (25.0%)	19 (95.0%)	6 (30.0%)	17 (85.0%)
$\chi^2 (1, N=37)$	2.47	4.03*	.50	.05

Note. Above counts were determined by the number of faculty members who responded that a particular type of training was available in their program; * $p < .05$

Table 8

Chi-Square of faculty reports of suicide risk intervention training

Program Type	Specialized Coursework	Topic in a Course	Specialized Workshop	Covered in Supervision
Combined Psychology (N=17)	1 (5.8%)	11 (64.7%)	6 (41.2%)	14 (82.4%)
Allied Mental Health (N=20)	4 (20.0%)	18 (95.0%)	8 (40.0%)	18 (95.0%)
$\chi^2(1, N=37)$	1.57	3.47	.09	.46

Note. Above counts were determined by the number of faculty members who responded that a particular type of training was available in their program; * $p < .05$

Table 9

Chi-Square of faculty reports of postvention training

Program Type	Specialized Coursework	Topic in Course	Specialized Workshop	Covered in Supervision
Combined Psychology (N=17)	1 (5.8%)	2 (11.8%)	1 (5.8%)	7 (41.2%)
Allied Mental Health (N=20)	2 (10.0%)	8 (40.0%)	1 (10.0%)	11 (55.0%)
$\chi^2(1, N=37)$.21	3.72*	.01	.70

Note. Above counts were determined by the number of faculty members who responded that a particular type of training was available in their program; * $p < .05$

Approximately half of the faculty in psychology programs (8 of 17; 47.1%) reported that their program had no formal protocol for responding to client suicide. Only 6 psychology faculty (35.3%) reported that their program did have a formal protocol while 3 (17.7%) faculty members reported that they were unaware if such a protocol existed. A higher proportion of faculty in allied mental health programs reported a formal protocol for responding to client suicide (13 out of 20; 65.0%), while 6 (30.0%)

reported no protocol and 1 (5.0%) reported being unaware of a protocol. The proportion of faculty members reporting the existence or awareness of formal protocols for the death of clients to suicide did not significantly differ between program type, $\chi^2(2, N=37) = 3.65, p = .16$. Of the programs that had protocols, faculty typically reported that these included debriefing with students and offering them emotional support if needed as well as a review of the records and possible consultation with legal entities.

Table 10 presents the results of the Chi-square analysis for types of training in suicide risk assessment by program type for students.

Table 11 presents the results of the Chi-square analysis for types of training in suicide intervention by program type for students. Table 12 presents the Chi-square analysis for types of training in postvention for students. Students reported significantly different proportions of specialized coursework related to suicide risk assessment ($\chi^2(1, N=62) = 5.24, p = .02$) and intervention ($\chi^2(1, N=62) = 3.91, p = .05$), with more students in allied mental health programs reporting specialized coursework. Additionally, significantly higher proportions of students in combined psychology programs reported covering the topics of suicide risk assessment ($\chi^2(1, N=62) = 6.00, p = .01$) and postvention ($\chi^2(1, N=62) = 4.88, p = .03$) in supervision, with coverage of suicide intervention in supervision ($\chi^2(1, N=62) = 2.96, p = .09$) approaching significance.

Table 10

Chi-Square of student reports of suicide risk assessment training

Program Type	Specialized Coursework	Topic in Course	Specialized Workshop	Covered in Supervision
Combined Psychology (N=34)	1 (2.9%)	27 (79.4%)	16 (47.1%)	25 (73.5%)

Allied Mental Health (N=28)	6 (21.4%)	17 (60.7%)	9 (32%)	12 (42.9%)
χ^2 (1, N=62)	5.24*	2.61	1.42	6.00*

*Note. Above counts were determined by the number of students who responded that a particular type of training was available in their program; *p < .05*

Table 11

Chi-Square of student reports of suicide intervention training

Program Type	Specialized Coursework	Topic in Course	Specialized Workshop	Covered in Supervision
Combined Psychology (N=34)	1 (2.9%)	24 (70.6%)	12 (35.3%)	22 (64.7%)
Allied Mental Health (N=28)	5 (17.9%)	17 (60.7%)	11 (39.3%)	12 (42.9%)
χ^2 (1, N=62)	3.91*	.67	.11	2.96

*Note. Above counts were determined by the number of students who responded that a particular type of training was available in their program; *p < .05*

Table 12

Chi-Square of student reports of postvention training

Program Type	Specialized Coursework	Topic in Course	Specialized Workshop	Covered in Supervision
Combined Psychology (N=34)	0 (0.0%)	11 (32.4%)	1 (2.9%)	10 (29.4%)
Allied Mental Health (N=28)	2 (7.1%)	12 (42.9%)	4 (14.3%)	2 (7.1%)
χ^2 (1, N=62)	2.5	.73	2.67	4.88*

*Note. Above counts were determined by the number of students who responded that a particular type of training was available in their program; *p < .05*

Next, exposure to suicidal behavior was compared across program type. One case was excluded from the analyses of suicidal clients seen due to an extreme outlier

(43,230). Of the remaining cases, 86.1% (n=31) of students in psychology programs and 72.4% (n=21) of students in allied mental health programs reported working with at least one suicidal client. These proportions did not significantly differ ($\chi^2(1, N=65) = 1.88, p = .17$). The range of suicidal clients seen by students in psychology programs (n=36) was 0 to 100 with a mean of 13.9 and a standard deviation of 22.1. The range of suicidal clients seen by students in allied mental health programs (n=29) was 0 to 30 with a mean of 4 and a standard deviation of 6.6. The frequency distributions of suicidal clients for students in both psychology and allied mental health programs were positively skewed due to the amount of students who reported seeing no suicidal clients. I determined that parametric statistical tests would not be appropriate for analyzing the data due to the high degree of skewness, and opted instead for nonparametric tests. An independent samples Kruskal-Wallis Test showed that the frequency distributions of students in psychology programs and allied mental health programs were significantly different ($p=.04$), with psychology students seeing more suicidal clients than allied mental health students.

The proportion of students in psychology programs (n=14; 38.8%) and students in allied mental health programs (n=8; 27.6%) who reported working with at least one client who attempted suicide while receiving services were not significantly different ($\chi^2(1, N=65) = .92, p = .34$). The range of attempted suicides seen by students in psychology programs (n=36) was 0 to 10 with a mean of .9 and a standard deviation of 2. The range of attempted suicides seen by students in allied mental health programs (n=29) was 0 to 10 with a mean of .7 and a standard deviation of 2. The frequency distributions of suicidal clients for students in both psychology and allied mental health programs were positively skewed due to the amount of students who reported seeing no suicidal clients.

An Independent Samples Kruskal-Wallis Test showed that the frequency distributions of students in psychology programs and allied mental health programs who experienced a suicide attempt of an active client were not significantly different ($p=.43$).

Only one student reported experiencing the death of an active group therapy client to suicide. This student was in a psychology program and, notably, reported that they were still unsure of whether their program had an official protocol for dealing with client suicide. Of students in psychology, 22 out of 30 (73.3%) reported being unaware of their program's protocol regarding client suicide. Of the students in allied mental health programs, 11 out of 21 (52.4%) reported being unaware of any formal protocols and 2 out of 21 (9.5%) reported that their program did not have a formal protocol. The proportion of students reporting the existence or awareness of formal protocols for the death of clients to suicide did not significantly differ between program type, $\chi^2(2, N=51) = 4.21, p = .12$. The most common protocol that students were aware of related to client suicide was to immediately discuss the suicide with their supervisor.

Stage 3: Analysis of the Implications of Exposure to Suicidality

A series of regression analyses were run to test the effects of exposure to suicidal clients and client suicide attempts on the emotional functioning of graduate trainees. Due to the skewed distributions of the number of suicidal clients seen and client suicide attempts, these were transformed into two separate dichotomous variables indicating either the presence or absence of having worked with each type of client.

Student Clinician Mental Health. A multivariate regression was run using the DASS-21 subscales as outcomes and the dichotomous variables related to exposure to suicide as predictors, controlling for program type. There were no main effects for

suicidal clients, $\Lambda = .89$, $F(3, 49) = 2.00$, $p = .13$, partial $\eta^2 = .11$ or for client suicide attempts, $\Lambda = .97$, $F(3, 49) = .56$, $p = .65$, partial $\eta^2 = .03$. Univariate results for each of the DASS-21 subscales are presented in Table 13 while marginal means for each of the DASS-21 subscales compared across individuals who have and have not seen suicidal clients are reported in

Table 14. Univariate results for DASS-21 subscales for client suicide attempts are presented in

Table 15 while the marginal means DASS-21 subscales by client suicide attempts are presented in Table 16.

Table 13

Univariate results for DASS-21 subscales by exposure to suicidal clients

		Sum of Squares	df	Mean Square	F	p	Partial η^2
Depression	Contrast	.75	1	.75	.08	.78	.00
	Error	489.29	51	9.59			
Anxiety	Contrast	.03	1	.12	.00	.96	.00
	Error	426.11	51	8.36			
Stress	Contrast	49.51	1	49.51	2.90	.09	.05
	Error	869.61	51	17.05			

Table 14

Marginal Means of DASS-21 subscales by exposure to suicidal clients

DASS-21 Subscale	Suicidal Clients	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Depression Scale	No	1.84	.96	-.08	3.76
	Yes	2.14	.48	1.18	3.11
Anxiety Scale	No	2.13	.89	.34	3.92
	Yes	2.07	.45	1.17	2.98
Stress Scale	No	7.22	1.27	4.66	9.78
	Yes	4.77	.64	3.48	6.06

Table 15

Univariate Results for DASS-21 subscales by client suicide attempts

		Sum of Squares	df	Mean Square	F	<i>p</i>	Partial η^2
Depression	Contrast	5.08	1	5.08	.53	.47	.01
	Error	489.29	51	9.59			
Anxiety	Contrast	.61	1	.61	.07	.79	.00
	Error	426.11	51	8.36			
Stress	Contrast	40.96	1	40.96	2.40	.13	.05
	Error	869.61	51	17.05			

Table 16

Marginal means of DASS-21 subscales by exposure to client suicide attempts

DASS-21 Subscale	Suicide Attempts	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Depression Scale	No	2.27	.56	1.15	3.93
	Yes	1.58	.75	.07	3.10
Anxiety Scale	No	2.17	.52	1.12	3.22
	Yes	1.93	.70	.52	3.35
Stress Scale	No	6.24	.75	4.74	7.74
	Yes	4.28	1.00	2.26	6.30

Self-Efficacy in Suicide Assessment and Intervention. A multivariate regression was run using the CSAES second-order assessment scale and intervention subscale as outcomes and the dichotomous variables related to exposure to suicide as predictors, controlling for program type. There were no main effects for suicidal clients, $\Lambda = .92$, $F(2, 47) = 2.03$, $p = .14$, partial $\eta^2 = .08$ or for client suicide attempts, $\Lambda = .96$, $F(2, 47) = .91$, $p = .41$, partial $\eta^2 = .04$. Univariate results for the CSAES subscales

compared across individuals who have and have not seen suicidal clients are presented in = .02.

Table 17 while marginal means for each of the CAES subscales compared across individuals who have and have not seen suicidal clients are reported in Table 18.

Notably, students who reported working with suicidal clients reported significantly higher self-efficacy in assessing for suicide risk, $F(1, 48) = 5.43, p = .02, \text{partial } \eta^2 = .10$, but not for suicide-related intervention, $F(1, 48) = 1.07, p = .31, \text{partial } \eta^2 = .02$.

Table 17

Univariate results for CSAES subscales across exposure to suicidal clients

		Sum of Squares	df	Mean Square	F	p	Partial η^2
Assessment	Contrast	3.16	1	3.16	5.43	.02	.10
	Error	27.95	48	.58			
Intervention	Contrast	.72	1	.72	1.07	.31	.02
	Error	32.29	48	.67			

Table 18

Marginal means of CSAES subscales by exposure to suicidal clients

CSAES Subscale	Suicidal Clients	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Assessment	No	3.42	.24	2.94	3.90
	Yes	4.05	.13	3.80	4.30
Intervention	No	3.49	.25	2.97	4.00
	Yes	3.79	.13	3.52	4.06

Univariate results for CSAES subscales for client suicide attempts are presented in Table 19 while the marginal means for client suicide attempts across CSAES subscales are presented in Table 20. Again, students exposed to client suicide attempts reported

significantly higher suicide assessment self-efficacy, $F(1, 48) = 5.49, p = .02$, partial $\eta^2 = .10$ but self-efficacy in intervention did not significantly differ, $F(1, 48) = 1.81, p = .19$, partial $\eta^2 = .04$.

Table 19

Univariate results for CSAES subscales across exposure to client suicide attempts

Assessment	Contrast	Sum of Squares	df	Mean Square	F	<i>p</i>	Partial
		3.19	1	3.19	5.49	.02	.10
	Error	27.95	48	.58			
Intervention	Contrast	1.22	1	1.22	1.81	.19	.04
	Error	32.29	48	.67			

Table 20

Marginal means of CSAES subscales by client suicide attempts

CSAES Subscale	Suicidal Clients	Mean	Std. Error	95% Confidence Interval	
				Lower Bound	Upper Bound
Assessment	No	3.65	.14	3.37	3.93
	Yes	4.22	.20	3.82	4.62
Intervention	No	3.57	.15	3.27	3.87
	Yes	3.92	.21	3.49	4.35

Skill in responding to client suicide. A linear regression was run using the SIRI-2 as the outcome and the dichotomous variables related to exposure to suicide as predictors, controlling for program type. Table 21 contains results of the regression analysis. Exposure to client suicidal behavior and program type accounted for 33% of the variance in skill in responding to suicidal clients; however, neither exposure to clients or client suicide attempts significantly predicted skill in responding to client suicide. Notably, program type significantly predicted skill in responding to client suicide attempts, $t = 4.49, p < .00$. Specifically, students in the combined allied mental health

category had scores on the SIRI-2 that were, on average, .38 points (95% CI = .21 - .55) higher than students in the combined psychology category.

Table 21

Linear regression of SIRI-2 total scores predicted by exposure to suicidality

	B	SE	t	p Value	95% Confidence Interval	
					Lower Bound	Upper Bound
Intercept	.87	.11	7.76	.00	.64	1.20
Suicidal Clients	.03	.09	.16	.87	-.16	.19
Suicide Attempts	.01	.12	.27	.79	-.21	.27
Program Type	.38	.08	4.49	.00	.21	.55

Note. $R^2 = .33$

Preparedness for Client Suicide. A linear regression was run using the PFCS-Student as the outcome and the dichotomous variables related to exposure to suicide as predictors, controlling for program type. Results of the regression are reported in Table 22. Exposure to suicide and program type only accounted for 3% of the variance in PFCS – Student scores and none of these variables were significantly predictive of preparedness for client suicide.

Table 22

Linear regression of PFCS-Student scores predicted by exposure to suicidality

	B	SE	t	p Value	95% Confidence Interval	
					Lower Bound	Upper Bound
Intercept	5.50	.28	19.33	.00	4.93	6.06
Suicidal Clients	.45	.29	1.56	.12	-.12	1.02
Suicide Attempts	-.15	.21	-.74	.46	-.56	.26
Program Type	-.09	.19	-.47	.64	-.47	.29

Note. $R^2 = .03$

CHAPTER IV

Discussion

The current study aimed to update the literature regarding graduate training in suicide risk assessment, intervention, and postvention for mental health professionals, as well as develop a parallel set of scales for students and faculty to assess their program's climate related to losing clients to suicide. Most studies in this realm rely on reports from either students or faculty members in graduate training programs, which leads to an incomplete picture of the state of training. Accordingly, the current study sought input from both students and faculty supervisors. Additionally, the current study directly compared reports of training across several disciplines in order to determine if there were differences in suicide-related training between psychology and allied mental health fields as well as between master's and doctoral training programs. Finally, the current study examined the effects of exposure to client suicidal behavior on several variables including mental health, self-efficacy in suicide assessment and intervention, skill in responding to suicidal statements, and preparedness for client suicide.

Stage 1: Construction and Preliminary Validation of the Preparedness for Client Suicide Scales

In developing the parallel set of scales to assess program climate related to client suicide, a Delphi procedure was used to refine the content of the items. As described in the results section, the original proposed faculty items were revised to focus more so on the training opportunities offered in the program rather than the skills of one particular student or group of students, which may differ based on factors outside the program's control. The revised items demonstrated excellent reliability. The student items required

less revision, but several items were combined and the wording was updated for clarity. Additionally, one item was excluded from the scale after analysis because of its poor correlation to the other items. It is likely that this item (“I worry about my ability to handle a situation such as the death of a client to suicide.”) was too broad. Further, the item likely relates more closely to the personal characteristics of the trainee rather than the program culture.

Once the final group of student items was refined, the student version of the scale demonstrated adequate reliability. Additionally, it demonstrated good convergent validity with the scales of the CSAES, which makes sense given that the PFCS – Student assesses student perceptions of their readiness to appropriately handle the consequences of client suicide, a concept closely related to self-efficacy. The PFCS – Student was not significantly correlated with age, year in program, years providing client services, type of program, suicidal clients seen, or number of suicide attempts of active clients which lends support to the measure’s discriminant validity given that it is intended to assess climate of particular training programs rather than personal characteristics of trainees. Finally, the distribution of both the student and faculty scales did not significantly differ from one another, which provides support for their parallel structure.

Future studies should continue to examine the validity of the PFCS scales. Recruitment of participants for the initial Delphi study proved difficult and thus did not include as many experts as optimal. Additionally, only one participant responded to the second round of feedback. While the results of the current Delphi study were useful in revising the existing items, a future Delphi studies incorporating additional expert opinions would be useful in further refining the items of the PFCSS. Additionally, a

study recruiting dyads of peers and their supervisors could provide more precise support for the scale's parallelism. Although the current study includes students and faculty from the same training programs, it is unclear whether the faculty who responded to the study were responsible for supervising the students from their programs who responded to the study. Further, future studies could include measures of supervisor-supervisee alliance in order to assess the influence of the quality of the supervisory relationship on preparedness for client suicide. Additionally, comparing responses from students and their supervisors would be fruitful in that it would provide a better picture of potential discrepancies in perceptions of preparedness, which would then provide valuable information to training programs and supervisors about where they might be able to strengthen their training.

In the initial generation of items for the PFCS scales, several of the items were designed to tap into the internal processes of trainees and supervisors in preparing for client suicide. Through the feedback of the Delphi panelists, the items were revised to assess more concrete aspects of training, such as whether particular training structures were in place in programs. While these questions are much easier for supervisors to answer about their program more broadly, this leaves room for an additional measure that addresses emotional preparation for client suicide. By restricting responses to specific supervisor-supervisee dyads, as suggested above, some of the subjectivity of supervisors answering for a set of supervisees rather than a particular supervisee would be eliminated.

Stage 2: Comparison of Training and Exposure to Suicidal Behavior

The rates of reported exposure to suicidal behavior, including suicidal clients, client suicide attempts, and client suicides were consistent with previous estimates of exposure

to suicidal behavior in clinical psychology doctoral programs (Dexter-Mazza & Freeman, 2003; Mackelprang et al., 2014; Kleespies et al, 1990). Although in the present study reports of exposure to suicidal clients and client suicide attempts were not significantly different between students in combined psychology (which comprised primarily doctoral students) and students in allied mental health (which comprised primarily master's students), students in psychology consistently reported higher rates of exposure to suicide and indeed, the sole client suicide reported in the study was reported by a doctoral student in psychology. It is possible that the reason for this higher exposure to suicide for doctoral programs relates to the diversity and depth of training available in doctoral level programs versus master's level programs, as well as the longer length of doctoral programs. Although faculty members were asked about potential practicum placements for their students in the current study, this question was not asked of students. Given that the likelihood of practitioners losing clients to suicide varies based on their practice setting, future studies should examine how practicum setting impacts exposure to suicidality as well as training available related to suicide risk assessment, intervention, and postvention. In addition, a variable that should be incorporated into future research is whether or not program training clinics screen for suicidality prior to accepting a client for services, which may limit trainees exposure to suicidal clients (MA Conroy, personal communication, November 6, 2018).

Regarding the prevalence of training in suicide-related matters, faculty from each program in the study indicated they offered at least one type of training. The most common type of training for combined allied mental health professionals was as a topic in a course. In contrast, combined psychology programs indicated that suicide risk

assessment was most commonly addressed in supervision. Indeed, significantly more allied mental health programs than combined psychology programs indicated that they covered suicide risk assessment and postvention in their coursework despite no other significant differences in offerings. While the estimates of the availability of suicide-related training in the current study appear higher than previous estimates (Bongar & Harmatz, 1991; Dexter-Mazza, et al., 2003), the discrepancy in the amount of training between allied mental health professionals and psychologists is concerning. This is particularly true given that doctoral programs generally provide a greater breadth and depth of training than terminal master's programs. Although individualized supervision can provide an environment conducive to in-depth exploration of a clinical topic, this setting is less standardized than a classroom environment, which ensures that all students will receive at least a baseline level of training. Thus, in order to provide breadth and depth of training, programs should strive to incorporate coverage of suicide-related topics in both coursework and supervision.

Regarding student reports of training in suicide-related matters, significantly more students in allied mental health training programs reported that they had access to specialized coursework in suicide risk assessment and intervention than students in psychology training programs; however, there were no significant differences in student reports of receiving suicide-related training as a topic in a course. Again, the discrepancy in access to specialized coursework raises concerns given that students in doctoral programs take significantly more coursework than students in master's programs. Although the difference between the reported number of faculty members with specialized training in suicide-related matters between allied mental health and

psychology programs was not statistically significant, faculty from allied mental health programs on average did report more faculty members with specialized training. It is possible that this is what is driving the difference in access to suicide-related coursework, both in stand-alone courses and as a topic in courses.

Another significant difference in student reports of suicide-related training is in coverage of these topics in supervision. Specifically, students in psychology reported receiving significantly more supervision in suicide risk assessment and postvention than students in allied mental health. This should not be surprising given that students in psychology programs typically receive supervision for a longer period of time and, according to the students in the current study, experience significantly more client suicide attempts than students in allied mental health programs.

Across both program type and training type, rates of training in matters related to suicide postvention were low, and relatively consistent with coverage of postvention found by Mackelprang et al. (2014). This likely explains the reasoning for such a high proportion of students indicating that they were unaware of their program's protocol following the death of a client to suicide. This issue is further compounded by a large proportion of faculty reporting that their program in fact does not have a formal protocol for responding to client suicide. The numbers of programs that reported no formal protocol are in line with Ellis and Dickey's (1998) assessment, although theirs was focused on pre-doctoral internship training. Nevertheless, the current findings indicate that there has not been a significant push to incorporate formalized protocols for responding to client suicide, despite several simple frameworks to specifically address

postvention in training programs proposed by Lerner et al. (2012) and Veilleux and Bilsky (2016).

Each of the participants in the current study were affiliated with a program accredited by an accrediting body intended to ensure that the program meets specific standards of training. The standards of each accrediting body include provisions to ensure that the curriculum addresses particular topics and that students meet a specific set of competencies in order to successfully graduate. A review of the standards of accreditation from each governing body revealed major differences in mandatory suicide-related training across disciplines. The Council for Accreditation of Counseling and Related Educational Programs (CACREP) sets forth the most explicit guidelines, specifically requiring courses to address “suicide prevention models and strategies...crisis intervention...[and] procedures for assessing risk...of self-inflicted harm or suicide” (CACREP, 2015, pg. 13). The Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) also includes suicide in a required list of topics to be covered in coursework (COAMFTE, 2017). Neither the Council on Social Work Education (CSWE) nor the American Psychological Association (APA) explicitly mention suicide or crisis intervention in their most recent standards of accreditation (APA, 2015; CSWE, 2015), which could further account for the differences found between psychology and allied mental health training programs.

Stage 3: Analysis of the Implications of Exposure to Suicidality

The current study did not find evidence that exposure to suicidality is related to depression, anxiety, or stress in graduate students. This result is somewhat surprising given the profound emotional effects suicide can have on trainees (Speigleman & Werth,

2005). However, it is possible that distress levels were overall lower since only one participant in the study lost a client to suicide. Additionally, it is possible that the dichotomization of the variables related to suicide exposure reduced some of the nuance and variability within the data, thereby making it more statistically difficult to pick up on differences in distress related to exposure to client suicide.

The current study did, however, find evidence that exposure to both working with suicidal clients and client suicide attempts were related to higher self-efficacy related to suicide assessment, but not intervention. It is quite possible that this boost in self-efficacy may be a result of increased coverage of suicide risk assessment in supervision when a student is seeing a client who is at risk for suicide. However, this theory does not explain why the increase in self-efficacy occurs only in an assessment setting. It appears as though students feel more well-equipped to ask the appropriate questions to identify clients who are at risk for suicide rather than implement strategies to specifically target those risk factors. Perhaps beginning to offer more specialized coursework in the treatment of suicidal clients would allow for more confidence in intervening with suicidal clients.

Interestingly, although exposure to suicidality was not significantly associated with skill in responding to client suicide, students in allied mental health programs scored significantly higher on the SIRI-2 than students in psychology programs. While at first glance this could be due to the greater availability of specialized coursework in suicide-related matters, Mackelprang et al. (2014) did not find significant differences in performance on the SIRI-2 for clinical psychology doctoral students based on exposure to classroom training. There, the authors suggest that the current state of classroom training

in doctoral programs is inadequate. Perhaps not only do students in allied mental health programs have access to more coursework, but better quality coursework related to suicide. Future studies should begin to investigate the specific content of coursework related to suicide. In particular, it may be useful to compare the content available to the core competencies and recommendations proposed by Cramer et al. (2013) as a measure of the quality of suicide-related curriculum.

Finally, exposure to suicide did not significantly predict scores on the PFCS-Student scale. This is possibly related to some of the issues raised above, and in particular the issue that the PFCS was designed to assess program culture related to client suicide. Thus, it is likely that scores on the PFCS would be more influenced by factors related to the type and amount of postvention training received and relationship with supervisors rather than exposure to suicide alone.

Summary and Conclusions

Suicide is one of the most high-risk clinical situations faced by a mental health professional, and a substantial portion of mental health professionals will lose a client to suicide during their career. The results of the current study suggest that despite the likelihood that students in training will have exposure to suicidal clients as well as clients who attempt suicide while receiving services, training in suicide risk assessment, intervention, and especially postvention, is inadequate. Beyond this, psychology programs appear to be lagging behind allied mental health programs despite the typically greater breadth and depth of training that is generally available in a doctoral program in psychology. The results of the current study should serve as a call to action for all mental health training programs, but doctoral programs in psychology in particular, to include

more quality, formalized educational opportunities for students to develop skills in assessing and treating suicidal clients and especially in how to appropriately survive the death of a client to suicide.

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5910/a000062

APPENDIX

Original PFCS Scale Items

Faculty Items. Please rate your agreement with the following statements (1 = strongly disagree and 7 = completely agree)

1. I feel confident that our program administration could adequately support a student who experienced the death of a client by suicide.
2. I feel confident that our program faculty and staff would adequately support a student who experienced the death of a client by suicide.
3. I have confidence our students would support a peer who experienced the death of a client by suicide.
4. I believe our students would feel comfortable disclosing the death of a client by suicide to their supervisor.
5. I feel confident in our students' abilities to personally cope with the death of a client by suicide.
6. I feel confident in our students' abilities to professionally cope with the death of a client by suicide.
7. I feel confident our students could find someone to talk to after experiencing the death of a client by suicide.
8. I feel confident our students would be able to engage in appropriate self-care after experiencing the death of a client by suicide.
9. I worry about our students' ability to handle a situation such as the death of a client by suicide.

Student Items. Please rate your agreement with the following statements (1 = completely disagree and 7 = completely agree)

1. I feel confident that my program's administration could adequately support me if I experienced the death of a client by suicide.
2. I feel confident that program's faculty and staff would adequately support me if I experienced the death of a client by suicide.
3. I feel confident my peers would adequately support me if I experienced the death of a client by suicide.
4. I believe I would feel comfortable disclosing the death of a client by suicide to my supervisor.
5. I feel confident in my ability to personally handle the death of a client by suicide.
6. I feel confident in my ability to professionally handle the death of a client by suicide.
7. I feel confident I could find someone to talk to after experiencing the death of a client by suicide.
8. I feel confident I would be able to engage in appropriate self-care after losing a client to suicide.
9. I worry about my ability to handle a situation such as the death of a client by suicide.

Final PFCS Scale Items

Faculty Items. Please rate your agreement with the following statements (1 = strongly disagree and 7 = completely agree)

1. I feel confident that our program faculty would know how to appropriately support a student who experienced the death of a client to suicide.

2. I feel confident that our program faculty would appropriately support a student who experienced the death of a client to suicide.
3. I have confidence that our training program fosters an environment that would allow students to appropriately support a peer who experienced the death of a client to suicide.
4. I believe our training program environment fosters open discussion of issues related to client suicide.
5. I believe our training program encourages students to cope with difficult clinical situations, such as client suicide, in healthy ways.
6. I believe our training program adequately addresses the possibility of client suicide in our curriculum.
7. I believe our training program adequately addresses the consequences of client suicide in our curriculum.

Student Items. Please rate your agreement with the following statements (1 = strongly disagree and 7 = completely agree)

1. I feel confident that my program's faculty would know how to support me if I experienced the death of a client to suicide.
2. I believe I would feel comfortable telling my program faculty what kind of support I need if I experienced the death of a client to suicide.
3. I believe I would feel comfortable disclosing the death of a client by suicide to my supervisor.
4. I believe my peers in my program would appropriately support me if I experienced the death of a client to suicide.

5. I feel confident in my ability to cope with the death of a client by suicide in a healthy way.
6. I worry about my ability to handle a situation such as the death of a client to suicide.
(This item was excluded from the final analyses in order to improve overall reliability)

VITA

Elise M. Yenne, M.A.

EDUCATION

- Candidate** **Doctor of Philosophy (Clinical Psychology, Forensic Emphasis)**
 Sam Houston State University
Dissertation: A multilevel examination of client suicide in training programs in psychology and allied mental health fields
 (Proposal Defended: 09/2017)
Advisor: Craig Henderson, Ph.D.
- 2016** **Master of Arts (Clinical Psychology, Forensic Emphasis)**
 Sam Houston State University
Thesis: Use your imagination: The relationship between pornography use, relationship satisfaction, and attention to alternatives
Advisor: Rowland Miller, Ph.D.
- 2014** **Bachelor of Science**
 Psychology, *Summa Cum Laude*
Bachelor of Arts
 Sociology (Concentration: Criminology & Criminal Justice), *Summa Cum Laude*
 Colorado State University
Minors: Applied Statistics, Interdisciplinary Minor in Leadership Studies
Study Abroad: Comparative Criminology & Criminal Justice; Prague, Czech Republic (Summer 2012)
Honors Thesis: Calling and Meaning for Volunteers and Employees in the Correctional System: A Qualitative Analysis
Advisor: Bryan Dik

CLINICAL EXPERIENCE

June 2018 – Present **Practicum Intern**
Austin State Hospital
 Austin, Texas

Responsibilities: • Provide individual evidence-based interventions to adults

- Conduct comprehensive assessments addressing referral questions including psychodiagnostic, cognitive, symptom validity, violence risk, suicide risk, and competency to stand trial
- Facilitate therapeutic and psychoeducational groups including competency restoration groups
- Observe involuntary commitment and involuntary medication hearings
- Develop and implement trainings and supervision related to competence to stand trial for treatment teams

Population: Adult inpatients with severe mental illness hospitalized for voluntary commitment, involuntary commitment, and competency restoration

Supervisor: Keeley Crowfoot, Psy.D.

September 2017 – Present

Student Clinician and Co-Therapist

Team Forensic Services

Huntsville, Texas

- Responsibilities:*
- Co-facilitate bi-monthly, mandated, evidence-based, manualized group treatment with a Licensed Sex Offender Treatment Provider
 - Provide individual, evidenced-based psychotherapy for group members whose needs extended beyond the group context
 - Observe meetings with sexual offenders' external support groups

Population: Primarily low-income, rural, multi-ethnic adult males on probation or parole for sexual offenses

Supervisor: Holly Miller, Ph.D., LSOTP

August 2016 - Present

Assistant Forensic Evaluator

Psychological Services Center

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Conduct court-ordered pre-trial evaluations (i.e. competency to stand trial and mental state at the time of the offense for adults; fitness to proceed and criminal responsibility for juveniles)
 - Consult with supervisors to formulate psycholegal opinions in accordance with state statutes
 - Co-author forensic evaluation reports for the court including psycholegal opinion and treatment recommendations

Population: Ethnically diverse, male and female, adults and adolescents involved in the justice system in several rural counties; evaluations conducted in jails or in outpatient clinic

Supervisors: Mary Alice Conroy, Ph.D., ABPP & Wendy Elliott, Ph.D.

**May 2017 –
May 2018**

Clinic Coordinator

*Psychological Services Center at Sam Houston State University
Huntsville, Texas*

- Responsibilities:*
- Completed telephone intake interviews of potential clients and managed waitlists and clinical case assignments
 - Led weekly meetings of clinicians and supervisors to assign cases and facilitate group discussion of clinical/ethical issues and mediated clinic concerns between student clinicians, staff, and supervisors
 - Arranged free and reduced cost clinical services for survivors of Hurricane Harvey and DACA recipients
 - Facilitated and arranged services from outside referral agencies to the clinic
 - Supervised peers in clinic policy, procedure, and record-keeping and conducted Quality Assurance reviews of clinic case files each semester

Population: A diverse, low-income, multi-ethnic population of children, adolescents, and adults with diagnoses including serious mental illness, substance use history, mood and anxiety disorders, personality disorders, family, and academic stress

Supervisor: Mary Alice Conroy, Ph.D., ABPP, Clinic Director

**May 2016 –
May 2017**

**Practicum Student – Individual and Group Therapist,
Evaluator**

*Walker County Adult Probation Department
Huntsville, Texas*

- Responsibilities:*
- Conducted psychodiagnostic evaluations including achievement, cognitive, and personality measures as well as substance abuse evaluations
 - Provided voluntary and mandated, individual, evidence-based psychotherapy and substance use treatment
 - Co-facilitated court-mandated, manualized anger management groups
 - Consulted with probation officers regarding mental health needs of probationers as well as crisis intervention

Population: Ethnically diverse, male and female, adults involved on probation for felony and misdemeanor charges in several rural counties

Supervisor: Wendy Elliott, Ph.D.

**October 2014 –
May 2018**

Practicum Student-Individual Evaluator

*Psychological Services Center at Sam Houston State University
Huntsville, Texas*

- Responsibilities:*
- Conduct psychodiagnostic evaluations on juveniles as ordered by the juvenile courts or probation departments from multiple surrounding counties
 - Authored integrated reports, and provided treatment and placement recommendations

Population: Ethnically diverse, justice-involved youth

Supervisor: Wendy Elliott, Ph.D.; Darryl Johnson, Ph.D.

**August 2015 –
May 2018**

Practicum Student-Individual Therapist & Evaluator

*Psychological Services Center
Sam Houston State University
Huntsville, Texas*

- Responsibilities:*
- Provide individual evidence-based interventions to adults and families
 - Conduct intake evaluations and author intake reports
 - Formulate detailed treatment plans and closely monitor treatment goals
 - Engage in suicide risk assessment and prevention
 - Conduct comprehensive assessments utilizing methods such as clinical and collateral interviews, intelligence and achievement testing, personality and psychopathology testing, neuropsychological testing, and autism testing
 - Author comprehensive, integrated reports
 - Communicate assessment results and recommendations to clients

Population: • A diverse, low-income, multi-ethnic population of children, adolescents, and adults with diagnoses including serious mental illness, substance use history, mood and anxiety disorders, personality disorders, family, and academic stress

Supervisors: Jaime Anderson, Ph.D.; Wendy Elliott, Ph.D.; Darryl Johnson, Ph.D.; Ramona Noland, Ph.D., LSSP; Chelsea Ratcliff, Ph.D.; Adam Schmidt, Ph.D.

ADDITIONAL CLINICAL/PROFESSIONAL EXPERIENCE

June 2018

Crisis Management Training

National Institutes of Corrections

Bryan, Texas

- Responsibilities:*
- Assisted in content development and production of a series of training films for law enforcement officers responding to mentally ill offenders
 - Interviewed inmates and jail administrators on camera about mental health symptoms, psychotropic medications, crisis intervention, and de-escalation tactics

Supervisor: Mary Alice Conroy, Ph.D., ABPP

**August 2013 –
July 2014**

AmeriCorps Intern

Community Literacy Center

Fort Collins, Colorado

- Responsibilities:*
- Developed and facilitated weekly creative writing program with an emphasis in journal therapy techniques
 - Assisted in the compilation, publication, and dissemination of bi-annual journal showcasing the work of incarcerated writers
 - Trained and managed three volunteer facilitators

Population: Adult male inmates in a county jail in suburban Colorado

Supervisor: Tobi Jacobi, Ph.D.

TEACHING EXPERIENCE

August 2018 - Present **Instructor of Record**

Psychology and the Law – Online Course (PSYC3383)

Department of Psychology and Philosophy

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Create lecture videos and online activities related to theories, definitions, controversies, and practical skills in the field of forensic psychology
 - Topics covered included, but not limited to, competency to stand trial, corrections, criminal responsibility, eyewitness memory,

expert testimony, psychopathy, risk assessment, and wrongful convictions

- Prepared and graded student exams and written assignments and tracked student grades

Supervisor: James Crosby, Ph.D.

**June 2018 –
August 2018**

Graduate Teaching Assistant

Introduction to Doctoral Practicum (PSYC 8381)

Department of Psychology & Philosophy

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Supervised first-year clinical psychology doctoral students performing mock therapy sessions
 - Developed and implemented lecture on suicide risk assessment and intervention
 - Provided feedback and assisted with progress evaluations including reviewing and providing feedback on written assignments such as mock mental status write-ups

Supervisor: Mary Alice Conroy, Ph.D., ABPP

**June 2018 –
August 2018**

Graduate Teaching Assistant

Assessment of Intelligence and Achievement (PSYC 5395)

Department of Psychology & Philosophy

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Instructed students regarding standardized administration of various intelligence and achievement measures
 - Supervised administration and scoring of numerous intelligence, achievement, and adaptive behavior measures to ensure student competence upon course completion in preparation for further clinical training

Supervisor: Ramona Noland, Ph.D.

SUPERVISORY EXPERIENCE

**May 2016 –
August 2016**

Peer Supervisor

Introduction to Doctoral Practicum Course (PSYC 8382)

Department of Psychology & Philosophy

May 2018 –

Sam Houston State University

August 2018

Huntsville, Texas

- Responsibilities:*
- Co-facilitated supervision sessions of first year doctoral students with clinic director
 - Reviewed mock therapy session videos with supervisees
 - Provided feedback on basic counseling skills
 - Served as mock therapy client for students practicing suicide risk assessments

Supervisor: Mary Alice Conroy, Ph.D.

**August 2017 –
May 2018****Peer Supervisor***Capstone Practicum (PSCY 8381)*

Department of Psychology & Philosophy

Sam Houston State University

- Responsibilities:*
- Co-facilitated supervisions sessions of second-year doctoral students with licensed staff psychologist
 - Reviewed therapy and assessment session videos with supervisee and provided feedback on clinical documentation, case materials, and integrated reports
 - Reviewed and provided feedback on materials for the Capstone comprehensive exam

Supervisors: Jaime Anderson, Ph.D.; Wendy Elliott, Ph.D.

RESEARCH EXPERIENCE

**August 2017 –
Present****Graduate Research Assistant***Discrimination and substance use among ethnic minority emerging adults*

Department of Psychology and Philosophy

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Assisted in preparation of internally funded faculty research grant (\$15,000)
 - Assisted in data analysis

Supervisor: Craig Henderson, Ph.D.

July 2017 – Present**Principal Investigator***A multilevel examination of client suicide in training programs in psychology and allied mental health fields (Dissertation Project)*

Department of Psychology and Philosophy

Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Developed a project exploring the current state of graduate training in suicide risk assessment, intervention, and postvention in psychology and allied mental health fields
 - Implemented a Delphi study procedure to develop a measure designed to assess program climate and readiness to address client suicide

Supervisor: Craig Henderson, Ph.D.

March 2015 – August 2018 **Graduate Research Assistant**

Comparison of test administrator use of a keyboard, stylus writing, and pencil writing during WAIS-IV verbal subtest administration: Are there meaningful differences

Department of Psychology and Philosophy
Huntsville, Texas

- Responsibilities:*
- Administered WAIS-IV Verbal Composite subtests and WIAT-III subtests using a variety of administration methods
 - Assisted in preparation of conference submission

Supervisor: Ramona Noland, Ph.D.

November 2016 – March 2017 **Graduate Research Assistant**

The effects of telepsychology on interview disclosure

Department of Psychology and Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Assisted in data collection for a project examining the difference in disclosures of sensitive information between in-person and videoconferencing interviews
 - Developed and managed database of responses
 - Assisted in preparation of conference submission and poster presentation

Supervisor: Jorge Varela, Ph.D.

May 2016 – August 2016 **Contract Researcher**

The Lone Star Project: Study of offender trajectories, associations, and reentry

College of Criminal Justice
Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Interviewed Texas Department of Criminal Justice offenders as part of an NIJ-funded study exploring the implications of gang membership for prison group affiliation, recidivism, and reentry
 - Coded and transcribed data collected from in-person interviews

Supervisor: Erin Orrick, Ph.D.

**August 2014 –
May 2016**

Graduate Research Assistant

Exercise and Mental Health Lab

Department of Psychology and Philosophy

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Coordinated data collection for two-week long daily diary study of exercise, alcohol use, and mental health
 - Assisted in designing a contingency management/Motivational Interviewing intervention for college students engaging in problematic alcohol use
 - Led development, data collection, and data analysis of scale measuring drinking and physical activity motives
 - Assisted in manuscript preparation

Supervisor: Craig Henderson, Ph.D.

**August 2014 –
February 2016**

Graduate Research Assistant

Genres of pornography and their links to sexual behavior and relationship functioning

Department of Psychology and Philosophy

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Designed and implemented statistical analyses using parallel mediation, moderation, and discriminant function analysis
 - Authored full-length manuscript and successfully defended Master's thesis
 - Authored conference submission and poster presentation

Supervisor: Rowland Miller, Ph.D.

**May 2015 –
January 2016**

Contract Researcher

The National Center on Addiction and Substance Use

Columbia University

New York City, New York

- Responsibilities:*
- Participated in weekly didactics and coding groups with fellow research assistants
 - Analyzed and coded videos of Multidimensional Family Therapy sessions using the Therapist Behavior Rating Scale

Supervisor: Molly Bobek, M.A.

August 2013 – August 2015 **Co-Principal Investigator**

An evaluation of the ally development process of community literacy volunteers

Community Literacy Center
Colorado State University
Fort Collins, Colorado

- Responsibilities:*
- Designed and implemented project focused on ally development process of volunteers in a community literacy center
 - Conducted, transcribed, and coded qualitative interviews with community literacy volunteers working at multiple sites
 - Authored book chapter

Supervisor: Tobi Jacobi, Ph.D.

September 2014 – May 2015 **Graduate Research Assistant**

An interdisciplinary multi-site examination of the effects of relational violence and sexual orientation

Department of Psychology and Philosophy
Sam Houston State University
Huntsville, Texas

- Responsibilities:*
- Designed and implemented data analysis plan for grant technical report
 - Assisted in preparation of conference submission and paper presentation

Supervisor: Robert Cramer, Ph.D.

August 2013 – May 2014 **Principal Investigator**

Calling and meaning for volunteers and employees in the correctional system: A qualitative analysis

Department of Psychology
Colorado State University
Fort Collins, Colorado

- Responsibilities:*
- Conducted semi-structured interviews with 20 volunteers in jails and community corrections organizations
 - Transcribed and coded interviews using a grounded theory approach

- Authored full-length manuscript and successfully defended undergraduate thesis

Supervisors: Bryan Dik, Ph.D.; Tara Opsal, Ph.D.

**April 2012 –
May 2013**

Undergraduate Research Assistant

Commitment to treatment in the Czech Republic: An application of the investment model

Department of Sociology

Colorado State University

Fort Collins, Colorado

- Responsibilities:*
- Influenced the development, implementation, and analysis of a comparative study of commitment to drug treatment in Prague, Czech Republic
 - Administered surveys at needle exchange and inpatient drug treatment programs in Prague
 - Established and maintained database of survey responses

Supervisor: Mike Hogan, Ph.D.

PUBLICATIONS

Yasuhara, K., Formon, D., Phillips, S., & **Yenne, E.** (In press). Development of a measure of mental health stigma including police behaviors. *Psychiatry, Psychology, and Law*.

Yenne, E. (2017, Invited Article). Student voice: Learning the importance of professional advocacy. *The National Psychologist*, 26(4), 20.

Cramer, R. J., Wechsler, H. J., Miller, S.L., & **Yenne, E.** (2017). Suicide prevention in correctional settings: Current standards, and recommendations for research, prevention, and training. *Journal of Correctional Health Care*, 23(3), 313-328.

Yenne, E., Alessi, L., & Jacobi, T. (2015). Lockstep literacies: The challenge of social justice work behind bars. In Concannon, K. & Finley, L. (Eds.) *Peace and Social Justice Education on Campus: Faculty and Student Perspectives*. United Kingdom: Cambridge Scholars Publishing.

Yenne, E. (2014, Invited Article). I was in prison and you visited me. *American Jails*, 28(2), 30-34.

PROFESSIONAL RESEARCH PRESENTATIONS

- Yenne, E.**, Henderson, C., & Johnson, D. (2017, November). Training recommendations for responding to client suicide in psychology doctoral training programs. Paper presented at the TPA Annual Conference, Houston, TX.
- Schiafo, M., Henderson, C., **Yenne, E.**, Goodson, A., & Falgout, R. (2017, November). A behavioral economic analysis of the effect of planned next day exercise on alcohol use. Poster presented at the TPA Annual Conference, Houston, TX.
- Formon, D. L. **Yenne, E.**, & Schmidt, A. T. (2017, August). Child and caregiver perceptions of prison stigma: A pilot study of children with incarcerated parents. Paper presented at the APA Annual Conference. Washington, D.C.
- Mattos, L. A., Bernhard, P. A., Varela, J. G., **Yenne, E.**, Kavish, N., Long, T., Holdren, S. M., & Mannose, M. (2017, March). The effects of telepsychology on interview disclosure. Poster presented at the annual meeting of the American Psychology-Law Society, Seattle, Washington.
- Yenne, E.**, Miller, R., Gemberling, T., Lawrence, J., Henderson, C., & Noland R. (2017, January). Use your imagination: Pornography use, attention to relationship alternatives, and relationship satisfaction. Poster presented at the meeting of the Society of Personality and Social Psychology, San Antonio, Texas.
- Henderson, C. E., **Yenne, E.**, Sledd, M., Schiafo, M., Mena, C., Figueroa, M., Missimo, C., Goodson, A., & Langemeier, D. (2016, November). Don't drink and exercise: New research on exercise and alcohol use among college students. Symposium presented at the Annual Meeting of the Texas Psychological Association, Austin, TX.
- Weschler, H.J., Cramer, R.J., Miller, S.L., & **Yenne, E.** (2016, March). Suicide risk assessment and management in correctional settings: Current practices and recommendations for practice, training, and research. In R.J. Cramer (Chair), *Suicide as Self-Directed Violence: Advancements in Conceptualization, Research, Practice, and Training*. Symposium conducted at the meeting of the American Psychology and Law Society, Atlanta, GA.
- Henderson, C. E., Manning, J., Mena, C., **Yenne, E.**, Fabian, J., Nicholas, R., & Thompson, K. (2015, November). The Impact of Daily Physical Activity on Daily Alcohol Use. Poster presented at the annual meeting of the Association of Cognitive and Behavioral Therapies, Chicago, IL.
- Gemberling, T. M., Cramer, R. J., **Yenne, E.**, Nobles, M. R., & Wright, S. (2015, May). The personality of BDSM practitioners. Paper presented at the Alternatives Sexualities Conference, Chicago, IL.

- Yenne, E.** (2014). *Thinking Inside the Box: Community Literacy with Confined Populations*. Poster presented at the Celebrate Undergraduate and Research Symposium, Fort Collins, CO.
- Yenne, E.** (2014). *Serving a Life Sentence: A Qualitative Analysis of Volunteers and Non-sworn Employees in a County Jail*. Poster Presented at the Celebrate Undergraduate and Research Symposium, Fort Collins, CO.
- Jones, M., **Yenne, E.**, Oliva, C., Wang, D., & Zheng, B. (2014). *CoCoRaHS: Analysis of Multiple Day Reports*. Poster presented at the Celebrate Undergraduate Research Symposium, Fort Collins, CO.
- Yenne, E.**, Conrad, L. (2013). *Calling as it Pertains to Homemakers: A Preliminary Study*. Poster presented at the Celebrate Undergraduate Research and Creativity Symposium, Fort Collins, CO.
- Loebel, G., **Yenne, E.**, Ahn, J., & Conrad, L. (2012). *How Presence of Calling Relates to Interests, Personality, and Values*. Poster presented at the Celebrate Undergraduate Research and Creativity Symposium, Fort Collins, CO.
- Yenne, E.** (2011). *Encore Careers*. Poster Presented at the Celebrate Undergraduate Research and Creativity Symposium, Fort Collins, CO.

WORKSHOP PRESENTATIONS

- Yenne, E.**, Salami, T., & Henderson, C. (2018). But I have a ___ friend!: The impact of microaggressions in every day life. Workshop presented at the Sam Houston State University 14th annual Diversity Leadership Conference, Huntsville, TX.
- Long, T., **Yenne, E.**, & Henderson, C. (2018, February). *SHSU Clinical Psychology Doctoral Program Diversity Committee: Successes, Challenges, and Future Directions*. Workshop presented at the 14th annual Diversity Leadership Conference, Huntsville, TX.
- Alessi, L., **Yenne, E.**, Pait, O., Devens, B., & Jacobi, T. (2014, March). *Locked in a Gendered Box: The Interaction between Gender and Incarceration*. Workshop presented at the Colorado State University Women's Conference, Fort Collins, CO.

PROFESSIONAL SERVICE AND LEADERSHIP

**September 2018 –
Present**

Student Representative
Capital Area Psychological Association
Austin, Texas

- Responsibilities:*
- Serve as the sole student member of the executive committee
 - Participate in legislative visits to advocate for legislative issues pertaining to the practice of psychology

Supervisor: John Godfrey, Ph.D.

April 2017 – August 2018 **Student Member**
Clinical Psychology Doctoral Program Diversity Committee
 Department of Psychology and Philosophy
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Founding member of committee developed to recruit and retain diverse faculty and students and improve doctoral training in diversity issues
 - Assisted in the development of committee mission statement
 - Participated in diversity segment of faculty interviews
 - Coordinated training for junior doctoral students in working with LGBTQ+ clients

Supervisor: Craig Henderson, Ph.D.

June 2017 – May 2018 **Student Extern**
Sam Houston Area Psychological Association
 The Woodlands, Texas

- Responsibilities:*
- Organized, advertised, and attended monthly meetings and professional development presentations/discussions
 - Recorded and maintained business meeting minutes and other society documentation
 - Attended several Texas Psychological Association Legislative Day events in Austin, Texas to advocate for legislative issues pertaining to the practice of psychology

Supervisors: Wendy Elliott, Ph.D. & Craig Henderson, Ph.D.

August 2015 – August 2016 **Student Representative to the Doctoral Program Faculty**
Clinical Psychology Doctoral Program
 Sam Houston State University
 Huntsville, Texas

- Responsibilities:*
- Attended weekly faculty meetings and recorded and communicated faculty and program business to student body

- Acted as liaison between students and faculty regarding faculty and program news and concerns and suggestions for program improvement
- Organized, administered, and communicated annual program review feedback from students to faculty and vice versa
- Coordinated and planned interview weekend for candidates for admission to the doctoral program
- Served as student member of faculty search committee to relay student feedback about job candidates for tenure track faculty positions

Supervisor: Jorge Varela, Ph.D.

**January 2015 –
May 2015**

Research Mentor

Psi Chi Honors Society

Department of Psychology and Philosophy

Sam Houston State University

Huntsville, Texas

- Responsibilities:*
- Led monthly article discussions with Psi Chi members
 - Taught basic statistics tutorials

Supervisor: Robert Cramer, Ph.D.

HONORS, AWARDS, & SCHOLARSHIPS

**August 2010 –
May 2014**

Boettcher Foundation Scholarship

Boettcher Foundation

**August 2010 –
May 2014**

Honors Scholarship

Colorado State University

**August 2010 –
May 2014**

Green and Gold Scholarship

Colorado State University

May 2014

Academic Enrichment Award

Colorado State University

April 2014

1st Place Service Learning Award

Celebrate Undergraduate Research and Creativity Symposium

Colorado State University

April 2014

Colorado Experience Student Delegate

Colorado Leadership Alliance

April 2014

Student Leader of the Year

Colorado Leadership Alliance

Summer 2013	<i>Educational Enrichment Grant (\$3,500)</i> Boettcher Foundation
Fall 2013	<i>Honors Enrichment Grant (\$350)</i> Colorado State University
Fall 2013	<i>Featured Student Profile on Colorado State University Website</i> http://www.colostate.edu/features/elise-yenne.aspx

PROFESSIONAL MEMBERSHIPS

2018 – Present	Capital Area Psychological Association
2016 – Present	Texas Psychological Association
2015 – Present	American Psychology-Law Society
2015 – Present	American Psychological Association
2017 – 2018	Sam Houston Area Psychological Association
2016 – 2017	Society for Personality and Social Psychology