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Suicide Intervention Skills: Graduate Training and Exposure to Suicide among Psychology Trainees

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Suicide is a serious public health problem. More than 38,000 Americans completed suicide in 2010, making it the 10th leading cause of death in the United States (Centers for Disease Control and Prevention, 2012). One-third of individuals who complete suicide met with a mental health professional in the year prior to their death, and 20% had contact with a mental health professional during the final month of their life (Luoma, Martin, & Pearson, 2002).

Providing care to clients at risk of suicide is common among mental health professionals, even during their graduate training years. As many as 99% of psychologists during graduate school treated one or more clients who endorsed suicidal ideation or suicidal behavior (Dexter-Mazza & Freeman, 2003; Kleespies, Penk, & Forsyth, 1993). One in six psychology interns has worked with a client who completed suicide (Kleespies, Becker, & Smith, 1990; Kleespies et al., 1993), and between 22% and 29% of psychologists have had a client who died by suicide (Chemtob, Hamada, Bauer, Torigoe, & Kinney, 1988; Pope & Tabachnick, 1993). These numbers have led some researchers to suggest that experiencing the death of a client by suicide is an “occupational hazard” among psychologists (Chemtob, Bauer, Hamada, Pelowski, & Muraoka, 1989).

Death of a client by suicide may have serious personal and professional ramifications for clinicians, including viewing the client’s demise as a personal failure and feeling incapacitated with professional self-doubt (Foster & McAdams, 1999). Clinicians-in-training report more stress (Rodolfa, Kraft, & Reilley, 1988) and endorse more severe

reactions after client suicide than do clinicians whose careers are more advanced (Kleespies et al., 1990). Trainees who have had a client die by suicide also describe feelings of failure, disbelief, self-blame, shame, shock, sadness, and depression (Hendin, Lipschitz, Maltsberger, Haas, & Wynecoop, 2000; Kleespies et al., 1993). Although some attention has been paid to the experiences of trainees who have had a client die by suicide, literature on clinicians' personal experiences of bereavement resulting from suicide (e.g., suicide of a family member) is virtually nonexistent.

Integrating formal training in suicide risk assessment and management within doctoral psychology curricula is fundamental to providing students with the requisite skills to treat high-risk clients. Preparing novice clinicians to assess and to treat competently individuals who are at risk for suicidal behavior has life-saving implications. Despite the frequency with which trainees provide care to clients who are at risk of suicide, there is a lack of graduate training in the assessment and management of suicidal clients. In the late 1980s, Bongar and Harmatz (1989) conducted a seminal study that revealed the dearth of training on the study of suicide in clinical psychology programs. Of the 92 doctoral programs surveyed, only 35% reported offering their students formal training in managing suicidal clients. Over a decade later, Dexter-Mazza and Freeman (2003) surveyed 131 predoctoral internship programs across the United States and found that training had only increased by roughly 10%. These findings suggest that there are likely large numbers of fledgling clinicians who are ill-equipped to assess or to treat their most at-risk clients, which highlights the need for increased training in graduate programs.

This topic has received minimal attention in the literature over the last decade. In the past year, however, a resurgence of compelling arguments has emphasized the critical importance of effective training of professionals who will provide care to clients at risk of suicide. As stated by Schmitz and colleagues (2012), "Competence in the assessment of suicidality is an essential clinical skill that has consistently been overlooked and dismissed by the colleges, universities, clinical training sites, and licensing bodies that prepare mental health professionals" (p. 3). The 2012 National Strategy for Suicide Prevention (see Supplemental Table 1) stressed the importance of integrating effective training in suicide prevention and intervention to curricula for clinicians-in-training (U.S. Department of Health and Human Services, 2012). A task force organized by the American Association of Suicidology recently provided recommendations to increase the accountability of mental health training and accrediting bodies as a means of rectifying this gap (Schmitz et al., 2012). Additionally, in 2012, Washington became the first state to pass a law mandating that mental health professionals complete training in suicide assessment, treatment, and management as part of their continuing education requirements.

The purposes of the current study were (1) to investigate the relationships among training-related variables (e.g., year in graduate training, length of clinical practicum experience, formal training in suicide assessment) and competence to respond to suicidal client statements, (2) to determine the prevalence of personal experiences of bereavement by suicide among psychology graduate students, and (3) to examine the relationship between personal exposure to suicide and competence to respond to suicidal client statements. It was hypothesized that trainees who were more advanced in their graduate program or who had

received formal training in suicide assessment and management would respond more skillfully to suicidal client statements than those with less training. It was also hypothesized that no differences would be observed between students who had or had not been bereaved by suicide.

Method

Procedure

Participants were recruited between September 2010 and February 2011 at an American Psychological Association (APA)-accredited clinical psychology doctoral program in the southern United States. Students at all levels of doctoral training were invited to participate. Data were collected in all classes in which faculty members agreed to allow their students to be recruited. Students were also recruited during a lunch-hour lecture on a topic unrelated to suicide that was open to all students.

Students were informed that their participation was voluntary, that their grade would not be affected by their willingness to participate, and that their responses to the questionnaires would remain anonymous. Students were informed that the purpose of the study was to learn about their perspectives on suicide and training experiences. Each student was provided with a survey packet; the cover page included a consent form that described the purpose of the study. Study procedures were approved by the university's Institutional Review Board.

Measures

Demographic and Training Information—Participants were asked to indicate their age, sex, ethnic/racial background, year in graduate training, and level of practicum training. Participants were asked a series of other questions related to their exposure to training in suicide assessment, supervision on suicide assessment and intervention, perceived knowledge about risk factors for suicide, and confidence in assessing and documenting suicide risk. They were also queried about the extent to which they had worked with clients who endorsed suicidality or who had engaged in some form of self-directed violence (e.g., non-suicidal self-injury). They were also asked how common they believed it is for trainees to work with clients at risk of suicidal behavior. Finally, we inquired about participants' personal experiences with bereavement by suicide (i.e., "Have you ever known anyone who completed suicide?") and solicited information about survivors' relationship to the person(s) they had known who died by suicide.

Suicide Intervention Response Inventory–Revised (SIRI-2)—The SIRI is a self-administered questionnaire designed to assess respondents' competence in selecting appropriate therapeutic responses to suicidal statements (Neimeyer & Pfeiffer, 1994). The SIRI-2 is comprised of 25 hypothetical client statements that imply some degree of suicidality. Each item includes two "helper" replies. The original scoring system required respondents to identify the more appropriate of the two responses. That system demonstrated a ceiling effect among more skilled respondents, making it less sensitive to the effects of training. The SIRI-2 revision involved a modification from dichotomous scoring to a 7-point Likert scale scoring method, which removed ceiling effects and improved psychometric

properties (Neimeyer & Bonnelle, 1997). Respondents are asked to rate the level of helpfulness of each helper response on a 7-point Likert scale, ranging from +3 (“highly appropriate”) to −3 (“highly inappropriate”). Scores are calculated based on the summed discrepancy from responses that were obtained from a group of experts in the field of suicidology, with lower scores indicating superior performance. Scores range from 12.90 to 247.28. Robust internal consistency (.90 - .93) and test-retest reliability (.92) have been reported for this measure (Neimeyer & Bonnelle, 1997). Since initial analyses revealed that SIRI-2 scores were positively skewed, medians, rather than means, are reported when discussing SIRI-2 scores, and nonparametric tests were used. Participants’ SIRI-2 scores ranged from 28.7 to 96.0, with a median score of 45.4.

Results

Participants

Fifty-nine doctoral clinical psychology students participated in this study. Most participants were female (91.5%) and ranged in age from 22 to 48 years, with a mean age of 26.77 ($SD = 4.92$). The majority (66.1%) identified as Caucasian. Participants were most commonly in their third year of doctoral training (49.2%) and were completing their second year of clinical practicum (33.9%; see Table 1 for additional demographic and training information).

Training Experiences and Perception of Skills

The majority of trainees (76.3%) reported receiving in-class training on suicide assessment or intervention during their current graduate training program. Twenty-six students reported attending a prior graduate program; of those, only 6.8% reported in-class training during their prior training program. Of the 40 students who had begun treating clients in the context of clinical practica, only 8 (20.0%) reported receiving clinical supervision focused on suicide assessment. Other means of learning about suicidality and the most common training topics to which students had been exposed in class, during clinical supervision, or by self-study are shown in Table 2. Participants were also asked to rate on a 4-point Likert scale (i.e., *strongly disagree*=1, *disagree*=2, *agree*=3, *strongly agree*=4) how knowledgeable and confident they perceived themselves to be in working with suicidal clients. Scores on those items were normally distributed, with few students endorsing the extremes (see Figure 1).

Trainees’ Exposure to Clients with Suicidal Behavior

Of the participants whose clinical training had begun (i.e., they had started at least their first practicum; $n = 40$), almost half (45.0%) reported seeing clients who endorsed non-suicidal self-injury. Twenty trainees (50.0%) reported treating clients who endorsed suicidal ideation, most of those trainees provided care to one or two clients who endorsed suicidal thoughts; however, one respondent reported having as many as 50 clients who had reported suicidal ideation. Almost half of the students who had started practicum (45.0%) reported working with clients who had one or more prior suicide attempts. One trainee indicated that she had worked with a client who completed suicide while in her care.

Bereavement by Suicide among Trainees

Forty-one percent ($n = 24$) of study participants reported knowing someone personally (i.e., outside of their professional work) who had completed suicide. Most trainee survivors knew one ($n = 12$) to two ($n = 10$) people who died by suicide, though two trainees reported knowing four or more. Respondents indicated that the person who completed suicide was most commonly a friend (19.0%; see Table 1).

Impact of Demographic Factors and In-Class Training on SIRI-2 Scores

As shown in Table 3, results of a Mann-Whitney U test demonstrated that Caucasian participants' SIRI-2 scores were significantly lower (i.e., they responded more skillfully) compared to those who identified as any other ethnicity. SIRI-2 scores did not differ between males and females, and scores were unrelated to age, $r(56) = .16, p = .23$.

The hypothesis that more advanced trainees would perform better on the SIRI-2 was partially supported. A Kruskal-Wallis test indicated no significant differences in SIRI-2 scores across year in the graduate program, $\chi^2(3, 59) = 1.18, p = .76$. However, there was a trend toward significance between practicum levels, with students in their second year of practicum tending to score better on the SIRI-2 than those in their first year of practicum, $\chi^2(3, 59) = 7.40, p = .06$.

It was hypothesized that students who reported formal training in suicide prevention/intervention would outperform students who did not endorse training. This hypothesis was not supported (see Table 3). Of the students who had started their clinical practica, those who had received program-sanctioned supervision specifically focused on suicide assessment did not obtain significantly different scores on the SIRI-2 compared to those who denied exposure to clinical supervision on this topic. Furthermore, SIRI-2 scores of students who were exposed to both supervision and formal training on matters related to suicide did not significantly differ from the scores of students who had only supervision, only formal training, or neither, $\chi^2(2, 40) = 1.86, p = .39$.

Bereavement by Suicide, Clinical Experience, and SIRI-2 Performance

As hypothesized, participants who knew someone who completed suicide performed similarly on the SIRI-2 compared to trainees without a history of bereavement by suicide (see Table 3). Of the students who had started their clinical practica, those who reported treating client(s) who endorsed suicidal ideation or a history of suicide attempts scored significantly better on the SIRI-2 than those who denied seeing client(s) with suicidal thoughts or a history of suicide attempts. Students who reported working with client(s) with non-suicidal self-injury did not score differently on the SIRI-2 compared to respondents who denied ever having clients with non-suicidal self-injury.

Relationship Between Self-Perception and SIRI-2 Performance

SIRI-2 scores were found to vary as a function of self-ratings of knowledge about risk factors, $\chi^2(3, 59) = 10.23, p = .02$, with those who "agreed" scoring better ($Md = 44.0$) than those who "disagreed" ($Md = 50.3, p = .01$). SIRI-2 scores also differed significantly across ratings of perceived confidence in ability to document suicidality appropriately, $\chi^2(3, 58) =$

8.07, $p = .04$, with “agree” ($Md = 44.8$) respondents scoring significantly better than those who answered “strongly disagree” ($Md = 61.9$, $p = .02$). Kruskal-Wallis tests indicated no significant differences in SIRI-2 scores based on self-ratings of one’s confidence to assess for suicidality, $\chi^2(3, 59) = 5.21$, $p = .16$, or perceived knowledge of legal and/or ethical issues related to suicide, $\chi^2(3, 58) = 4.30$, $p = .23$.

Discussion

The purposes of this study were to characterize graduate psychology students’ training experiences in relationship to their skills in responding effectively to hypothetical statements by suicidal clients and to investigate psychology graduate students’ experiences with bereavement by suicide. Consistent with prior research (Dexter-Mazza & Freeman, 2003; Kleespies et al., 1993), the majority of trainees who had started clinical work reported providing care to clients who endorsed either non-suicidal self-injury, suicidal ideation, or a past suicide attempt. Most trainees indicated they had received some in-class education on suicide assessment, which is promising given the dearth of such training that has been noted in prior studies. Nevertheless, 20.0% of students who were engaged in client care reported that suicide had been discussed in the context of clinical supervision, and five of those students also denied receiving formal training on suicide assessment. These findings are particularly concerning given the high rate of students who reported treating at-risk clients. Many trainees had independently accessed sources of information to augment their knowledge of issues related to suicidality, most frequently through personal reading. This suggests that students appreciate that issues related to suicidality are important and that their training and supervision on such topics may not be as extensive as they desire. Forty-one percent of the current sample reported having known someone who died by suicide. Rates of survivorship among the general population are unknown, thus precluding us from making inferences about whether bereavement by suicide is more or less common among graduate psychology trainees. Trainees who were bereaved by suicide performed similarly to their non-bereaved peers on the SIRI-2, suggesting that personal experiences with suicide do not necessarily improve or impede one’s skill in responding to suicidal statements made by clients.

In partial support of our hypothesis, there was a trend toward more skilled responding among students who had completed more clinical training, which suggests that skills in suicide assessment and intervention do mature with experience (Range & Richards, 2001). Moreover, treating a client(s) with suicidal ideation and/or a history of suicide attempts was associated with better performance on the SIRI-2, indicating that exposure to suicidal clients may promote skill development, though this does not in and of itself ensure preparedness to treat high-risk clients. In contrast to our hypothesis, no differences in SIRI-2 performance were observed between students who had been exposed to classroom training on suicide assessment or intervention and those who had not. This may indicate that the formal training that is being implemented is inadequate. We concur with Schmitz and colleagues (2012) who purported that information alone is necessary but not sufficient for fostering the development of skills to treat clients who are suicidal. No differences were observed among students who reported receiving supervision on the topic of suicidality, but the small number

of respondents who endorsed receiving supervision likely left the analysis underpowered, possibly obscuring differences between groups.

Among doctoral students in the current sample, Caucasian trainees performed better on the SIRI-2 than did non-Caucasian trainees. Similar findings were reported in a prior study by Brown and Range (2005). While this finding may be a manifestation of cultural differences, we propose that it may also be indicative of other underlying factors that may influence one's perspective on the topic of suicide, such as socioeconomic status or prior life experiences. It may also be useful in future research to investigate cultural differences in responding, which may have implications for tailoring responses to be as culturally appropriate as possible.

Implications for Training

The results of this study have valuable implications for training but may also raise more questions than answers. For instance, although no differences were observed between trainees who were bereaved by suicide compared to those who were not on the SIRI-2, the finding that so many trainees have lost someone to suicide may have implications for training. Are students who know someone who completed suicide more or less likely to perceive risk or to assess suicidality among their clients? Are they more or less likely to bring up this topic in supervision? Are they more likely to seek peer supervision? These questions have not yet been explored in the research literature.

Students who felt confident in their knowledge of risk factors and skill in documenting suicidality responded more effectively on the SIRI-2 than students whose confidence was lacking. This finding suggests that students' self-perceptions may be a reasonably accurate gauge of their skill levels. Surveying students about their knowledge base may be a useful way to begin to implement targeted training. However, if knowledge alone is insufficient to prepare trainees for the responsibility of providing care for clients who are at risk of self-directed violence, as suggested by Schmitz et al. (2012), then alternative ways to facilitate trainees' mastery of these skills must be developed. Our findings indicate that exposure to clients who are suicidal is associated with better performance on the SIRI-2, suggesting that exposure to high-risk clients may be crucial skill-building experience for new clinicians. There is a growing body of research evaluating the efficacy of training in suicide assessment and intervention. Fenwick, Vassilas, Carter, and Haque (2004) utilized the SIRI-2 to track whether full-day workshops or half-day lectures improved health professionals' skills in responding to suicidal statements by hypothetical clients. Both delivery formats yielded improved performance, and gains were maintained at two-month follow-up. Studies have demonstrated that training may yield increased proficiency in assessment, documentation, and risk management skills (McNiel et al., 2008; Morriss, Gask, Battersby, Francheschini, & Robson, 1999), as well as increased confidence in treating clients who are suicidal (Oordt, Jobes, Fonseca, & Schmidt, 2009; Sockalingam, Flett, & Bergmans, 2010). These findings underscore that with evidence-based training, skill—and presumably client care—can be improved.

Although there is mounting evidence that brief trainings may yield lasting benefits, a more gradual approach may be more appropriate, particularly for novice clinicians. We contend

that honing skills for effectively managing such clients is a fundamental domain of competency for psychology trainees, and determining how best to prepare trainees for the responsibility of managing clients who are suicidal requires diligence on the part of graduate programs and predoctoral internships. Consistent with the APA Task Force on the Assessment of Competence in Professional Psychology (2006), Kleespies (2014) described a multimodal teaching paradigm that enables clinicians-in-training to learn from a supervising mentor(s) and to gradually assume clinical responsibility as their skills mature. The importance of evaluating skills development in real-world settings (e.g., emergency department) or settings that replicate as closely as possible those situations that are likely to be encountered in clinical practice (e.g., standardized patients) is emphasized. Such an approach may prove advantageous for promoting mastery of key competencies associated with assessing and managing clients at risk of self-directed violence, as well as for reducing the stress associated with the process of acquiring these skills.

Limitations

This study has a number of important limitations that warrant discussion. First, the study sample was small, and data were collected at a single doctoral program in the southern United States, which may limit the power of the analyses as well as the generalizability of findings. We found that over 75% students had received in-class training on suicide assessment in their current graduate program, compared to less than 10% in their prior program. This finding should be interpreted with caution, as it may suggest that this particular program is fairly diligent in addressing this topic, at least in the classroom. It does not necessarily indicate that graduate training programs in general are more attuned to this aspect of training than in the past. Moreover, females were overrepresented in this study, with women making up over 90% of the sample compared to 75% nationally in doctoral psychology departments (Hart, Wicherski, & Kohout, 2010). Further study of a larger sample of students from a representative selection of graduate training programs is warranted. Finally, because this study relied exclusively on self-report, the ways in which training experiences may have varied from student-to-student were impossible to discern.

Summary and Conclusions

By the time that graduate students in psychology have completed their training, nearly all have treated clients with a history of or current suicidal thoughts or behaviors. As graduate training in psychology shifts increasingly toward a competency-based training paradigm (Schaffer, Rodolfa, Hatcher, & Fouad, 2013), identifying benchmarks for skill development in suicide assessment and intervention is critical to advancing training in this area. Cramer, Johnson, McLaughlin, Rausch, and Conroy (2013) recently proposed a series of core competencies in suicide risk assessment training for doctoral programs in psychology. It would behoove training programs to consider how curricula may be augmented to include real-world training experiences and supervision that facilitate attainment of critical knowledge- and skill-based competencies related to the assessment and management of suicidal clients. Curricula should also be sensitive to ways in which personal or professional exposure to suicidality might influence trainees' attitudes about suicide. As gatekeepers of the profession, it is the responsibility of training institutions and accrediting bodies to attend

to the needs of students and to the public by preparing fledgling clinicians to effectively meet the needs of their most at-risk clients.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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References

- APA Task Force on the Assessment of Competence in Professional Psychology. APA Task Force on the Assessment of Competence in Professional Psychology: Final report. Washington, DC: American Psychological Association; 2006 Oct.
- Bongar B, Harmatz M. Graduate training in clinical psychology and the study of suicide. *Professional Psychology: Research and Practice*. 1989; 20(4):209–213.
- Brown MM, Range LM. Responding to suicidal calls: Does trait anxiety hinder or help? *Death Studies*. 2005; 29(3):207–216. [PubMed: 15816112]
- Centers for Disease Control and Prevention. Web-based Injury Statistics Query and Reporting System (WISQARS). Leading causes of death reports, national and regional, 1999 – 2010. 2012. Retrieved from www.cdc.gov/injury/wisqars/index.html
- Chemtob CM, Bauer GB, Hamada RS, Pelowski SR, Muraoka MY. Patient suicide: Occupational hazard for psychologists and psychiatrists. *Professional Psychology: Research and Practice*. 1989; 20(5):294–300.
- Chemtob CM, Hamada RS, Bauer G, Torigoe RY, Kinney B. Patient suicide: Frequency and impact on psychologists. *Professional Psychology: Research and Practice*. 1988; 19(4):416–420.
- Cramer RJ, Johnson SM, McLaughlin J, Rausch EM, Conroy MA. Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and Education in Professional Psychology*. 2013; 7(1):1–11. [PubMed: 24672588]
- Dexter-Mazza ET, Freeman KA. Graduate training and the treatment of suicidal clients: The students' perspective. *Suicide and Life-Threatening behavior*. 2003; 33(2):211–218. [PubMed: 12882422]
- Fenwick CD, Vassilas CA, Carter H, Haque MS. Training health professionals in the recognition, assessment and management of suicide risk. *International Journal of Psychiatry in Clinical Practice*. 2004; 8(2):117–121. [PubMed: 24926844]
- Foster VA, McAdams CR III. The impact of client suicide in counselor training: Implications for counselor education and supervision. *Counselor Education & Supervision*. 1999; 39(1):22.
- Hart, BM.; Wicherski, M.; Kohout, JL. 2008–2009 master's- and doctoral-level students in U.S. and Canadian graduate departments of psychology. Washington, DC: Center for Workforce Studies: American Psychological Association; 2010.
- Hendin H, Lipschitz A, Maltzberger JT, Haas AP, Wyncoop S. Therapists' reactions to patients' suicides. *American Journal of Psychiatry*. 2000; 157(12):2022–2027. [PubMed: 11097970]
- Kleespies, PM. Decision making in behavioral emergencies: Acquiring skill in evaluating and managing high-risk patients. Washington, DC: American Psychological Association; 2014.
- Kleespies PM, Becker BR, Smith MR. Psychology interns as patient suicide survivors: Incidence, impact, and recovery. *Professional Psychology: Research and Practice*. 1990; 21(4):257–263.
- Kleespies PM, Penk WE, Forsyth JP. The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research and Practice*. 1993; 24(3): 293–303.

- Luoma JB, Martin CE, Pearson JL. Contact with mental health and primary care providers before suicide: A review of the evidence. *American Journal of Psychiatry*. 2002; 159(6):909–916. [PubMed: 12042175]
- McNiel DE, Fordwood SR, Weaver CM, Chamberlain JR, Hall SE, Binder RL. Effects of training on suicide risk assessment. *Psychiatric Services*. 2008; 59(12):1462–1465. [PubMed: 19033175]
- Morriss R, Gask L, Battersby L, Francheschini A, Robson M. Teaching front-line health and voluntary workers to assess and manage suicidal patients. *Journal of Affective Disorders*. 1999; 52(1–3):77–83. doi: [http://dx.doi.org/10.1016/S0165-0327\(98\)00080-9](http://dx.doi.org/10.1016/S0165-0327(98)00080-9). [PubMed: 10357020]
- Neimeyer RA, Bonnelle K. The Suicide Intervention Response Inventory: A revision and validation. *Death Studies*. 1997; 21(1):59–81. [PubMed: 10169714]
- Neimeyer RA, Pfeiffer AM. Evaluation of suicide intervention effectiveness. *Death Studies*. 1994; 18(2):131–166. [PubMed: 10133100]
- Oordt MS, Jobes DA, Fonseca VP, Schmidt SM. Training mental health professionals to assess and manage suicidal behavior: Can provider confidence and practice behaviors be altered? *Suicide and Life-Threatening Behavior*. 2009; 19(1):21–32. [PubMed: 19298147]
- Pope KS, Tabachnick BG. Therapists' anger, hate, fear, and sexual feelings: National survey of therapist responses, client characteristics, critical events, formal complaints, and training. *Professional Psychology: Research and Practice*. 1993; 24(2):142–152.
- Range K, Richards LM. Is training in psychology associated with increased responsiveness to suicidality? *Death Studies*. 2001; 25(3):265–279. [PubMed: 11785543]
- Rodolfa ER, Kraft WA, Reilley RR. Stressors of professionals and trainees at APA-approved counseling and VA medical center internship sites. *Professional Psychology: Research and Practice*. 1988; 19(1):43–49.
- Schaffer JB, Rodolfa ER, Hatcher RL, Fouad NA. Professional psychology competency initiatives: Reflections, contrasts, and recommendations for the next steps. *Training and Education in Professional Psychology*. 2013; 7(2):92–98.
- Schmitz WM Jr, Allen MH, Feldman BN, Gutin NJ, Jahn DR, Kleespies PM, Simpson S. Preventing suicide through improved training in suicide risk assessment and care: An American Association of Suicidology Task Force report addressing serious gaps in U.S. mental health training. *Suicide and Life-Threatening Behavior*. 2012; 42(3):292–304. [PubMed: 22494118]
- Sockalingam S, Flett H, Bergmans Y. Pilot study in suicide intervention training using a group intervention for patients with recurrent suicide attempts. *Academic Psychiatry*. 2010; 34(2):132–135. [PubMed: 20224024]
- U.S. Department of Health and Human Services. 2012 National Strategy for Suicide Prevention: Goals and objectives for action. Washington, DC: HHS; 2012. Retrieved from <http://www.surgeongeneral.gov/library/reports/national-strategy-suicide-prevention/full-report.pdf>

Figure 1.
Trainees' perceived knowledge of suicide-related topics and confidence in assessment and documentation of suicide risk.

Table 1

Sample Demographics, Training Experiences in Suicide Assessment or Intervention, and Exposure to Bereavement by Suicide

	<i>n</i>	%
Ethnicity		
African American, Afrocaribbean, or Black	7	11.9
Asian American or Pacific Islander	3	5.1
Caucasian or White	39	66.1
Hispanic or Latino(a)	9	15.3
Did not report	1	1.7
Year in graduate training		
First year	15	25.4
Second year	8	13.6
Third year	29	49.2
Fourth year or higher	7	11.9
Level of clinical practicum experience		
No practicum experience	19	32.2
First practicum year	13	22.0
Second year practicum	20	33.9
Completed all required practica	7	11.9
Knew someone who completed suicide (<i>n</i> = 24)		
Knew 1 person	12	20.3
Knew 2 people	10	16.9
Knew 3 people	0	0.0
Knew 4 or more people	2	3.4
Relationship to person who completed suicide		
Father	1	1.7
Grandparent	2	3.4
Aunt or uncle	2	3.4
Friend	11	18.6
Coworker	2	3.4
Classmate	2	3.4
Acquaintance	9	15.3
Client or patient	1	1.7
Other ^a	4	6.8

^aFamily friend (*n* = 1), roommate (*n* = 1), not specified (*n* = 2)

Table 2

Trainees' Means of Learning about Suicidality and Exposure to Training Topics in Class, Clinical Supervision, or Self-Study

	<i>n</i>	%
Other means of learning about suicidality		
Personal reading	28	47.5
Continuing education courses open to students	22	37.3
Socialization with peers	21	35.6
Employment outside graduate training	14	23.7
Training topics		
Suicide risk assessment	38	64.4
Legal and/or ethical issues	32	54.2
Suicide prevention	31	52.5
No-harm contracting	29	49.2
Charting/documentation	25	42.4
Postvention	13	22.0

Table 3

Results of Mann-Whitney U Tests Comparing SIRS-2 Scores (n = 59)

		Median SIRS-2 Score	n	U	p	r
Gender						
Male		47.7	5	127	.84	.03
Female		45.2	54			
Ethnicity						
Caucasian		43.7	39	148	<.001	.48
Non-Caucasian		64.7	19			
Bereaved by suicide						
Yes		44.6	24	390	.92	.01
No		45.4	33			
Received formal training						
Yes		45.1	46	262	.49	.09
No		48.4	13			
Received supervision ^a						
Yes		42.8	8	89	.19	.21
No		47.5	32			
Ever had client(s) with SI ^a						
Yes		43.0	20	108	.01	.39
No		53.4	20			
Ever had client(s) with a history of suicide attempt(s) ^a						
Yes		42.0	18	108	.01	.39
No		53.4	22			
Ever had client(s) with NSSI ^a						
Yes		45.0	18	158	.28	.17
No		52.8	22			

^a Analysis includes only participants who had started clinical practicum (n = 40)

SI = suicidal ideation; NSSI = non-suicidal self-injury