Structure and Facilitation in Clinical Supervision when Clients Present with Varying Levels of Suicidal Risk

by

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ABSTRACT

In this study, I investigated supervisory practices (i.e., structure and facilitation) when training therapists of differing levels of experience and self-efficacy are working with clients presenting with varying levels of suicidal risk (i.e., low or high). While previous research has supported that trainees need and want less structure and direction from their supervisors and become more self-efficacious as they gain more experience, this same assumption may not hold for crisis situations, such as when clients present with suicidal risk. To examine how trainees rate the quality of clinical supervision when working with clients presented with varying levels of suicidal risk, and how this may vary according to trainee experience level and trainee self-efficacy, an experimental design was used in which trainees read vignettes of pretend clients and supervisory sessions. It was hypothesized that quality ratings of supervision and client risk level, trainee experience level, and trainee self-efficacy would be moderated by the type of supervisory practice received. Results found significant main effects for trainee experience level, client risk level, and type of supervision received on supervision quality ratings, but no significant moderations. Clinical implications for supervisory practices and future directions for research are discussed.

DEDICATION

For Simon, without whom none of this would have been possible.

Für Simon, ohne den das alles nicht möglich gewesen wäre.

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CHAPTER 1

PROBLEM IN PERSPECTIVE

Therapists in training (trainees) are likely to work with a client presenting with suicidal risk during their graduate program (Dexter-Mazza & Freeman, 2003; Watcher Morris & Barrio, 2012). Clients' thoughts, plans, access to means, and intent to end their lives must be assessed, in addition to protective factors, to determine the probability of risk so appropriate steps can be taken to best protect client welfare (American Psychological Association, 2017; Shea, 2011). However, few graduate programs implement coursework or separate specific trainings on suicide risk assessment and intervention (Dexter-Mazza & Freeman, 2003; Watcher Morris & Barrio Minto, 2012; Wozny, 2005). Therefore, trainees may depend on their supervisor to provide them with guidance and information when clients are presenting with suicidal concerns (Dexter-Mazza & Freeman 2003; Hoffman, Osborn, & West, 2013; Mackelprang, Karle, Reihl, & Cash, 2014). One model supervisors may use is the Suicide Assessment Five-step Evaluation and Triage (SAFE-T), which guides clinicians through assessing client risk level (i.e., low, moderate, or high) based upon risk and protective factors to help them inform their choice of intervention that is best suited for the client's welfare (APA, 2003; SAFE-T, 2009). As each risk level requires different inventions and assessment skills, supervisors may choose different supervisory techniques to best help their trainees through the risk assessment and intervention process and protect client welfare. However, how supervisory approaches may vary according to client risk level has not been well examined.

Developmental models of trainee progress, such as the Integrated Developmental Model, (IDM; Stoltenberg, 1981; Stoltenberg & McNeill, 2010; Stoltenberg, McNeill, & Delworth, 1998) posit that trainees' supervisory needs vary depending on their level of experience (Stoltenberg, McNeill, & Crethar, 1994). Level 1 trainees tend to be highly anxious, self-focused, and motivated. Level 2 trainees have developed the ability to focus more on the client, experience varying levels of motivation, and may often clash with their supervisor as they struggle between dependency on their supervisor and their own developing autonomy. Level 3 trainees generally have found a balance in which they are able to focus on their own and the client's experience, can navigate setbacks, and share the power in supervision as they view their supervisor as more of a consultant. Level 3*i* trainees can be considered "experts" and know when to consult (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997).

Supervisors should be mindful of their trainees' experience level when choosing supervisory interventions to best ensure trainees' needs are being met. Two main types of supervisory interventions are structured approaches (e.g., receiving direct advice or feedback; Heron, 1990) and facilitative approaches (e.g., incorporation of trainee ideas and expertise; Heron, 1990). As Level 1 trainees feel highly anxious and are self-focused, they benefit from structured approaches to help reduce anxiety and develop confidence, so they can begin to enter the client's worldview more. Additionally, as they are highly motivated, they respond well to specific direction or resources as they test out and develop their basic counseling skills. Level 2 trainees respond well to a mix of structured and facilitative approaches as this can help further develop their beginning sense of autonomy, yet continued reliance on the supervisor. Facilitative approaches can

also help Level 2 trainees to develop their self-awareness, which means trainees can incorporate more interpersonal processes approaches with their client. By Level 3, structured approaches can be used to help trainees develop skills in areas that may be lacking, but in general, facilitative approaches are used to help trainees continue to develop awareness of their own growth edges and better understand the complex interpersonal processes playing out with the client. The supervision of Level 3*i* trainees is more of a consultation and is similar to supervision of Level 3 trainees (McNeill & Stoltenberg, 2016).

In general, trainees want and need less structured approaches and more facilitative approaches as they advance in their training (McNeill & Stoltenberg, 2016; McNeill, Stoltenberg, & Romans, 1992; Stoltenberg & McNeill, 1997), however this assumption may not hold when clients present with suicidal risk (e.g., Tracey, Ellickson, & Sherry, 1989) as supervisors are more active and engaged in the client case when clients present with suicidal risk (Hoffman et al., 2013; McGlothlin, Rainey, & Kindsvatter, 2005). Additionally, trainees may feel highly anxious and doubt their abilities when working with a client presenting with suicidal risk (Binkley & Leibert, 2014; Bryan & Rudd, 2006; Douglas & Watcher Morris, 2015; Reeves & Mintz, 2001). As such, trainees and supervisors must be able to successfully navigate the situation to ensure client welfare (APA, 2017; Binkley & Leibert, 2014). Self-efficacy, or the belief trainees hold about their abilities, tends to increase as trainees gain more experience (Larson, Suzuki, Gillespie, Potenza, Bechtel, & Toulouse, 1992; Leach, Stoltenberg, McNeill, & Eichenfield, 1997; Mullen, Uwamahoro, Blount, & Lambie, 2015; Sipps, Sugden, & Faiver, 1988). Self-efficacy regarding abilities to manage client's suicidal risk also tends

to increase with experience (Binkley & Leibert, 2014; Douglas & Watcher Morris, 2015), and trainees' self-efficacy levels may influence their expectations about supervision, such that trainees higher in self-efficacy may want less structure and more autonomy (Friedlander & Snyder, 1983).

Overall, trainees' needs in supervision change over time and this change may be associated with client risk level, trainee experience level, and trainee self-efficacy level, and it is important for supervisors to be aware of best supervisory practices to help trainees develop their skills appropriately (McGlothlin et al., 2005) and protect client welfare (APA, 2017). To this purpose, this study adopted an experimental approach to examine how trainees view structure and facilitation in supervision when working with clients presenting with varying levels of suicidal risk (i.e., low or high). Additionally, this study examined how trainees' quality ratings of structure and facilitation in supervision may vary according to trainee variables (i.e., experience level and self-efficacy). Specifically, it was hypothesized that quality ratings of supervision environment and client risk level, trainee experience level, and trainee self-efficacy will be moderated by the supervisory environment. It was expected that supervision quality ratings, client risk level, and trainee development will be moderated by supervision environment such that as risk level increased, the quality of structured supervision would increase regardless of trainee experience level. As the risk level decreased, the quality of structured supervision would decrease, and quality ratings of facilitative supervision would increase as trainee experience level increases. Additionally, it was expected that supervision quality ratings, client risk level, and trainee self-efficacy would be moderated by supervision environment such that as risk level increased, the quality of structured supervision would

increase, and quality ratings of facilitative supervision would decrease as trainee self-efficacy decreases. As the risk level decreased, the quality of structured supervision would decrease, and quality ratings of facilitative supervision would increase as trainee self-efficacy increased.

Chapter 2 discusses the relevant literature on the above-discussed topics and presents the research questions and hypotheses for this study in more detail. Chapter 3 covers the method used for this study, including participants and recruitment, research procedure, measures, and analyses. Chapter 4 presents the results of this study, and finally, Chapter 5 discusses the results in relation to the relevant literature, and the strengths and limitations of this study. Recommendations for supervisors and trainees, and future areas of research are also given.

CHAPTER 2

LITERATURE REVIEW

This chapter consists of a literature review of the salient topics to outline a theoretical and empirical justification for this study. The following topics are reviewed: suicidal risk in clinical work, suicide assessment, the Integrated Developmental Model of trainee experience, structured and facilitative supervisory approaches, supervision across trainee experience levels, supervision practices when clients present with suicidal risk, and self-efficacy of trainees when working with a client presenting with suicidal risk. Following a review of these areas, the research questions and hypotheses are given.

Suicidal Risk in Clinical Work

A 2017 report from the Substance Abuse and Mental Health Services Administration (SAMHSA) puts suicide as the 10th leading cause of death in the United States, with over 44,000 deaths in 2016. In 2016, 9.8 million adults in the U.S. (4.0% of total U.S. adult population) had serious thoughts about suicide, with 1 in 4 of these adults developing a plan for suicide (2.6 million; 1.1% of total U.S. adult population), and 1 in 7 attempting suicide (1.3 million; 0.5% of total U.S. adult population). However, it is likely these numbers are lower than actual rates due to underreporting due to the stigma associated with suicide and mental health concerns, and difficulty in reaching certain groups of people (e.g., individuals who are homeless, on active military duty, or in monitored living arrangements).

Individuals with suicidal thoughts or plans are likely to have contact with mental health professionals in the month or year before completing suicide (Luoma, Martin, & Pearson, 2002), including contact with training therapists. Many trainees report working

with a client endorsing suicidal thoughts or behavior during their Master-level internship (82.90%; Watcher Morris & Barrio, 2012) or in their doctoral training (99%; Dexter-Mazza & Freeman, 2003). Despite the high probability that trainees will work with a client presenting with suicidal risk, the degree to which trainees are exposed to risk assessment and intervention training is variable throughout training programs. Studies have estimated that only around 50% of doctoral-level therapists receive formal suicide training (i.e., coursework, seminars, workshops, or practicum) within their program (Dexter-Mazza & Freeman, 2003), while among Master-level clinicians, the percentage of students who report receiving no explicit training within their program is higher at 67.36% (Watcher Morris & Barrio Minto, 2012). In a 2005 study, only 2% of surveyed Master programs accredited by the Council for Accreditation and Counseling and Related Educational Programs (CACREP) and only 6% of master programs in Marriage and Family Therapy (MFT) reported offering a course in suicide assessment or intervention (Wozny, 2005).

As few graduate programs implement specific suicidal risk assessment training, trainees working with a client presenting with suicidal concerns may turn to their clinical supervisor for information and to facilitate skill development (Dexter-Mazza & Freeman 2003; Hoffman et al., 2013; Mackelprang et al., 2014). Additionally, as trainees may feel anxious and doubt their clinical abilities when working with clients presenting with suicidal concerns (Bryan & Rudd, 2006; Reeves & Mintz, 2001), there can be long-lasting negative impacts on trainees if a client completes suicide (Kleespies, Penk, & Forsyth, 1993; McAdams & Foster, 2000). To best help the trainee in their training process, and to safeguard the client's welfare (American Psychological Association

(APA), 2017), it is important for supervisors to be aware of best practices for helping trainees navigate this experience. Indeed, in one qualitative study with licensed counselors who were no longer receiving supervision and had been working in the field for up to 22 years, they discussed the essentiality of clinical supervision, as opposed to administrative supervision, when a client is experiencing a crisis. Counselors reported wanting a supervisor to help them navigate the crisis and to process their own emotional reaction (Dupre, Echterling, Meixner, Anderson, & Kielty, 2013). While this study examined experienced counselors, it implies that counselors want and need supervision when facing client crisis and the potential impact supervision can have on the counselor.

While there specific training guidelines for supervisors when a trainee has a client die by suicide (e.g., Foster & McAdams, 1999; Knox, Burkard, Jackson, Schaack, & Hess, 2006), there has been limited research on best supervision practices when trainees are working with a client presenting with suicidal concerns (e.g., Hoffman et al., 2013; McGlothlin et al., 2005). The unique and complex considerations that must be attended to when working with a client presenting with suicidal risk demand effective clinical supervision (Foster & McAdams, 1999). Knowing that trainees are highly likely to work with a client presenting with suicidal concerns, it is imperative for clinical supervisors to be prepared to supervise trainees effectively to ensure client welfare and continued growth of the trainee.

Suicide Assessment Five-step Evaluation and Triage (SAFE-T)

Supervision practices for trainees who are working with a client presenting with suicidal risk must include a formalized assessment of risk and protective factors to determine the probability of risk (Shea, 2011). However, assessing for suicidal risk can

be challenging as a therapist must assess and weigh many factors that vary over time and situation (Bryan & Rudd, 2006) and it is impossible to predict with absolute certainty who will attempt suicide (APA, 2003). One assessment model is the Suicide Assessment Five-step Evaluation and Triage (SAFE-T) as developed by SAMHSA in accordance with the American Psychiatric Association (APA) Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors originally published in 2003. The SAFE-T model has five steps to guide mental health professionals through a risk assessment: 1) identify risk factors, 2) identify protective factors, 3) conduct suicide inquiry, 4) determine risk level/intervention, and 5) document.

In the first step, clinicians should assess for risk factors, such as: suicidal behavior, including previous suicide attempts or self-injurious behavior, psychiatric disorders, precipitating stressful event(s), specific symptoms, such as anhedonia or hopelessness, suicide attempts and mental health history of the client's family, access to lethal methods, such as firearms, and any changes in treatment, such as a recent discharge from a hospital. Clinicians should be mindful of risk factors that can be modified to reduce risk, such as feelings of hopelessness (APA, 2003; SAFE-T, 2009).

Next, clinicians identify protective factors, which are factors that may reduce the probability of clients attempting suicide. Protective factors can be internal or external. Internal protective factors are those such as stress/frustration resilience, coping behaviors, or religious beliefs about what will happen to one after death. External protective factors can be the support of social relationships (e.g., family, friends, romantic partners, and/or therapist) or feelings of responsibility to others or life commitments (e.g., work, therapy). Therapists should pay special attention to protective factors that can be enhanced, such as

coping abilities, social support, or other life responsibilities. It is noted that while protective factors should be assessed and discussed during a risk assessment, protective factors may not be sufficient to prevent harm to clients (APA, 2003; SAFE-T, 2009).

In the third step, direct questions about suicidal thoughts, intent, plan, and behavior are asked, such as if clients have developed a specific plan for suicide, or how frequently they have thoughts of suicide. Clients' responses to these questions may prompt additional questioning, such as if clients endorse a plan for suicide, the clinician will ask about any preparatory behaviors (e.g., note writing, giving away possessions), access to the mean of suicide (e.g., firearm), and lethality of the plan. The clinician should assess for reasons for living and dying (APA, 2003; SAFE-T, 2009).

Once the clinician has assessed the above areas, current risk level is determined according to three levels: low, moderate, and high. It is important to note that while the SAFE-T provides some guidelines for determining risk level and suggestions for possible interventions according to each risk level (e.g., hospital admission for high risk), there is no way to predict who will attempt suicide and who will not (APA, 2003). As such, final judgment of appropriate intervention needs to be based on a thorough assessment of the relevant risk and protective factors, the context in which the client lives, and sound clinical judgement. Once risk level has been determined and appropriate interventions implemented, the clinician must appropriately document the client interaction specifically detailing the clinical rationale for how risk level was determined, and which interventions were used (APA, 2003; SAFE-T, 2009).

The SAFE-T model recently incorporated the Columbia-Suicide Severity Rating Scale (C-SSRS; Posner et al., 2011), which provides examples of questions to ask an

individual about any suicidal ideation or behavior within different time periods. The C-SSRS was not specifically used in this study as there is no interaction between the trainee participant and hypothetical client, so therefore no questions were asked to the hypothetical client. Additionally, while the SAFE-T model includes risk categories for low, moderate, and high, only low and high risk levels were examined in this study. Overall, the SAFE-T model can be used in clinical supervision to help trainees assess for risk and intervene appropriately according to the client's risk level. However, it is unclear how supervisory practices may change according to the client's risk level. The purpose of this study was to explore best supervisory practices when trainees are working with clients presenting with different levels of suicidal risk, and how these supervisory practices may vary according to trainee level of development and trainee self-efficacy.

The Integrated Developmental Model

Bernard and Goodyear (2014) define supervision as:

> An intervention provided by a more senior member of a profession to a more junior colleague or colleagues who typically (but not always) are members of that same profession. This relationship: is evaluative and hierarchical; extends over time, and; has the simultaneous purposed to enhancing the professional functioning of the more junior person(s); monitoring the quality of professional services offered to the clients that she, he, or they see; and serving as gatekeeper for the particular profession the supervisee seeks to enter (p. 9)

Indeed, supervision is a critical component of clinical training, and supervisors can use models of trainee development to understand what trainees want and need in supervision to best support and continue their clinical growth. While there are many supervisory models, it is important to examine how trainees develop over time as research has supported that trainees' supervisory needs change as they advance (McNeill & Stoltenberg, 2016; McNeill et al., 1992; Stoltenberg & McNeill, 1997; Stoltenberg et al.,

1994). One developmental model is the Integrated Developmental Model (IDM; Stoltenberg, 1981; Stoltenberg & McNeill, 2010; Stoltenberg, McNeill, & Delworth, 1998), which argues that supervision should be matched to the experiential needs of trainees as they advanced in their training to new levels (i.e., Level 1, 2, 3, or 3*i*) across three general structures: self-other awareness, motivation, and autonomy. Self- and other awareness refers to the ways in which trainees are aware of and focused on their own experience and that of the client. Motivation refers to trainees' interest and effort in their work, and autonomy refers to how much independence or dependence trainees display in relation to their supervisor (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 2010). While there is individual variation for how trainees function at different levels, there are general tendencies displayed by each level.

Level 1. Level 1 trainees tend to focus on developing basic attending and listening skills, some intervention skills, and a theoretical orientation. At this stage for self- and other awareness, trainees tend to be self-focused and highly anxious. This self-focus is often negative, yet trainees remain highly motivated to perform and develop skills, which may be reflected in trainees' wanting to know the "best" or the "right" approach to working with a specific client. As such, Level 1 trainees tend to be highly reliant on their supervisor for guidance and may want structure in supervision (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997).

Level 2. By Level 2, trainees' self- and other awareness has shifted to focus on the complex inner world of clients. This shift can result in increased ability of Level 2 trainees, as compared to Level 1 trainees, to become more aware of and use client responses and reactions to guide session and provide a deeper conceptualization of the

client. However, as trainees are typically working with more complex client cases and taking on more of the client's perspective rather than being self-focused, they may struggle with motivation, such that they may fluctuate between feeling highly motivated in one session or disengaged in another. As they become more aware of the limits of their knowledge and their own strengths and weaknesses, trainees may wonder if a career as a therapist is the correct choice, especially as they compare their progress and outcomes to others. The struggle between their developing autonomy and continued dependence on the supervisor often results in increased conflict between trainees and supervisors as trainees attempt to assert their own views and ideas (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997).

Level 3. By Level 3, trainees feel more stable in their abilities, such that they can focus on themselves and the client to allow spontaneous responses from "in the moment" and use their "self" (e.g., personality, genuineness) in session. Trainees have developed an idea of the therapeutic process and are able to draw on previous experiences to understand client concerns, which helps them find balance between the client's experience and the trainees' own self-awareness and insight to form conceptualizations. Doubts that inevitably happen about one's ability are no longer threatening to trainees but spark further exploration into one's professional identity. Additionally, Level 3 trainees have a high level of autonomy and often view supervision as a place to consult and focus on professional development (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997).

Level 3*i*. Level 3*i* was later added by Stoltenberg and Delworth (1987), which reflects when trainees have reached Level 3 across multiple domains (e.g., intervention

skills, theoretical orientation, professional ethics) and are generally considered "experts". Trainees now focus on expanding their skills into new domains to continue to develop their knowledge base, while remaining creative and flexible in treatment. Trainees' self- and other awareness allows them to develop a personalized understanding of therapy, which helps them monitor their own efficacy and how they continue to use themselves in the therapy room. Additionally, trainees are able to integrate their professional identity across multiple clinical roles they may hold (e.g., therapist, supervisor, and teacher). Trainees' motivation levels remain stable and they are able to identify if motivation is waning and possible reasons. Trainees are highly autonomous and stable in their professional identity and know when consultation with other professionals is necessary (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997).

While the IDM proposes specific levels of trainee development, determining at which level a trainee falls is difficult and current measures do not provide a way to organize trainees into levels (e.g., McNeill et al., 1992). Therefore, trainee experience level has been used to determine where a trainee may be in terms of their training (McNeill, Stoltenberg, & Pierce, 1985; McNeill et al., 1992), which is what this study used. More information about how trainee experience level was determined is discussed in Chapter 3.

Supervisory Approaches: Structure & Facilitation

The IDM describes best supervisory practices based upon the work of Loganbill, Hardy, and Delworth (1982), which was based upon the organizational development work of Blake and Mouton (1976). They describe five types of supervisory interventions: facilitative, prescriptive, conceptual, confrontive, and catalytic. Heron (1990) also built upon the work of Blake and Mouton (1976) and described six types of supervisory

interventions -prescriptive, informative, confronting, cathartic, catalytic, and supportive- which he organized into two main categories: authoritative and facilitative (authoritative interventions: prescriptive, informative, and confronting; facilitative interventions: cathartic, catalytic, and supportive). Due to the considerable overlap between the models of Loganbill, Hardy, and Delworth (1976) and Heron (1990; e.g., both models describe a prescriptive approach) and Heron's (1990) broad categorization of the interventions, Heron's (1990) model will be used for this study. Heron (1990) argues that in authoritative interventions, the supervisor takes more responsibility than the trainee, whereas in facilitative interventions the supervisor encourages the trainee to take responsibility to become more independent. The type of intervention used varies depending on the needs of each trainee (Heron, 1990). For the purpose of this study, authoritative supervision will be referred to as "structured" supervision to remain consistent with other supervisory studies, especially ones that have examined supervision in relation to clients presenting with suicidal risk (e.g., Tracey et al., 1989). Each type of supervisory intervention is explained below.

Structured Supervision

Prescriptive. When supervisors give direct advice or feedback with the intention of influencing a trainee's behavior, they are using a prescriptive approach (e.g., "I think this is what you should do next"). With a prescriptive approach, there may be varying levels to which the supervisor's power and role play. At one end of the continuum, a supervisor may adopt a directive prescription approach with the use of direct requests or commands, and at the other end, a supervisor may provide suggestions and encourage trainee input.

While the trainee may have some input into what will occur, it is expected that the trainee will follow the supervisor's advice when a prescriptive approach is used (Heron, 1990).

Informative. Supervisors may wish to enhance the knowledge base of their trainees by sharing knowledge or interpretations to help trainees learn and eventually become more self-directive. There are several ways in which supervisors can use informative interventions, such as by imparting new knowledge that the trainee may not have (e.g., "The SAFE-T model can provide a way of conceptualizing client risk"), or through interpretations about the meaning of a client's behavior or concern (e.g., "I think the client really wanted to do X when she said Y"; Heron, 1990).

Confronting. Finally, a confronting intervention refers to the supervisor attempting to raise awareness in the trainee about discrepancies between the trainee's actions, feelings, or attitudes of which the trainee may be unaware (Heron, 1990). For this study, a confronting approach was not used due to the difficulty of incorporating such an intervention when there was no interaction between the participant and depicted supervisor.

Facilitative Supervision

Cathartic. With cathartic interventions, the supervisor seeks to help the trainee release affect. For example, supervisors may encourage trainees to share their affective reaction to a client or situation by giving permission (e.g., "It's ok to talk about this") or by paying attention to non-verbal cues, which may suggest something is happening internally for the trainee. Cathartic interventions are designed to help trainees better understand how they interact with clients and encourage self-introspection and reflection (Heron, 1990).

Catalytic. When using a catalytic intervention, a supervisor asks open-ended questions designed to encourage the trainee to engage in self-exploration and problem-solving. The end goal of catalytic interventions is to help trainees take more responsibility for their choices and how to handle difficult clinical situations as trainees will one day become independent practitioners and must be capable of self-monitoring clinical decision making (Falender & Shafranske, 2004). When using this approach, a supervisor may ask open-ended questions (e.g., "What do you think should happen next?") or encouraging trainees to reflect on potential meanings of a situation (e.g., "What were you feeling in that moment?"; Heron, 1990).

Supportive. Finally, supportive interventions refer to ones that affirm and validate the trainee and the trainee's experience (Heron, 1990). For this study, catalytic and cathartic approaches were used only in the facilitative supervision session as supportive interventions, such as validating the trainee or developing a strong alliance, are important components of any supervisory session (Ladany, Ellis, & Friedlander, 1999) and were therefore used in both conditions (i.e., facilitative and structured).

To summarize, this study included prescriptive and informative practices as part of the structured supervision sessions, and cathartic and catalytic practices as part of the facilitative supervision sessions. Both types of supervision included supportive elements.

Supervision across IDM Developmental Levels

The IDM posits that "the supervision environment should change in response to the differing needs, issues, and perceptions of the developing supervisee" (McNeill & Stoltenberg, 2016, p. 65). In general, the IDM assumes that as trainees become more advanced (i.e., move from Level 1 to Level 3*i*), they require and want less structure and

more autonomy in supervision (McNeill & Stoltenberg, 2016; McNeill et al., 1992; Stoltenberg & McNeill, 1997). In a review of 53 studies examining developmental models and how supervisory behavior changes over time as trainees become experienced, the idea that supervision changes over time as trainees gain experience was supported, except in two studies (Stoltenberg et al., 1994). McNeill and Stoltenberg (2016) used the supervisory interventions mentioned above to lay out specific recommendations for supervision according to each experience level.

Level 1. For Level 1 trainees, supervision may be a source of confusion and anxiety as they most likely have not experienced supervision before and are worried about how their supervisor perceives them. Level 1 trainees benefit from structure within supervisory experiences to help reduce feelings of anxiety, to meet the trainee in terms of expectations surrounding the "expert" role of the supervisor, and to help develop confidence. Informative approaches, such as the supervisor's suggestion of developmentally appropriate resources or readings, can provide structure and help meet trainees' needs. Additionally, trainees benefit from specific skills training or role plays that focuses on basic counseling skills, or prescriptive approaches in which supervisors give suggestions about what to do next in the work with the client. Supportive approaches should be used generously to normalize trainees' experiences, and trainees generally respond well to supervisors' sharing personal experiences to help reduce the trainee's anxiety (McNeill & Stoltenberg, 2016).

Level 2. For supervisors working with Level 2 trainees, it is important to provide less structure than with Level 1 trainees to foster continued growth of trainees' emerging autonomy. However, it is common that conflict arises during supervision at this stage as

trainees begin to develop their sense of autonomy yet still feel unsure about their abilities. To avoid outward conflict, trainees may not bring up certain topics with their supervisor, especially if they think their supervisor may disagree with their decision, or the trainee may agree with the supervisor in supervision but then not enact these suggestions in clinical practice. To this end, structured interventions should be used more sparingly and facilitative approaches, especially normalizing trainees' experiences, should be used more at Level 2. Additionally, supervisors can use more process-oriented techniques with trainees as Level 2 trainees' self- and other focus is shifting toward a more interpersonal understanding of the relationship between the trainee and client. Catalytic interventions may be necessary to help trainees understand their views of and reactions toward the clients, especially since Level 2 trainees may overidentify with clients. Supervisors may focus on helping trainees increase self-awareness to prevent overidentification with the client and think of different ways of conceptualizing a client (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997).

Level 3. Facilitative approaches are still used to encourage Level 3 trainees, while structured interventions are only used to help trainees develop skills in new domains (e.g., intervention skills, assessment techniques), where trainees may be functioning at a Level 1 or 2 (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997). When trainees reach Level 3, they guide supervision, rather than the supervisor, as they are self-aware of their needs. They tend to view supervisors as mentors and consultants, and power is shared more in supervision than with previous levels. Trainees are now aware of clinical options in a situation and may use their supervisor as a consultant in the decision-making process rather than asking specifically what to do. Supervisors can continue to help

trainee development by exploring complex interpersonal processes (e.g., transference, countertransference, parallel processes). The use of confrontative and catalytic interventions will be used the most to help trainees become aware of blind spots and continue to make forward progress in therapy (McNeill & Stoltenberg, 2016).

Level 3*i*. Most professionals at this level are no longer trainees, but rather licensed professionals working independently. Supervision is received only when necessary and is viewed as a consultation and means of support. When supervision is received, the process looks similar to that of a Level 3 trainee (McNeill & Stoltenberg, 2016).

Support for McNeill and Stoltenberg's (2016) recommendations as well as the assumption in the IDM that as trainees advance in their training, their needs in supervision change, such that trainees want and need less structured inventions, has been supported in several studies with experience level being defined in different ways. In one study (Stoltenberg, Pierce, & McNeill, 1987), experience was defined in three different ways: years of graduate education, number of semesters providing counseling, and number of semesters receiving supervision. Ninety-one counseling and clinical psychology trainees (n = 50 female) from across the United States were divided into three groups for each experience variable and completed a questionnaire (Supervisee Needs Questionnaire) regarding their needs in supervision. Using t-tests, it was found that those with the lowest amount of experience across all three categories (e.g., education years, counseling semesters, and supervision semesters) preferred more structure, feedback, and endorsed more overall needs as compared to the groups with the highest amount of experience in all three categories. For education level, those with the middle level of education preferred more structure compared to those with the highest level of education.

For semesters of counseling experience, those with the fewest semesters of counseling experience preferred more feedback than the middle group. Finally, for supervision experience, the middle group prefers more feedback and overall perceived needs as compared to those with the most semesters of supervision. Overall, the authors posit that as trainees advance in their development, they shift from having needs in supervision, with an emphasis on structure, to needing less (Stoltenberg et al., 1987).

Using the same data set (n = 91 counseling and clinical psychology trainees; x = 41 female), participants from eight different programs in the United States were divided into three groups (beginning = 34, intermediate = 32, and advanced = 25) by totaling the score of all experiential variables (semesters of counseling experience, semesters of supervision experience, and years of education) for each participant and then dividing participants into three equal groups. Specifically using ANOVAs, they found beginning trainees reported less Self and Other Awareness than intermediate and advanced trainees, indicating beginning trainees had a higher self-focus. Additionally, beginning trainees scored lower on Dependency-Autonomy than both intermediate and advanced trainees, and intermediate trainees scored lower on Dependency-Autonomy than advanced trainees. These results support the notion that trainees begin as dependent on their supervisor but become more autonomous as they advance. Finally, they found advanced trainees reported higher application of theory and skills than intermediate or beginning trainees. Overall, the results support the IDM assumption that trainees experience developmental gains as they advance in training, such that advanced trainees are more autonomous, apply specific interventions, and are aware of their own skill as clinicians (McNeill et al., 1985).

While the IDM posits that supervisory needs change over time as trainees advance such that they want and need less structure, this assumption may not hold over certain situations, such as when clients present with suicidal risk. When clients present with suicidal risk, supervisors are inherently more involved in the client case due to the focus on client safety (Hoffman et al., 2013). As such, it is important to examine the supervisory needs of trainees across varying levels of experience when clients present with suicidal risk.

Supervision when Clients Present with Suicidal Risk

Differences in supervision expectations according to the IDM, especially when clients present with suicidal risk has been found in multiple studies. In a study of 78 trainees in APA counseling psychology programs, it was found that beginning trainees (i.e., those who had one semester of practicum completed) preferred structured supervision as compared to advanced trainees (i.e., those who had two or more semesters of practicum completed), however, when presented with a client presenting with suicidal concerns, all trainees, regardless of experience level, preferred structured supervision (Tracey et al., 1989). Additionally, mental health professionals may still experience fear and discomfort when working with a client presenting with suicidal concerns, even after up to 43 years of experience (*n* = 289 mental health professions; 50 trainees/students; Jahn, Quinnett, & Ries, 2016). Taken together, these results suggest that supervision is different when clients present with risk as compared to what would be expected according to developmental models.

Despite the difference, there has been limited research on supervisory practices when clients present with suicidal risk. Hoffman, Osborn, and West (2013) attempted to fill this

gap through a study adopting a grounded theory approach of 5 clinical supervisors who had supervised a trainee who worked with a client endorsing suicide within the last two years. They named the emerging theory as Supervision for Suicidal Clients as an Immediate, Versatile, Collaboration Between Counselor Trainees and Counselor Supervisors, from which there are four main themes: 1) role of the supervisor, 2) formative learning experiences, 3) impact on the supervisory relationship, and 4) differences in supervision. Overall, supervisors in this study reported the need to adopt different roles, such as educator, supervisor, and gatekeeper, the importance of their trainees developing competency to work with clients presenting with risk, the stronger collaborative nature of the supervisory relationship, and that supervision was different in that supervisors had to change the way they provided supervision to ensure trainee's needs were being met and client welfare was being protected. Supervisors reported increased amounts of support given to the trainee, such as debriefing and balancing constructive feedback with support to help trainees feel empowered, rather than discouraged and overwhelmed. Supervisors reported being more directive by offering concrete ideas and being more involved in the client's treatment (Hoffman et al., 2013).

McGlothlin, Rainey, and Kindsvatter (2005) propose another model entitled the Cube Model of Supervision and Suicide, which details a framework for supervisors to determine their supervisory approach (teacher, counselor, consultant) when their trainees are working with clients presenting with suicidal risk according to the trainee's level of development under the IDM (Level 1, 2, or 3) and level of suicide lethality (low, moderate, high). For Level 1 trainees, supervisors may need to educate their trainees on how to identify a client's suicidal thoughts and how to conduct a suicide risk assessment.

Trainees at Level 1 may also require attention to their emotional experience and benefit from normalization. It is not recommended to allow Level 1 trainees high amounts of autonomy due to ethical and legal considerations. At Level 2, supervisors may continue to educate their trainees on suicide assessment, but this may focus more on empirically-based suicide assessments and diagnostic criteria. The need for support is still prevalent in Level 2 and supervisors may shift to helping trainees develop effective methods of coping. Finally, at Level 3 trainees, supervisors may help trainees develop a more complex conceptualization of clients and their suicidal concerns and supervisors tend to take on more of a consulting role in that they help trainees integrate certain approaches or techniques. Supervisors should continue to provide support for trainees (McGlothlin et al., 2005). However, there is currently no empirical support for this model.

Overall, supervision appears to follow different trajectory than what would be expected according to developmental models such as the IDM. Supervision when a trainee is working with a client presenting with suicidal concerns appears to require more structure and support for the trainee. However, there is currently limited research on how to best support trainees in supervision when working with a client presenting with suicidal concerns, and this study attempts to fill that gap.

Self-Efficacy

It is clear that working with clients presenting with suicidal risk presents a challenge to trainees of all levels (Jahn et al., 2016; Kleespies et al., 1993) and supervision needs of trainees are different when trainees are working with clients presenting with suicidal risk (Hoffman et al., 2013; McGlothlin et al., 2005; Tracey et al., 1989). Despite the challenge and complexity in these cases, trainees must be able to successfully address suicidal

thoughts and behaviors of clients to ensure client welfare (APA, 2017; Binkley & Leibert, 2014). The belief that one can "can successfully execute the behavior required to produce the outcome" (Bandura, 1977, p. 193) has been defined as self-efficacy. For this study, self-efficacy is the beliefs trainees hold about their abilities to successfully work with the client presenting with suicidal risk to reach the desired clinical outcome.

Self-efficacy can be considered within an experiential framework such that as trainees advance, they develop higher self-efficacy regarding their clinical abilities in general. Results from one study showed that among 322 counseling master and doctoral-level trainees (n = 216 female; 93% White), those who had at least two years of counseling experience report higher counseling self-efficacy than those with less than two years of experience, and those with at least one semester of supervision report higher counseling self-efficacy than those with no supervisory experience (Larson et al., 1992). Additionally, a quasi-experiment of 78 counseling trainees (n = 53 female) found that first and second year students reported lower self-efficacy in regard to outcome (i.e., what the trainee hoped the client would do) as compared to third and fourth year students (Sipps et al., 1988). Further support is given through another quasi-experiment of 142 counseling trainees (n = 90 women; n = 54 master-level trainees) in which participants were divided into Level 1 or Level 2 according to the IDM. Results found that Level 2 trainees reported higher self-efficacy than Level 1 trainees (Leach et al., 1997). A longitudinal study of 179 trainees (x = 151 female; 74.3% White) in a terminal CACREP master's degree program examined the level of trainees' self-efficacy at three time points in their graduate education (i.e., beginning of program, midpoint of program, and end of

program). The results showed that self-rated self-efficacy of the trainees increased significantly at each time point (Mullen et al., 2015).

While general clinical self-efficacy among trainees tends to increase over time, the same result has been found with clients presenting with suicidal concerns. In a study of 113 master-level prepracticum trainees (*n* = 83.2% women) in a counseling program, it was found that students who reported no previous training in suicide response, assessment, or procedures felt less confident working with a client presenting with suicidal concerns than those who had some training either within or outside their current academic program. It was also found that trainees who had received training from their current program and from outside their current program reported greater confidence in working with a client presenting with suicidal concerns than those who had received training from their current academic program only (Binkley & Leibert, 2014). Additionally, self-efficacy among trainees and licensed mental health professionals (*n* = 324; 79.63% female; 95 graduate students) varied according to different areas of suicide assessment and intervention (e.g., assessment of suicide history, suicide interventions). It may be that trainees feel confident in their abilities to assess for risk but may not feel confident in their abilities to intervene appropriately (Douglas & Watcher Morris, 2015). To help with this lack of confidence, trainees may turn to their supervisors for support in selecting appropriate interventions.

Aside from general support from supervisors about risk interventions, trainee's level of self-efficacy may influence a trainee's expectations of supervision. Friedlander and Snyder (1983) examined how trainees' self-efficacy may predict their supervisory expectations among 84 trainees across three levels of experience (beginning master

practicum = 29; advanced doctoral practicum = 31; doctoral interns = 22) from three training programs in the United States. The results showed that trainees who rated themselves higher in self-efficacy regarding their clinical abilities expected their supervisors to be higher in the social influence attribute of "expertness" (i.e., how prepared and experienced the supervisor seemed) and evaluation (i.e., providing feedback, encouragement of trainee experimentation).

Taken together, the results of these studies suggest that self-efficacy increases over time as trainees gain more experience in general and when working with clients presenting with suicidal risk. As such, it is important to examine how self-efficacy may moderate the anticipated association between experience level and supervision preference.

Present Study

In summary, trainees are highly likely to work with a client presenting with suicidal risk (Dexter-Mazza & Freeman, 2003; Watcher Morris & Barrio, 2012) and turn to their supervisor for support and guidance (Dexter-Mazza & Freeman 2003; Hoffman et al., 2013; Mackelprang et al., 2014). To assure clients are receiving appropriate interventions for their risk level, supervisors and trainees can use the SAFE-T model to assess a client's risk level (APA, 2003; SAFE-T, 2009). In accordance with the IDM, supervisors should match supervisory interventions to trainee's experience levels (Stoltenberg, 1981; Stoltenberg & McNeill, 2010; Stoltenberg et al., 1998). Two main types of supervisory interventions are facilitative (e.g., asking open ended questions to facilitate problem-solving by the trainee) or structured (e.g., giving direct advice on what to do next; Heron, 1990). The IDM posits that as trainees gain experience, they want less structure in

supervision (McNeill & Stoltenberg, 2016; McNeill et al., 1992; Stoltenberg & McNeill, 1997). However, this assumption may not hold when clients are presenting with suicidal risk (e.g., Tracey et al., 1989). Additionally, trainee self-efficacy levels may dictate supervisory needs and expectations, such that as trainees become more self-efficacious, they want less structure in supervision (Leach et al., 1997). As such, supervisors need to be aware of best supervisory practices to meet trainees where they are experientially (McGlothlin et al., 2005) and protect client welfare (APA, 2017).

The goal of the present study was to examine how trainees view structure and facilitation in supervision when working with clients presenting with varying levels of suicidal risk (i.e., low or high). Additionally, this study examined how trainees' perceptions of structure and facilitation in supervision may vary according to experience level of the trainee and self-efficacy of the trainee. Specifically, the aim of this study was to examine the following research questions (RQ) and hypotheses (H):

RQ1: Will perceptions of supervision quality vary across supervision environment (structured, facilitative) and client risk level (low, high), and will these relations vary by trainee experience level?

H1a: There will be no differences in supervision quality ratings across supervision environment. There will be differences in supervision quality ratings across risk level and trainee experience level.

H1b: The relation between quality ratings of supervision and client risk level will be moderated by supervision environment such that quality ratings of structured supervision will be higher and quality ratings of facilitative supervision will be lower as risk level increases.

H1c: Quality ratings of supervision and trainee experience level will be moderated by supervision environment such that quality ratings of structured supervision will decrease, and quality ratings of facilitative supervision will increase as trainee experience level increases.

H1d: Quality ratings and client risk level and trainee experience level will be moderated by supervision environment such that as risk level increases, the quality of structured supervision will increase regardless of trainee experience level. As the risk level decreases, the quality of structured supervision will decrease, and quality ratings of facilitative supervision will increase as trainee experience level increases.

RQ2: Will perceptions of supervision quality vary across supervision environment (structured, facilitative) and client risk level (low, high), and will these relations vary by trainee self-efficacy?

H2a: There will be no differences in supervision quality ratings across supervision environment. There will be differences in supervision quality ratings across risk level and trainee self-efficacy level.

H2b: Quality ratings of supervision and client risk level will be moderated by supervision environment such that quality ratings of structured supervision will increase and quality ratings of facilitative supervision will decrease as risk level increases.

H2c: Quality ratings of supervision and trainee self-efficacy will be moderated by supervision environment such that quality ratings of structured supervision will

decrease, and quality ratings of facilitative supervision will increase as trainee self-efficacy increases.

H2d: Quality ratings and client risk level and trainee self-efficacy will be moderated by supervision environment such that as risk level increases, the quality of structured supervision will increase, and quality ratings of facilitative supervision will decrease as trainee self-efficacy decreases. As the risk level decreases, the quality of structured supervision will decrease, and quality ratings of facilitative supervision will increase as trainee self-efficacy increases.

CHAPTER 3

METHOD

Development and Validation of Intervention

Sample. Data were collected from trainees and supervisors in the United States, who were recruited via email. Nine trainees agreed to participate and met inclusion criteria, but one trainee was removed due to incomplete data for a total of eight trainees (*n* = 5 women). Of the eight trainees, seven were completing Ph.D. programs (*n* = 2 Clinical Psychology; *n* = 4 Counseling Psychology; *n* = 1 Counselor Education) and one was completing a master's degree in mental health counseling. The trainees were on average 27 years old (*SD* = 2.73 years; *range* = 24 to 32 years). Three trainees identified as Hispanic or Latinx, two as Asian or Asian-American, two as White or European American, and one as multiracial. Experience level of the trainees was on average 23.13 (*SD* = 10.12; *range* = 5 to 39).

Five supervisors (*n* = 3 women) agreed to participate and met inclusion criteria. Of the five supervisors, three completed doctoral degrees (*n* = 1 Ph.D. Clinical Psychology; *n* = 1 Psy.D. Clinical Psychology; *n* = 1 Ph.D. Counselor Education) and two completed master's degrees (*n* = 1 M.S. Counseling; *n* = 1 Master of Counseling). All were currently independently licensed, and five were working at a university counseling center and two were in private practice. Three of the supervisors identified as White or European American and two as multiracial. The average age of supervisors was 40.80 years old (*SD* = 4.09 years; *range* = 34 to 44). Experience level of the supervisors was on average 31 (*SD* = 9.57; *range* = 14 to 39). See Table 1 for the distribution of participants in each condition.

Table 1

Distribution of Pilot Test Participants across Conditions

	Trainees		Supervisors	
	Low Risk	High Risk	Low Risk	High Risk
Structured	2	3	1	1
Facilitation	2	1 (1 deleted)	1	2

Procedures. First, I developed and wrote some of the materials proposed to be used in this study (i.e., client case vignettes, supervision session vignettes, pilot testing questions). These materials were reviewed by my chair and experienced counseling psychology faculty and students. Feedback was incorporated, and formal pilot testing of the materials was conducted using the above-mentioned sample of trainees and supervisors.

To take part in pilot testing, trainees had to meet the following criteria: 1) be 18 years or older, 2) currently enrolled in a graduate program in counseling psychology, clinical psychology, clinical mental health counseling, counseling or mental health counseling, social work, family and marriage therapy, or counselor education or counselor education and supervision, and 3) currently enrolled in or have completed one semester of clinical/counseling practicum and provided therapy to clients as the direct therapist. Supervisors had to meet the following criteria: 1) be 18 years or older, 2) have graduated from a graduate program in counseling psychology, clinical psychology, clinical mental health counseling, counseling or mental health counseling, social work, family and marriage therapy, or counselor education or counselor education and supervision, and 3) have provided clinical supervision to trainees for at least 5 months.

Data collection for pilot testing took place in nine parts: 1) consent and screening, 2) presentation of client case, 3) self-efficacy measure, 4) pilot testing questions about the client case, 5) presentation of supervision session, 6) rating of supervision style questionnaire, 7) pilot testing questions about the supervision sessions, 8) collection of research and demographic questionnaires, and 9) free response questions about the study. All materials were hosted online by Qualtrics. Using the randomizer feature of Qualtrics, participants were randomly presented with one of two different client case presentations, which varied based on level of risk (i.e., client presenting with low or high risk), and randomly presented with one of four supervision sessions (i.e., facilitative or structured session), which corresponded to the level of risk of the presented client. For example, if a participant read about the client presenting with high risk, they would read either the facilitative or structured supervision session for a high risk client; the same was done for the low risk client. Total participation was around 30 minutes.

To gather information about the materials developed for this study, pilot test participants (trainees and supervisors) completed two questionnaires (see Appendix N & O). First, after participants read a client case vignette, they answered questions about the believability of the client case and about the client risk level. Trainees answered six questions about the believability of the client case and supervisors answered five questions. Both groups answered three questions about the risk level of the client. All questions were on a 7-point Likert scale (*Strongly Disagree* to *Strongly Agree;* see Appendix N). An example of a question assessing believability was "The client seemed like someone who could walk into my [supervisee's] counseling room", and an example of a question assessing risk level was "The client presented with a high amount of

suicidal risk". Two questions required reverse coding. A higher score indicated higher perceived believability and client risk level. Additionally, participants were presented with a screenshot of the SAFE-T (2009) categories of risk assessment and asked to classify the client's risk level. A free response item was then available for participants to provide any feedback.

Next, after participants read a supervision session vignette, they answered questions about the believability of, type of supervision provided in, and amount of support given in the supervision session. Trainees answered four questions about the believability and supervisors answered five questions. Both groups answered four questions about type of supervision provided and two questions about amount of support given. All questions were on a 7-point Likert scale (*Strongly Disagree* to *Strongly Agree;* see Appendix O). Example questions include: "The supervisor's suggestions were not things a real supervisor would do" (believability), "The supervisor gave lots of direction" (type of supervision provided), and "The supervisor validated [my] [the trainee's] experience" (support provided). One question required reverse coding. A higher score indicated higher perceived believability, a more facilitative approach to supervision, and more support provided. Participants were then provided with definitions of structured and facilitative supervision (Heron, 1990) and asked to select which they felt better represented the supervision session they read. Finally, a free response item was then available for participants to provide any feedback. All other materials presented during pilot testing were the same as described above, except for some questions which were reworded for the supervisors (see Appendix P).

Next, after feedback from the above-mentioned pilot test was incorporated, video recordings of the vignettes were made and informally reviewed by myself, my chair, and experienced counseling psychology faculty and students for viability to be used in this study. Based on this review, we decided to not use the videos, but rather present the written vignettes in the final study procedure.

Pilot testing results. All participants and supervisors correctly answered attention check questions, except for one trainee who answered one question (out of five) incorrectly. All participants correctly selected the client risk level (i.e., "How would you classify this client's risk level?") and type of supervisory approach (i.e., "Based on the above definitions of structure and facilitation in supervision, which do you think best describes the supervisory session you just read about?") for the condition in which they were placed. Means and standard deviations are presented for the pilot test questions for the client case in Table 2 and for the supervision session in Table 3. Means trended in the expected directions for each condition, and thus the vignettes were not changed for the main data collection. Minor grammatical or phrasing changes to some demographic questions were made based on participant feedback.

Table 2

Means and Standard Deviations of Client Case Pilot Questions for Trainees and Supervisors

	Low Risk			High Risk		
	n	*M*	*SD*	*n*	*M*	*SD*
Believability						
Trainees	4	6.92	.28	4	5.46	1.91
Supervisors	2	6.5	1.58	3	6.4	.74
Risk Level						
Trainees	4	2.75	1.48	4	6.5	.67

Supervisors	2	2.67	1.97	3	6.11	1.96

Note. Scaling on Likert scale: 1-7. Higher scores indicate more believability and more risk.

Table 3

Means and Standard Deviations of Supervision Session Pilot Questions for Trainees and Supervisors

	Structured			Facilitative		
	n	*M*	*SD*	*n*	*M*	*SD*
Believability						
Trainees	5	5.90	1.02	3	5.92	.51
Supervisors	2	4.10	1.91	3	4.27	2.09
Type of Supervision						
Trainees	5	2.6	1.8	3	5.16	1.85
Supervisors	2	2.25	.71	3	5.08	2.02
Support Provided						
Trainees	5	6.1	.88	3	6	.63
Supervisors	2	5	.82	3	6.5	.55

Note. Scaling on Likert scale: 1-7. Higher scores indicate more believability, more facilitative supervision, and more support provided.

Main Data Collection

Sample. The final sample was comprised of 473 trainees in which 117 were in the low client risk, facilitative supervision condition, 116 were in the low client risk, structured supervision condition, 116 were in the high client risk, facilitative supervision condition, and 124 were in the high client risk, structured supervision condition (for a research flowchart, including sample numbers, see Appendix Q). According to an a-priori power analysis using G*Power version 3.1.9.2 (2017), a total sample size of 293 would be sufficient for a small to moderate effect size (f^2 = .05; Cohen, 1988).

Overall, the sample identified primary as a woman (84.1%), White/European American (70.8%), and straight (76.3%). The average age of participants was 28.22 years

old (*SD* = 6.06). About half the sample was completing either a counseling psychology (23.3%) or clinical psychology (26%) degree. The sample was split roughly in half between those seeking a master's degree (47.6%) and those seeking a doctoral degree (50.7%), and almost all of these degree programs were accredited (96.2%). A majority of the sample was completing a graduate program in the southern region of the United Stated (37.2%), followed by the western region (26.2%). Regarding current clinical placements, 42.5% were on externship or a field placement external to their university, 22% were completing their Master's internship, 18.2% were on their first practicum, 7.4% were on predoctoral internship, 6.1% were not currently on placement, and 3.8% did not respond or responded they were completing a different type of placement. Most of the sample indicated they had completed some training in suicide assessment and intervention (e.g., coursework, seminar, practicum-related activities; 95.3%). Demographic information for trainees in each condition can be found in Table 4.

Table 4

Descriptive Statistics for All Study Variables According to Experimental Condition

Variable	LF	LS	HF	HS
Sample Size	117	116	116	124
Age	21.12 (4.25)	29.08 (7.56)	27.57 (5.16)	29.02 (6.51)
Current Program				
Counseling Psychology	22.2%	25%	24.1%	21.8%
Clinical Psychology	29.1%	21.6%	28.4%	25%
Counselor Education or Counselor Education & Supervision	2.6%	5.2%	5.2%	4.8%
Clinical Mental Health Counseling	11.1%	12.9%	13.8%	12.9%
Counseling or Mental Health Counseling	6.8%	7.8%	4.3%	10.5%
Social Work	12.0%	13.8%	9.5%	11.3%
Marriage & Family Therapy	16.2%	13.8%	14.7%	13.7%
Racial/Ethnic Identification				
Asian/Asian-American	11.1%	7.8%	7.8%	4.8%
Black/African-American	9.4%	5.2%	6.9%	6.5%
Hispanic/Latinx	6.0%	7.8%	5.2%	5.6%
Middle Eastern	0%	0%	0%	0.8%

Multiracial	3.4%	4.3%	6.0%	4.8%
Native American, Alaskan Native, or Pacific Islander	0%	0.9%	0.9%	0.8%
White/European American	66.7%	72.4%	69.8%	74.2%
Prefer Not to Answer	0%	0.9%	2.6%	0.8%
Missing	3.4%	0.9%	0.9%	1.6%
Gender				
Woman	82.9%	85.3%	87.1%	81.5%
Man	10.3%	12.1%	10.3%	12.1%
Other	3.4%	1.7%	0%	3.2%
Transgender	0%	0%	1.7%	0%
Prefer Not to Answer	0%	0%	0%	1.6%
Missing	3.4%	0.9%	0.9%	1.6%
Sexual Orientation				
Bisexual	10.3%	10.3%	12.9%	8.9%
Gay	1.7%	4.3%	0.9%	2.4%
Straight	76.9%	75%	75.9%	77.4%
Lesbian	4.3%	0%	2.6%	3.2%
Queer	3.4%	3.4%	0.9%	3.2%
Prefer Not to Answer	0%	1.7%	1.7%	1.6%
Other	0%	4.3%	4.3%	1.6%
Missing	3.4%	0.9%	0.9%	1.6%
Location of Current Program				
Northeast	12%	14.7%	15.7%	13.7%
Midwest	19.7%	17.2%	20.9%	24.2%
South	35%	38.8%	40.9%	34.7%
West	29.9%	27.6%	21.7%	25.8%
Missing	3.4%	0.9%	0%	1.6%
Outside the U.S.	0%	0.9%	0.9%	0%
Current Degree				
Master-level	47%	49.2%	45.6%	48.4%
Doctoral-level	49.6%	48.2%	53.5%	50%
Missing	3.4%	2.6%	0.9%	1.6%
Current Clinical Placement				
First Practicum	15.4%	18.1%	17.2%	21.8%
Externship/Field Placement	47.9%	45.7%	39.7%	37.1%
Master's Internship	21.4%	22.4%	20.7%	23.4%
Predoctoral Internship	5.1%	6.0%	11.2%	7.3%
Not on Placement	6.8%	3.4%	9.5%	4.8%
Other	0%	3.4%	0.9%	4.0%
Missing	3.4%	0.9%	0.9%	1.6%
Highest Degree Completed				
Bachelor's	46.2%	50%	51.7%	50%
Master's	49.6%	46.6%	45.7%	47.6%
Doctoral or Professional Degree	0%	2.6%	1.7%	0.8%
Missing	4.3%	0.9%	0.9%	1.6%
International Student				
No	92.3%	95.7%	91.4%	97.6%
Yes	4.3%	3.4%	7.8%	0.8%
Missing	3.4%	0.9%	0%	1.6%

Note. LF = Low Client Risk, Facilitative Supervision. *LS* = Low Client Risk, Structured Supervision. *HF* = High Client Risk, Facilitative Supervision. *HS* = High Client Risk, Structured Supervision.

Measures.

Consent and screening. All participants first completed the informed consent (see Appendix A) and then screened to ensure they meet requirements for this study as outlined above (see Appendix B).

Presentation of client case. Each participant was randomly presented one of two client cases vignettes. All cases featured a client presenting with concerns related to a recent end of a long-term relationship, which was chosen as it represents a common concern that trainees are likely to experience. Each vignette varied based on level of suicidal risk. Participants completed attention check questions to ensure they read the vignette.

Client presenting with low probability of suicidal risk. In this condition (see Appendix C), the client discussed the end of a long-term relationship, endorsed depressive symptoms (increased crying, feelings of depression and sadness, increase in fatigue, and difficulty focusing), reported passive suicidal ideation ("I've been wishing I just wouldn't wake up") and reported multiple protective factors (future orientation, engagement in treatment, social support, involvement in activities). According to the SAFE-T model, the client would be classified as having a low probability of risk (SAFE-T, 2009).

Client presenting with high probability of suicidal risk. In this condition (see Appendix D), the client discussed the end of a long-term relationship, endorsed depressive symptoms (increased crying, feelings of depression and sadness, increase in fatigue, change in sleeping habits, feelings of hopelessness, anhedonia, and difficulty focusing), reported changes to normal routine (not going to work or recreational

activities), reported suicidal thoughts with identified plan, intent, means, and rehearsal ("I've been thinking about shooting myself"; "I had the gun out last night and I was going to do it…"), and reported other risk factors (limited social support, not future oriented). According to the SAFE-T model, this client would be classified as having a high probability of risk (SAFE-T, 2009).

Self-efficacy. Therapist levels of self-efficacy for working with the client about whom they read was measured with an adapted version of the Perceived Preparation for Suicide Counseling Scale (PPSC; Binkley & Leibert, 2014; see Appendix E). The PPSC is an 8-item questionnaire on a 5-point Likert Scale (*Disagree* to *Agree*) with two items that need to be reverse-coded. Example items from the original scale include items like "When I think about counseling a suicidal client, I feel confident" and "I have no idea what to do if a client reports feeling suicidal". The psychometrics of the original PPSC were tested on a sample of 113 prepracticum trainees (83.2% female) from a counseling psychology master program in the United States. Using exploratory factor analysis, it was found that all eight items loaded onto one factor (*range of factor loadings* = .58-.86). The results showed good reliability (*Cronbach's* α = .89) for the overall sum score.

For this study, the questions were modified to remove the attention to the client being suicidal as to not lead participants. As such, example questions were: "When I think about counseling this client, I feel confident" and "I have no idea what to do with this client". Additionally, one item was removed (i.e., "If asked to perform my suicide role play tomorrow, I would feel calm") due to the irrelevance to the current study, for a total of seven items. A higher score indicated more self-efficacy with working with the client

depicted. The PPSC showed good reliability in this sample overall and for each condition (see Tables 5-9; overall *Cronbach's α* = .83).

Presentation of supervision session. Each participant was presented with one of four supervision sessions vignettes. Supervisory sessions were divided into facilitative or structured sessions, each with two sessions that correspond to the level of risk of the client case read by the participant. For example, if a participant read the high risk client session, they would either read the high risk facilitative supervision session or the high risk structured supervision session. Development of supervisory sessions that correspond to the client risk level allowed for specific details pertinent to each level of risk to be given; increasing the believability of the supervisory session.

Structured supervision. In the structured supervisory session (see Appendix F for low client risk; Appendix G for high client risk), the supervisor provided structure to the supervisee as outlined by the prescriptive and informative qualities of authoritative supervision (Heron, 1990). The supervisor provided direct recommendations and guidance in each condition to address the client's risk level according to the SAFE-T (2009) model (i.e., low risk: exploration; high risk: hospitalization). The supervisor discussed providing the trainee with resources (i.e., handout on risk assessment and book about break ups) and the expectation that the trainee will use them in the future. The supervisor provided an interpretation of the client's presenting concern and reported behaviors (e.g., "It's clear she's experiencing some depressive symptoms"; "She also seems to be resilient…"). Support was provided to the trainee through praise ("You're doing great work with this client"), establishment of the supervisor as on the trainee's

side ("…I'm here to support you moving forward with this client"), and normalization of the trainees' experience ("It can be scary to hear clients say things like this")

Facilitative supervision. In the facilitative supervision session (see Appendix H for low client risk; Appendix I for high client risk), the supervisor adopted cathartic and catalytic approaches associated with facilitative supervision as identified by Heron (1990). The supervisor indicated the importance of talking about the trainee's reaction to the client ("It's important for us as clinicians to be self-aware and engage in self-exploration"). The supervisor brought up the client's level of risk in all conditions and ask the trainee what to do next ("What do you think we should do to address her risk?"). Support was provided to the trainee through praise ("You're doing great work with this client"), establishment of the supervisor as on the trainee's side ("…I'm here to support you moving forward with this client"), and normalization of the trainees' experience ("It can be scary to hear clients say things like this")

Supervision quality. The quality of the supervision as presented in the supervision sessions was measured with the Counselor Rating Form-Short (CRF-S; Corrigan & Schmidt, 1983; see Appendix J). For the CRF-S, participants are presented with 12 different characteristics and asked to rate how well the characteristic represent the supervisor using a 7-point Likert Scale (*Not Very* to *Very*). There are three subscales, each with four items: 1) Attractiveness (e.g., "friendly"), 2) Expertness (e.g., "experienced"), and 3) Trustworthiness (e.g., "honest"). The psychometrics of the original CRF-S were tested among 133 college students (n = 83 female; 89% White) who watched and rated video clips of expert therapists (i.e., Carl Rogers, Fritz Perls, and Albert Ellis), and among 155 clients (n = 105 female; 86% White) receiving community

outpatient counseling services who rated their current therapist (n = 22 counselors; 12 female; 15 White). The results showed good reliability (*Cronbach's* α = .89-91 for Attractiveness; .85-.94 for Expertness; and .82-.91 for Trustworthiness). Intercorrelations between the subscales were between .57-.80 (Corrigan & Schmidt, 1983).

Previous research (Ponterotto & Furlong, 1985) has argued that while the CRF-S has three subscales, the CRF-S may be capturing a single factor. A single factor approach has been supported by additional studies which have found strong correlations between the subscales (e.g., Kokotvic & Tracey, 1987; LaCrosse & Barak, 1976; Zamostny, Corrigan, & Effert, 1981). For this study, a single factor was used where a higher score indicated a higher quality of supervision. Additionally, while originally created to measure the counselor's social influence, the CRF-S has been used to measure the quality of supervision (e.g., Tracey et al., 1989) as positive evaluations are associated with the CRF-S (Kokotovic & Tracey, 1987). The CRF-S showed good reliability in this sample overall and for each condition (see Tables 5-9; overall *Cronbach's* α = .95).

Trainee experience level. While a measure for examining trainees' experience level under the IDM does exist (e.g., Supervisee Levels Questionnaire-Revised; SLQ-R; McNeill, Stoltenberg, & Romans, 1992), this measure does not provide a way of organizing trainees into experience levels. Due to this limitation, trainee's experience level were measured using a modified version of the procedures of McNeill, Stoltenberg, and Pierce (1985) and McNeill, Stoltenberg, and Romans (1992; see Appendix K) who grouped samples of counseling and clinical psychology trainees in master and doctoral level programs in the United States into beginning, intermediate, or advanced by three components: semesters of counseling experience, semesters of supervision experience,

and years of graduate education. Groups were established by these researchers by assigning values (e.g., 1, 2, 3) to trainees according each of the three components, totaling these scores, and then dividing the participants into roughly equal groups. The authors acknowledge that while the groups may seem arbitrary, using multiple measures of development provides a stronger justification for classifying trainees than using a sole measure (e.g., practicum status).

For this study, a similar method was used such that the number of semesters of counseling, number of semesters of supervision, and number of semesters of graduate training by a trainee were added together to create their experience level. For example, a trainee who was in their second semester of counseling, second semester of receiving supervision, and third semester of graduate education received a total experience score of seven (e.g., 2 for counseling experience + 2 for supervision experience + 3 for graduate education = 7 total experience score). To create this score, participants were asked to provide the number of semesters of counseling, supervision, and graduate education they have completed, including the one in which they are currently enrolled. The created trainee experience level score showed good reliability in this sample overall and for each condition (see Tables 5-9; overall *Cronbach's* α = .93).

Demographic information. Participants were asked general demographic questions related to: age, gender, race and ethnicity, sexual orientation, type of program, experience working with clients presenting with suicidal risk, and experience with suicidal risk assessment and intervention (see Appendix L).

Free response and suicide assessment questions. To gather more information about how participants viewed the study and the conditions, several free-response and multiple-

choice questions were asked about risk assessment and what they would have done in the situation if this was a real client with whom they were working (see Appendix M).

Procedure. The main data collection for this study took place in five parts: 1) consent and screening, 2) presentation of a client case vignette, 3) self-efficacy measure, 4) presentation of a supervision session vignette, and 5) collection of research and demographic questionnaires. Only trainees were recruited to participate, and they had to meet the criteria outlined above for the pilot testing. All materials were hosted online by Qualtrics. Using the randomizer feature of Qualtrics, participants were randomly presented with one of two different client case vignettes, which varied based on level of risk (i.e., client presenting with low or high risk), and randomly presented with one of four supervision session vignettes (i.e., facilitative or structured session), which corresponded to the level of risk of the presented client. Total participation was around 15 minutes. Following completion of the research survey, participants had the option to enter a drawing for one $20 Amazon gift card. Payment was distributed upon completion of data collection.

Participants were recruited via advertisements sent to training directors of programs in the eligible helping fields, and university and professional Listservs, such as those associated with the American Counseling Association and American Psychological Association. Six hundred and forty-six participants consented to participate, and of them 70 did not meet screening requirements. Data were collected from the remaining 576 participants, and of this number, 103 participants were removed from final analyses due to incomplete data (n = 54; e.g., did not complete trainee experience level questions) or for answering at least one attention check incorrectly (n = 49). Of those removed for

incomplete data, 16 were in the low client risk, facilitative supervision condition, 12 were in the low client risk, structured supervision condition, 15 were in the high client risk, facilitative supervision condition, and 11 were in the high client risk, structured supervision condition. Of those removed for incorrect attention check answers, 12 were in the low client risk, facilitative supervision condition, 15 were in the low client risk, structured supervision condition, 14 were in the high client risk, facilitative supervision condition, and 8 were in the high client risk, structured supervision condition. Chi-square analyses indicated there was no significant difference for the rate of participant dropout across conditions (p = .42).

Data Analysis

Descriptive statistics were examined for all variables. To examine RQ1 (Will perceptions of supervision quality vary across supervision environment (structured, facilitative) and client risk level (low, high), and will these relations vary by trainee experience level?) a hierarchical regression was used. The CRF-S total score was the criterion variable. The first step examined H1a (There will be no differences in supervision quality ratings across supervision environment. There will be differences in supervision quality ratings across risk level and trainee experience level.) with supervision environment, dummy code of client risk level and trainee experience level total scores as the predictor variables. The second step examined H1b (Quality ratings of supervision and client risk level will be moderated by supervision environment such that quality ratings of structured supervision will increase and quality ratings of facilitative supervision will decrease as risk level increases.) with the interaction between supervision environment and dummy code of client risk level as the predictor variables.

The third step examined H1c (Quality ratings of supervision and trainee experience level will be moderated by supervision environment such that such that quality ratings of structured supervision will decrease, and quality ratings of facilitative supervision will increase as trainee experience level increases.) with the interaction between trainee experience level total scores and supervision environment, and the interaction between trainee experience level total scores and dummy coded client risk level as the predictor variables. Finally, the fourth step examined H1d (Quality ratings and client risk level and trainee experience level will be moderated by supervision environment such that as risk level increases, the quality of structured supervision will increase regardless of trainee experience level. As the risk level decreases, the quality of structured supervision will decrease, and quality ratings of facilitative supervision will increase as trainee experience level increases.) with the interaction between trainee experience level total scores, supervision environment, and dummy coded client risk level as the predictor variables.

To examine RQ2 (Will perceptions of supervision quality vary across supervision environment (structured, facilitative) and client risk level (low, moderate, high), and will these relations vary by trainee self-efficacy?) a hierarchical regression was also used. The CRF-S total score was the criterion variable. The first step examined H2a (There will be no differences in supervision quality ratings across supervision environment. There will be differences in supervision quality ratings across risk level and trainee self-efficacy.) with supervision environment, dummy code of client risk level and PPSC total scores as the predictor variables. The second step examined H2b (Quality ratings of supervision and client risk level will be moderated by supervision environment such that quality ratings of structured supervision will increase and quality ratings of facilitative

supervision will decrease as risk level increases.) with the interaction between supervision environment and dummy code of client risk level as the predictor variables. The third step examined H2c (Quality ratings of supervision and trainee developmental level will be moderated by supervision environment such that such that quality ratings of structured supervision will decrease, and quality ratings of facilitative supervision will increase as trainee self-efficacy increases.) with the interaction between trainee developmental level total scores and supervision environment, and the interaction between PPSC total scores and dummy coded client risk level as the predictor variables. Finally, the fourth step examined H2d (Quality ratings and client risk level and trainee self-efficacy will be moderated by supervision environment such that as risk level increases, the quality of structured supervision will increase, and quality ratings of facilitative supervision will decrease as trainee self-efficacy decreases. As the risk level decreases, the quality of structured supervision will decrease, and quality ratings of facilitative supervision will increase as trainee self-efficacy increases.) with the interaction between PPSC total scores, supervision environment, and dummy coded client risk level as the predictor variables.

CHAPTER 4

RESULTS

Descriptive Statistics

Descriptive statistics, reliabilities, and correlations for the entire sample are shown in Table 5, and for each condition in Tables 6 through 9. Overall results indicate that participants rated the quality of supervision as high and reported average to high levels of self-efficacy. Within each condition, all scales showed good internal consistency ranging from 0.80 to 0.96. Overall, there was a significant negative correlation between supervision quality ratings and trainee experience level and a significant positive correlation between trainee experience level and trainee self-efficacy (see Table 5). However, within each condition, only trainee experience level and trainee self-efficacy continued to show a significant positive correlation (see Tables 6, 7, 8, & 9).

Table 5

Means, SDs, Ranges, Reliabilities, and Correlations for Entire Sample on Study Variables

Variable	*M*	*SD*	*Range*	α	1	2	3
1. Sup Quality[a]	5.91	0.90	2.42-7	.95	1	-.104*	.038
2. Trainee Exp	16.55	10.83	3-65	.93		1	.220**
3. Trainee SE[b]	4.03	0.64	1.71-5	.83			1

Note. n = 473. *Sup* = Supervision, *Exp* = Experience, *SE* = Self-Efficacy. Scaling on Likert Scale: 1-7[a], 1-5[b]. * = 0.05, ** = 0.01

Table 6

Means, SDs, Ranges, Reliabilities, and Correlations for Participants in the Low – Facilitative Condition on Study Variables

Variable	*M*	*SD*	*Range*	α	1	2	3
1. Sup Quality[a]	5.93	0.91	2.67-7	.96	1	.044	.011
2. Trainee Exp	16.10	9.30	3-53	.90		1	.298**
3. Trainee SE[b]	4.23	0.65	2.29-5	.85			1

Note. n = 117. *Sup* = Supervision, *Exp* = Experience, *SE* = Self-Efficacy. Scaling on Likert Scale: 1-7[a], 1-5[b]. ** = 0.01

Table 7

Means, SDs, Ranges, Reliabilities, and Correlations for Participants in the Low – Structured Condition on Study Variables

Variable	*M*	*SD*	*Range*	α	1	2	3
1. Sup Quality[a]	6.01	0.80	3.25-7	.96	1	-.121	.021
2. Trainee Exp	15	9.13	3-45	.92		1	.328**
3. Trainee SE[b]	4.20	0.56	2.71-5	.80			1

Note. n = 116. *Sup* = Supervision, *Exp* = Experience, *SE* = Self-Efficacy. Scaling on Likert Scale: 1-7[a], 1-5[b]. ** = 0.01

Table 8

Means, SDs, Ranges, Reliabilities, and Correlations for Participants in the High – Facilitative Condition on Study Variables

Variable	*M*	*SD*	*Range*	α	1	2	3
1. Sup Quality[a]	5.65	0.85	3.25-7	.93	1	-.147	-.010
2. Trainee Exp	17.28	11.90	3-58	.93		1	.276**
3. Trainee SE[b]	3.89	0.58	1.71-5	.80			1

Note. n = 117. *Sup* = Supervision, *Exp* = Experience, *SE* = Self-Efficacy. Scaling on Likert Scale: 1-7[a], 1-5[b]. ** = 0.01

Table 9

Means, SDs, Ranges, Reliabilities, and Correlations for Participants in the High – Structured Condition on Study Variables

Variable	*M*	*SD*	*Range*	α	1	2	3
1. Sup Quality[a]	5.98	0.97	2.42-7	.96	1	-.137	.032
2. Trainee Exp	17.73	12.41	4-65	.96		1	.178*

3. Trainee SE[b]	3.83	0.66	1.71-5	.84	1

Note. n = 124. *Sup* = Supervision, *Exp* = Experience, *SE* = Self-Efficacy. Scaling on Likert Scale: 1-7[a], 1-5[b]. * = 0.05

Associations between Client Risk Level, Type of Supervision Received, Trainee Experience Level, and Supervision Quality Rating (RQ1)

A hierarchical regression was conducted to examine the association between client risk level, type of supervision received, trainee experience level, and supervision quality ratings (see Table 10). The first step (H1a) of the hierarchical regression revealed that type of supervision received, client risk level, and trainee experience level contributed significantly to the model, $F(3, 469) = 6.27$, $p < 0.001$, and accounted for 4.0% of the variation in supervision quality rating scores. There were significant main effects for each of the three variables. Type of supervision received significantly predicted quality of supervision ratings, $b = 0.14$, $t(469) = 3.01$, $p < 0.01$, suggesting that structured supervision was rated more highly than facilitative supervision. Client risk level significantly predicted quality of supervision ratings, $b = -0.10$, $t(469) = -2.17$, $p < 0.05$, suggesting that participants who read the high client risk vignette rated the quality of supervision they received as lower than those who read the low client risk vignette, regardless of which type of supervision they received. Finally, trainee experience level showed significant main effects, $b = -0.09$, $t(469) = -2.06$, $p < 0.05$, suggesting that trainees who were less experienced rated the supervision they received as higher quality than trainees who were more experienced. These results partially support H1a.

The second step (H1b) showed that the addition of the interaction between type of supervision received and client risk level did not significantly predict an additional

amount of variance in supervision quality ratings, $F(1, 468) = 5.02$, $p < 0.001$, $\Delta F = 1.27$, $p = .26$. Therefore, H1b was not supported.

The third step (H1c) included the addition of the interactions between type of supervision received and trainee experience level, and client risk level and trainee experience level. Neither contributed significantly to an additional amount of variance in supervision quality ratings, but the model remained significant overall, $F(2, 466) = 3.59$, $p < 0.01$, $\Delta F = 0.74$, $p = .48$, suggesting that H1c was not supported.

Finally, the fourth step (H1d) included the interaction between type of supervision received, trainee experience level, and client risk level. However, this did not explain a significant amount of variance in supervision quality ratings, but again, the model remained significant overall, $F(1, 465) = 3.20$, $p < 0.01$, $\Delta F = 0.86$, $p = .35$. Therefore, H1d was not supported.

Table 10

Results of Regression of Trainee Experience Level on Supervision Quality Ratings

Model		*df*	β	*t*	R^2	*F*	ΔR^2	ΔF
Step 1		3, 469			.04	6.27***	.039	6.27***
	Constant			65.18***				
	Sup Condition		.14	3.01**				
	Client Risk		-.10	-2.17*				
	Trainee Exp		-.09	-2.06*				
Step 2		1, 468			.04	5.02***	.003	1.27
	Constant			59.51***				
	Sup Condition		.09	1.31				
	Client Risk		-.15	-2.33*				
	Trainee Exp		-.10	-2.1*				
	Sup*Client		.09	1.13				
Step 3		2, 466			.04	3.59**	.003	.74
	Constant			41.41***				
	Sup Condition		.14	1.47				
	Client Risk		-.08	-.87				
	Trainee Exp		-.004	-.045				

Sup*Client		.09	1.16				
Sup*Trainee Exp		-.07	-.73				
Client*Trainee Exp		-.10	-.93				
Step 4	1, 465			.05	3.20**	.002	.86
Constant			35.75***				
Sup Condition		.22	1.71				
Client Risk		-.016	-.13				
Trainee Exp		.05	.48				
Sup*Client		-.02	-.16				
Sup*Trainee Exp		-.19	-1.18				
Client*Trainee Exp		-.20	-1.31				
Sup*Client*Trainee Exp		.16	.93				

Note. Sup = Supervision, *Exp* = Experience, *Client* = Client Risk Level. Supervision Dummy Codes: 0 = Facilitation, 1 = Structured. Client Risk Dummy Codes: 0 = Low, 1 = High. * = $p < 0.05$, ** = $p < 0.01$, *** = $p < 0.001$

Associations between Client Risk Level, Type of Supervision Received, Trainee Self-Efficacy Level, and Supervision Quality Rating (RQ2)

A hierarchical regression was conducted to examine the association between client risk level, type of supervision received, trainee self-efficacy level, and supervision quality ratings (see Table 11). The first step (H2a) of the hierarchical regression revealed that type of supervision received, client risk level, and trainee self-efficacy level contributed significantly to the model, $F(3, 469) = 4.84$, $p < 0.01$, and accounted for 3.0% of the variation in supervision quality rating scores. There was a significant main effect for type of supervision received, $b = 0.14$, $t(469) = 3.04$, $p < 0.01$, suggesting that structured supervision was rated more highly than facilitative supervision. Client risk level significantly predicted quality of supervision ratings, $b = -0.10$, $t(469) = -2.18$, $p < 0.05$, suggesting that participants who read the high client risk vignette rated the quality of supervision they received as lower than those who read the low client risk vignette. These results partially support H2a.

The second step (H2b) showed that the addition of the interaction between type of supervision received and client risk level did not significantly predict an additional amount of variance in supervision quality ratings, $F(1, 468) = 3.91$, $p < 0.05$, $\Delta F = 1.1$, $p = .29$. Therefore, H2b was not supported.

The third step (H2c) included the addition of the interaction between type of supervision received and trainee self-efficacy level, and client risk level and trainee self-efficacy level. Neither contributed significantly to an additional amount of variance in supervision quality ratings, but the model remained significant overall, $F(2, 466) = 2.61$, $p < 0.05$, $\Delta F = 0.04$, $p = .96$, suggesting that H2c was not supported.

Finally, the fourth step (H2d) included the interaction between type of supervision received, trainee self-efficacy level, and client risk level. However, this did not explain a significant amount of variance in supervision quality ratings, but again, the model remained significant overall, $F(1, 465) = 2.24$, $p < 0.05$, $\Delta F = 0.03$, $p = .86$. Therefore, H2d was not supported.

Table 11

Results of Regression of Trainee Self-Efficacy Level on Supervision Quality Ratings

Model		*df*	β	*t*	R^2	*F*	ΔR^2	ΔF
Step 1		3, 469			.030	4.84**	.03	4.84**
	Constant			19.89***				
	Sup Condition		.14	3.04**				
	Client Risk		-.10	-2.18*				
	Trainee SE		0.2	.31				
Step 2		1, 468			.032	3.91*	.002	1.103
	Constant			19.85***				
	Sup Condition		.09	1.39				
	Client Risk		-.15	-2.29*				
	Trainee SE		.02	.32				
	Sup*Client		.08	1.05				
Step 3		2, 466			.032	2.61*	.000	.041

Constant		12.25***				
Sup Condition	-.002	-.005				
Client Risk	-1.4	-4.5				
Trainee SE	.004	.05				
Sup*Client	.09	1.09				
Sup*Trainee SE	.09	.29				
Client*Trainee SE	-.01	-.05				
Step 4	1, 465		.033	2.24*	.000	.030
Constant		10.76***				
Sup Condition	.06	.12				
Client Risk	-.09	-.20				
Trainee Exp	.01	.12				
Sup*Client	-.002	-.004				
Sup*Trainee SE	.03	.07				
Client*Trainee SE	-.07	-.15				
Sup*Client*Trainee SE	.09	.17				

Note. Sup = Supervision, *SE* = Self-Efficacy, *Client* = Client Risk Level. Supervision Dummy Codes: 0 = Facilitation, 1 = Structured. Client Risk Dummy Codes: 0 = Low, 1 = High. * = $p < 0.05$, ** = $p < 0.01$.

CHAPTER 5

DISCUSSION

The goal of the present study was to examine how trainees rate the quality of structure and facilitation in supervision when working with clients presenting with varying levels of suicidal risk (i.e., low or high), and to examine how trainees' quality ratings of structure and facilitation in supervision may vary according to experience and self-efficacy of the trainee. A discussion of the results is provided below, along with limitations, implications, and future directions for research and clinical practice.

Trainee Experience Level (RQ1)

The first part of this study examined ratings of supervision quality across supervision environment (structured or facilitative), client risk level (low or high), and trainee experience level. Partial support was found for the first hypothesis (H1a) and support was not found for the other three hypotheses (H1b-H1d).

As predicted for H1a, significant main effects were found for trainee experience level and client risk level. Trainees who were less experienced rated the quality of supervision they received as higher than those who were more experienced when client risk level and type of supervision were controlled. Additionally, the correlational data showed a significant negative relationship such that more advanced trainees rated the supervision they received as lower quality or less advanced trainees rated the supervision they received as higher quality. This result fits with the IDM as less experienced trainees may more be reliant on their supervisor and look to them as the "authority" on what the "right" thing to do with a client is, while more experienced trainees may view supervision as a place to consult about their own clinical ideas and judgement. Less advanced trainees

may view any type of supervision as they receive as being higher quality, whereas advanced trainees may be more selective in what is helpful to them (McNeill & Stoltenberg, 2016; Stoltenberg & McNeill, 1997).

In additional support of H1a, a significant main effect was found for client risk level, such that trainees rated the quality of supervision as lower after reading the high client risk vignette compared to those who read the low client risk vignette. Previous research has suggested that trainees want supervision more when facing suicidal risk concerns from clients, especially high risk (Binkley & Leibert, 2014; Dexter-Mazza & Freeman 2003; Douglas & Watcher Morris, 2015; Hoffman et al., 2013; Mackelprang et al., 2014), and this finding suggests that when trainees encounter a high risk client, they may not view the quality of supervision as high as when clients present with low risk. Trainees may rate the quality of supervision higher after working with a low risk client, as trainees may feel highly anxious in situations where clients present with suicidal risk (Bryan & Rudd, 2006; Reeves & Mintz, 2001), and therefore in high risk situations, trainees may have higher expectations for the quality of supervision they receive and judge it more critically. Future studies could examine the associations between trainee anxiety, client risk level, and supervision quality ratings.

Additionally, previous research has suggested the importance of a strong supervisory relationship when clients present with suicidal concerns (Hoffman et al., 2013, Ladany, Lehrman-Waterman, Molinaro, & Wolgast, 1999). Considering the vignette nature of this study where trainees were asked to pretend the supervisor depicted was their supervisor, it may also be that trainees rated the quality of supervision higher in the low risk condition as they did not feel a strong rapport with the depicted supervisor and trusted the

supervisor less in the high risk condition as there is more complex decision making involved when clients present with high suicidal risk (Bryan & Rudd, 2006; Shea, 2011). As stated above, trainees could be more critical of supervision approaches when feeling anxious in high risk situations and this criticism may be heightened if rapport has not been established. The findings of this study may indicate that trainees may require additional support and rapport with their supervisors during high risk conditions, and future studies could examine supervisory alliance as a potential moderator of the potential association between trainee anxiety and supervision quality ratings when clients present with varying levels of risk.

In contrast to what was predicted in H1a, there was a significant main effect for type of supervision received such that structured supervision was rated as a higher quality than facilitative supervision. This finding may be again be related to supervisory alliance (Hoffman et al., 2013; Ladany et al., 1999) as the facilitative supervision asks several more personal questions about the trainee, such as their own reaction and clinical judgment about the client case, and without the supervisory rapport, they did not find this supervision as high of quality. Additionally, trainees in this study may have rated structured supervision higher than facilitative supervision as they are able to evaluate the validity of the supervisor's guidance more easily and quickly (e.g., "I think you should do X, Y, Z"). than in a facilitative approach where guidance is woven into a collaborative conversation. To combat the artifice of the design of this study, future studies could investigate real-world situations where a supervisory alliance has been built.

H1b, H1c, and H1d were not supported as supervision environment did not moderate any associations between trainee experience level or client risk level and quality of

supervision ratings. Regarding H1b, there was no significant moderation of type of supervision received between client risk level and supervision quality ratings. A previous study has found that when presented with client risk, trainees prefer structured supervision (e.g., Tracey et al., 1989), but this was not found in this study, which may suggest that client risk level may not be a significant contextual factor in how trainees rate supervision quality, but rather if risk is present or not. Other research has suggested that supervisors do act differently when clients their trainees are seeing present with suicidal concerns, such that supervisors report being more directive and involved (Hoffman et al., 2013; Jahn et al., 2016), especially in the immediate aftermath of the trainee seeing the client (Knox et al., 2006). It may be that regardless of risk level, trainees are more receptive to structured supervision to receive guidance on appropriately dealing with the client's risk, and then later are more receptive to processing their own emotional reaction, as done in facilitative supervision. Future research could adopt a longitudinal approach to examine structured and facilitative supervision over several sessions after a client presents with suicidal risk.

For H1c, there was no significant moderation of type of supervision received between trainee experience level and quality ratings of supervision, which does not support the Cube Model of Supervision and Suicide (McGlothlin et al., 2005) or IDM (McNeill & Stoltenberg, 2016); both of which suggest that as trainee experience level increases, they would prefer less structure and more facilitative approaches in supervision. Additionally, there was no significant three-way interaction of type of supervision received between trainee experience level, client risk level, and supervision quality ratings, which did not support H2d. While previous research has suggested that supervision may be different

when clients present with suicidal risk (Jahn et al., 2016; Tracey et al., 1989), there is limited research on how exactly supervision is different and how trainee experience level may play a role. This is the first study to our knowledge that examines trainee experience level as a continuous variable rather than a categorical one (e.g., Level 1, Level 2, etc.; beginning vs. advanced), and therefore supervision ratings across a spectrum of trainee experience levels may be more complex and may depend more on individual factors of the trainee that make up experience level, such as number of clients seen or type of clinical work (e.g., therapy vs. assessment). Additionally, some researchers (e.g., Simon, 2006) have argued that general clinical experience may not be enough, but rather the blend of experience and evidenced-based knowledge of suicide assessment and intervention. Therefore, important variables related to trainee experience to examine in the future may be specific experience working with clients presenting with suicidal concerns, and experience with evidenced-based knowledge and training. Previous studies have found support that training in suicide assessment and intervention enhances trainee self-reported competency (McNiel, Fordwood, Weaver, Chamberlain, Hall, & Binder, 2008), but it is unclear how training and experience with suicidal risk is related to supervision quality ratings. Trainee experience working with clients presenting with suicidal risk specifically should be examined in future research.

Trainee Self-Efficacy Level (RQ2)

In the second part of this study, ratings of supervision quality across supervision environment (structured or facilitative), client risk level (low or high), and trainee self-efficacy level were examined. As with the first part, partial support was found for the first hypothesis (H2a) and support was not found for the other three hypotheses (H2b-H2d).

Significant main effects were found for client risk level on supervision quality ratings consistent with H2a, such that those who read the high client risk vignette rated the supervision they received as lower quality than those who read the low client risk vignette, when controlling for type of supervision received and trainee self-efficacy level. There was also a significant main effect for type of supervision, such that structured supervision was rated more highly than facilitative supervision when controlling for client risk level and trainee self-efficacy level. Just as in the first regression, there was no significant moderation of type of supervision received between client risk level and supervision quality ratings, against what was hypothesized in H2b. These finding may be due to the reasons mentioned above regarding RQ1.

H2c was not supported as there was no significant moderation of type of supervision received between trainee self-efficacy and supervision quality ratings, and no significant moderation of client risk level between trainee self-efficacy and supervision quality ratings. Additionally, H2d was not supported as there was no significant three-way interaction between type of supervision received, trainee self-efficacy level, and client risk level. While previous research has suggested that trainee self-efficacy may be related to trainee expectations about supervision (Friedlander & Snyder, 1983), results in the hypothesized directions about self-efficacy may not have been found in this study due to the overall high self-efficacy reported by trainees. Additionally, Friedlander and Snyder (1983) suggest that as trainees gain self-efficacy, they expect supervisors to be more "expert", which is may be obvious within a structured approach as supervisors are actively displaying their skills through advice giving, whereas a facilitative approach emphasizes more collaboration (Heron, 1990). Since "expertness" is one of the factors

measured by the CRF-S (Coorigan & Schmidt, 1983), which was used as a measure of supervision quality, it is possible trainees in this study viewed the supervisor in the structured condition as more "expert". Additionally, as supervision is hierarchical relationship in which the supervisor has more power than the trainee (Bernard & Goodyear, 2009), trainees may tend to view their supervisors as more "expert" when supervisors use this power to give direct feedback. However, examining the subcomponents of the CRF-S and how they relate to type of supervision was beyond the scope of this study, and future studies could examine different components of supervision.

Additionally, many trainees in this study rated their self-efficacy as high, coming close to a ceiling effect, which has been found in previous studies when trainees have been asked to rate their own self-efficacy (Johnson, Baker, Kopala, Kiselica, & Thompson, 1989; Potenza, 1990) and it has been argued that therapists may overestimate their abilities (Tracey, Wampold, Goodyear, & Lichtenberg, 2014). Results in the expected directions may not have been found due to trainees systematically overestimating their confidence in their abilities.

Previous research has linked self-efficacy to experience (Larson et al., 1992; Leach et al., 1997; Mullen et al., 2015; Sipps et al., 1988), and this finding was supported in this study as there was a positive significant correlation between trainee experience level and trainee self-efficacy in the sample overall and within every condition. These correlations suggest that as trainee experience level increases, so does their self-efficacy or as trainee experience level decreases, so does their self-efficacy. However, many of these studies examined self-efficacy related to general clinical ability, whereas this study examined

specifically self-efficacy related to working with a client presenting with suicidal concerns. Therefore, these results support that self-efficacy for working with a client presenting with suicidal concerns increases as trainees have more experience with general counseling, supervision, and graduate training. Previous research has linked increased self-efficacy in working with a client presenting with suicidal concerns to amount of training in suicide intervention and assessment (Binkley & Leibert, 2014; Douglas & Watcher Morris, 2015), and while this study did not examine trainee experience with suicide assessment and interventions, future research should include this variable.

Limitations

It is important to note limitations of this study. First, generalizability may be limited due to the sample collected. While an effort was made to sample trainees from varied training programs and cultural backgrounds, the sample was comprised primarily of White women from Counseling or Clinical Psychology programs. According to data from a 2016 study by APA on trainee demographics within the psychology field, this study's percentage of women (84.1%) is higher than an estimated representation of women (75%) within the psychology field, while the percentage of White-identified individuals with in this study (70.8%) is slightly higher than White-identified individuals (70%; APA, 2016). Future research should strive to collect data from a more diverse sample. Additionally, many of the graduate programs that participating trainees attended were accredited, which may be reflective of recruitment efforts, as graduate programs were targeted for recruitment by examining lists of accredited programs. It may be that some graduate programs were missed by either being unaccredited or were accredited by entities other than those searched. Finally, there may be significant differences in trainees

who choose to voluntarily participate in research studies than those who do not. Therefore, caution should be used when generalizing these results to other trainee populations and training programs.

Second, this study only examined low and high client risk levels, while the SAFE-T (2009) model includes a moderate risk level. A client presenting with moderate suicidal risk may present unique challenges in that trainees and supervisors must navigate determining appropriate interventions when there may be more ambiguity in terms of risk. For example, with high risk ensuring the immediate safety of the client is paramount and with low risk, clients are usually allowed to leave after session and are seen the following week. When a client presents with moderate risk, trainees and supervisors must decide if the client is safe enough to leave until the next appointment or if a higher quality of care is required (SAFE-T, 2009). As such, clients presenting with moderate risk may be related to different supervision quality ratings or preferences, and future research should examine moderate risk situations. Additionally, this study did not include a third condition with no client risk mentioned. As previous studies have found a significant difference in supervision preference by trainees when comparing client risk to no client risk mentioned (e.g., Tracey et al., 1989), future studies should examine client cases with varying risk levels and no mention of client risk to examine supervision quality ratings across trainee experience and self-efficacy levels.

While the experimental design of this study is a strength, these data are cross-sectional and self-reported, which may limit findings across time and situations. To further examine the research questions and hypotheses posited in this study, a longitudinal design should be conducted in which trainees working with clients

presenting with chronic risk are examined. Moreover, a future study could examine real-world training situations in which clients with suicidal concerns who are seeking therapy, trainees, and supervisors are studied. While such a study would present its own challenges, examining how trainees and supervisors are working with clients presenting with suicidal risk in real-time is an important future direction.

Finally, while the measures used showed good reliability in this sample, and the CRF-S (Corrigan & Schmidt, 1983) has been used in previous studies as a single-factor measure of the quality of supervision (e.g., Tracey et al., 1989), it could be that other components of supervision were missed. Future studies should utilize different methods of quantifying supervision quality and preference by trainees, including measures that focus more on the aspects of supervision, rather than on the supervisor as with the CRF-S (Corrigan & Schmidt, 1983), and those that examine multiple dimensions of supervision.

Implications and Conclusion

Trainees are likely to work with a client presenting with suicidal risk during their graduate program (Dexter-Mazza & Freeman, 2003; Watcher Morris & Barrio, 2012), and many trainees report receiving minimal training in suicide assessment and intervention (Dexter-Mazza & Freeman, 2003; Watcher Morris & Barrio Minto, 2012; Wozny, 2005). For client welfare and trainee development, trainees may turn to their supervisors for guidance when clients present with suicidal risk Dexter-Mazza & Freeman 2003; Hoffman et al., 2013; Mackelprang et al., 2014), and therefore, it is important supervisors are knowledgeable about best supervision practices in these situations (APA, 2017). To best help their trainees, supervisors should be mindful of individual trainee factors that may influence how trainees view supervision, such as

trainee experience level (McNeill & Stoltenberg, 2016; McNeill et al., 1992; Stoltenberg & McNeill, 1997) and trainee self-efficacy level (Binkley & Leibert, 2014; Douglas & Watcher Morris, 2015; Friedlander and Snyder, 1983). This research suggests the importance of structured supervision, such that trainees may rate it more favorably compared to facilitative supervision.

These results also suggest the importance of supervisors being mindful that less experienced trainees may be more receptive to any type of supervision provided, whereas more advanced trainees may be more selective. As always, supervisors should be mindful of the power they hold as someone in a hierarchical and evaluative role (Bernard & Goodyear, 2014) to ensure less advanced trainees are not simply acquiescing but getting what they most need from supervision to help them advance in their skills. Additionally, supervisors can minimize their power to help more experienced trainees by developing a collaborative relationship, as suggested by the IDM (McNeill & Stoltenberg, 2016). As trainees in this study also rated supervision quality lower when clients presented with high risk, supervisors should also be mindful that supervision may be especially impactful and meaningful during these moments (e.g., Hoffman et al., 2013; McGlothlin et al., 2005).

Although no significant moderations were found in the sample, supervisors and research are encouraged to be aware of the importance of trainee experience level, client risk, and supervision condition, as they relate to supervision quality ratings, which was supported in this research. Researchers and supervisors should continue to investigate and implement best practices for supervision when clients present with suicidal risk to help trainees meet core competencies (American Association of Suicidology, 2006; Cramer,

Johnson, McLaughlin, Rausch, & Conroy, 2013) and enhance the quality of care provided to clients struggling with suicidal concerns.

REFERENCES

American Association of Suicidology. (2006). *Core competencies for the assessment and management of individuals at risk for suicide.* Newton, MA: Author.

American Psychiatric Association. (2003). *American Psychiatric Association Practice Guideline for the assessment and treatment of suicidal behaviors*. Arlington, VA: American Psychiatric Publishing.

American Psychological Association. (2016). *Summary Report, Graduate Study in Psychology 2017: Student Demographics.* Washington, D.C.: Author.

American Psychological Association. (2017). *Ethical Principles of Psychologists and Code of Conduct.* Washington, D.C.: Author.

Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review, 84*(2), 191-215.

Bernard, J.M. & Goodyear, R.K. (2014). *Fundamentals of Clinical Supervision* (5th ed.). Boston, MA: Pearson Education, Inc.

Binkley, E.E., & Leibert, T.W. (2014). Prepracticum counseling students' perceived preparedness for suicide response. *Counselor Education & Supervision, 54*, 98-108. doi: 10.1002/ceas.12007

Blake, R.R., & Mouton, J.S. (1976). *Consultation.* London, UK: Addison-Wesley

Bryan, C. J. & Rudd, D. M. (2006). Advances in the assessment of suicide risk. *Journal of*
Clinical Psychology 62 (2), 185-200.

Cohen J. E. (1988). Statistical Power Analysis for the Behavioral Sciences. Hillsdale, NJ: Lawrence Erlbaum Associates, Inc.

Corrigan, J. D., & Schmidt, L. D. (1983). Development and validation of revisions in the Counselor Rating Form. *Journal of Counseling Psychology, 30*(1), 64-75. doi 10.1037/0022-0167.30.1.64

Cramer, R. J., Johnson, S. M., McLaughlin, J., Rausch, E. M., & Conroy, M. A. (2013). Suicide risk assessment training for psychology doctoral programs: Core competencies and a framework for training. *Training and education in professional psychology, 7(1),* 1-11.

Dexter-Mazza, E., & Freeman, K. A. (2003). Graduate training and the treatment of suicidal clients: The students' perspective. *Suicide and Life-Threatening Behavior, 33*(2), 211-218. doi:http://dx.doi.org.ezproxy1.lib.asu.edu/10.1521/suli.33.2.211.22769

Dupre, M., Echterling, L.G., Meixner, C., Anderson, R., & Kielty, M. (2013). Supervision experiences of professional counselors providing crisis counseling. *Counselor Education & Supervision, 53*, 82-96. doi: 10.1002/j.1556-6978.2014.00050.x

Falender, C.A., & Shafranske, E.P. (2004). *Clinical supervision: A competency-based approach.* Washington, D.C.: APA.

Foster, V.A., & McAdams, C. R. (1999). The impact of client suicide in counselor training: Implications for counselor education and supervision. *Counselor Education & Supervision, 29*, 22-33.

Friedlander, M.L. & Snyder, J. (1983). Trainees' expectations for the supervisory process: Testing a developmental model. *Counselor Education & Supervision, 22*(4), 342-348.

G*Power Version 3.1.9.2 [Computer software]. (2017). Retrieved from http://www.gpower.hhu.de/en.html

Heron J. (1990) Helping the Client: A Creative Practical Approach. Sage, London.

Hoffman, R. M., Osborn, C. J., & West, J. D. (2013). Clinical supervision of counselors-in-training working with suicidal clients: A grounded theory investigation. *The Clinical Supervisor, 32*(1), 105-127. doi:http://dx.doi.org.ezproxy1.lib.asu.edu/10.1080/07325223.2013.780991

Jahn, D.R., Quinnett, P. & Ries, R. (2016). The influence of training and experience on mental health practitioners' comfort working with suicidal individuals. *Professional Psychology: Research & Practice, 47*(2). 130-138. doi: 10.1037/pro0000070.

Johnson, E., Baker, S., Kopala, M., Kiselica, M., & Thompson III, E. (1989). Counseling self-efficacy and counseling competence in pre-practicum training. Counselor Education and Supervision, 28, 205-218.

Kleespies, P.M., Penk, W.E., & Forsyth, J.P. (1993). The stress of patient suicidal behavior during clinical training: Incidence, impact, and recovery. *Professional Psychology: Research & Practice, 24*(3), 293-202.

Knox, S., Burkard, A. W., Jackson, J. A., Schaack, A. M., & Hess, S. A. (2006). Therapists-in-training who experience a client suicide: Implications for supervision. *Professional Psychology: Research and Practice, 37*(5), 547-557. doi 10.1037/0735-7028.37.5.547

Kokotovic, A.M. & Tracey, T.J. (1987). Premature termination at a university counseling center. *Journal of Counseling Psychology*, *34*, 80-82.

LaCrosse, M. B., & Barak, A. (1976). Differential perception of counselor behavior. *Journal of Counseling Psychology, 23*(2), 170-172. doi: http://dx.doi.org.ezproxy1.lib.asu.edu/10.1037/0022-0167.23.2.170

Ladany, N., Ellis, M.V., & Friedlander, M.L. (1999). The supervisory working alliance, trainee self-efficacy, and satisfaction. *Journal of Counseling & Development, 77*, 447-455.

Ladany, N., Lehrman-Waterman, D., Molinaro, M., & Wolgast, B. (1999). Psychotherapy supervisor ethical practices: Adherence to guidelines, the supervisory working alliance, and supervisee satisfaction. The Counseling Psychologist, 27, 443-475.

Larson, L.M., Suzuki, L.A., Gillespie, K.N., Potenza, M.T., Bechtel, M.A., & Toulouse, A.L. (1992). Development and validation of the counseling self-estimate inventory. *Journal of Counseling Psychology, 39*(1), 105-120.

Leach, M. M., Stoltenberg, C. D., McNeill, B. W., & Eichenfield, G. A. (1997). Self-Efficacy and Counselor Development: Testing the Integrated Developmental Model. *Counselor Education and Supervision, 37*(2), 115-124.

Loganbill, C., Hardy, E., & Delworth, W. (1982). Supervision: A conceptual mode. *The Counseling Psychologist, 10*, 3-42.

Luoma, J. B., Martin, C. E., & Pearson, J. L. (2002). Contact with mental health and primary care providers before suicide: a review of the evidence. *American Journal of Psychiatry, 159*(6), 909-916.

Mackelprang, J. L., Karle, J., Reihl, K. M., & Cash, R. E. (2014). Suicide intervention skills: Graduate training and exposure to suicide among psychology trainees. *Training and Education in Professional Psychology, 8*(2), 136-142. doi:http://dx.doi.org.ezproxy1.lib.asu.edu/10.1037/tep0000050

McAdams,Charles R., I.,II, & Foster, V. A. (2000). Client suicide: Its frequency and impact on counselors. *Journal of Mental Health Counseling, 22*(2), 107-121.

McGlothlin, J.M., Rainey, S., & Kindsvatter, A. (2005). Suicidal clients and supervisees: A model for considering supervisor roles. *Counselor Education & Supervision, 45*, 135-146.

McNiel, D.E., Fordwood, S.R., Weaver, C.M., Chamberlain, J.R., Hall, S.E., & Binder R.L. (2008). Effects of training on suicide risk assessment. *Psychiatric Services, 59*, 1462–1465. doi: 10.1176/appi.ps.59.12.1462.

McNeill, B. W., & Stoltenberg, C. D. (2016). *Clinical supervision essentials series. Supervision essentials for the integrative developmental model.* Washington, DC, US: American Psychological Association.

McNeill, B.W., Stoltenberg, C.D., & Pierce, R.A. (1985). Supervisees' perceptions of their development: A test of the counselor complexity model. *Journal of Counseling Psychology, 32*(4), 630-633.

McNeill, B.W., Stoltenberg, C.D., & Romans, J.S.C. (1985). The integrated developmental model of supervision: Scale development and validation procedures. *Professional Psychology: Research and Practice, 23*(6), 504-508.

McNeill, B. W., Stoltenberg, C. D., & Romans, J. S. (1992). The Integrated Developmental Model of supervison: Scale development and validation procedures. *Professional Psychology: Research and Practice, 23*(6), 504-508.doi: 10.1037/0735-7028.23.6.504

Mullen, P.R., Uwamahoro, O., Blount, A.W., & Lambie, G.W. (2015). Development of counseling students' self-efficacy during their preparation program. *The Professional Counselor, 5*(1), 175-184. doi: 10.15241/prm.5.1.175

Ponterotto, J. G., & Furlong, M. J. (1985). Evaluating counselor effectiveness: A critical review of rating scale instruments. *Journal of Counseling Psychology, 32*(4), 597-616. doi:http://dx.doi.org.ezproxy1.lib.asu.edu/10.1037/0022-0167.32.4.597

Posner, K., Brown, G.K., Stanley, B., Brent, D.A., Yershova, K.V., Oquendo, M.A., Currier, G.W., …Mann, J.J. (2011). The Columbia-suicide severity rating scale: Initial validity and internal consistency findings from three multisite studies with adolescents and adults. *American Journal of Psychiatry, 168*(12), 1266-1277. doi: 10.1176/appi.ajp.2011.10111704

Reeves, A., & Mintz, R. (2001). Counsellors' experiences of working with suicidal clients: An exploratory study. *Counselling and Psychotherapy Research, 1*(3), 172-176.

SAFE-T: Suicide Assessment Five-Step Evaluation And Triage. (2009). Rockville, Md.: U.S. Dept. of Health and Human Services, Substance Abuse and Mental Health Services Administration.

Shea, S.C. (2011). *The Practical Art of Suicide Assessment: A Guide for Mental Health Professionals and Substance Abuse Counselors*. Middletown, DE: John Wiley & Sons, Inc.

Simon, R. I. (2006). Suicide risk assessment: Is clinical experience enough? *Journal of the American Academy of Psychiatry and Law, 34 (3),* 276-278.

Sipps, G.J., Sugden, G.J., & Faiver, C.M. (1988). Counselor training level and verbal response type: Their relationship to efficacy and outcome expectations. *Journal of Counseling Psychology, 35*(4), 397-401.

Stoltenberg, C. D. (1981). Approaching supervision from a developmental perspective: The counselor complexity model. *Journal of Counseling Psychology, 28,* 59–65.

Stoltenberg, C. D., & Delworth, U. (1987). *The Jossey-Bass social and behavioral science series. Supervising counselors and therapists: A developmental approach.* San Francisco, CA, US: Jossey-Bass.

Stoltenberg, C. D., & McNeill, B. W. (1997). Clinical supervision from a developmental perspective: Research and practice. In C. E. Watkins, Jr. (Ed.), *Handbook of psychotherapy supervision* (pp. 184-202). Hoboken, NJ, US: John Wiley & Sons Inc.

Stoltenberg, C. D., McNeill, B. W., & Crethar, H. C. (1994). Changes in supervision as counselors and therapists gain experience: A review. *Professional Psychology: Research and Practice, 25*(4), 416-449. doi 10.1037/0735-7028.25.4.416

Stoltenberg, C.D., McNeill, B.W., & Delworth, U. (1998). *IDM: An Integrated Developmental Model for supervising counselors and therapists*. San Francisco, CA: Jossey-Bass.

Stoltenberg, C.D., & McNeill, B.W. (2010). *IDM Supervision: An integrative developmental model for supervising counselors & therapists* (3rd ed.). New York, NY: Routledge.

Stoltenberg, C.D., Pierce. R.A., & McNeill, B.W. (1987). Effects of experience on counselor trainees' needs. *The Clinical Supervisor, 5*(1), 23-32.

Substance Abuse and Mental Health Services Administration. (2017). *Key substance use and mental health indicators in the United States: Results from the 2016 National Survey on Drug Use and Health* (HHS Publication No. SMA 17-5044, NSDUH Series H-52). Rockville, MD: Center for Behavioral Health Statistics and Quality, Substance Abuse and Mental Health Services Administration. Retrieved from https://www.samhsa.gov/data/

Tracey, T.J., Ellickson, J., & Sherry, P. (1989). Reactance in relation to different supervisory environments and counselor development. *Journal of Counseling Psychology, 36*(3), 336-344. doi: 0022-0167/89/$00.75

Tracey, T. J. G., Wampold, B. E., Lichtenberg, J. W., & Goodyear, R. K. (2014). Expertise in psychotherapy: An elusive goal. *American Psychologist, 69,* 218- 229. doi:10.1037/a0035099

Watcher Morris, C. & Barrio Minton, C. (2012). Crisis in the curriculum? New counselors' crisis preparation, experiences, and self-efficacy. *Counselor Education and Supervision, 51*(4), 256.

Wozny, D. (2005). The prevalence of suicide and violence assessment/intervention courses in CACREP- and COAMFTE-accredited counseling curriculums. *VISTAS Online,* 271-274.

Zamostny, K., Corrigan, J.D., & Eggert, M.A. (1981). Replication and extension of social influence processes in counseling: A field study. *Journal of Counseling Psychology, 28*(6), 481-489.

APPENDIX A

INFORMED CONSENT

Informed Consent

Investigators: Jenny Holzapfel, MC, NCC (Student PI) and Terence Tracey, Ph.D. (Faculty PI)

Why is this research being done?
The purpose of the research is to gain a better understanding of supervisory practices. We are interested in understanding what trainees find most helpful from supervision when faced with different circumstances.

How long will the research last?
This study will take place in 2 parts: 1) screening survey and 2) research survey. We expect that individuals will spend 15 minutes completing this research.

How many people will be studied?
For this study, we are expecting about 200 people to participate.

What happens if I say yes, I want to be in this research?
You will first complete a screening survey to ensure that you meet the requirements for this study. You must be 18 years or older to participate. You will then be asked to complete a research survey, which should take no more than 15 minutes to complete. You will be asked to answer demographic questions, read two short vignettes, and complete several questionnaires.

What happens if I say yes, but I change my mind later?
You can leave the research at any time it will not be held against you.

Is there any way being in this study could be bad for me?
There are no known risks from taking part in this study, but in any research, there is some possibility that you may be subject to risks that have not yet been identified.

Will being in this study help me in any way?
We cannot promise any benefits to you or others from your participation in this research. However, some participants may find it helpful to think about clinical supervision.

What happens to the information collected for the research?
All information from this study will anonymous. Only the Primary Investigators will have access to your online responses to survey items. The data collected will be for a dissertation. You will not be asked to provide any identifying information, except an email address if you consent to enter the raffle for one $20 Amazon gift card (odds of winning are 1 in 5). Your email address will not be linked to your answers in any way and will only be used to notify you if you are selected from the raffle. Winners will be notified upon completion of data collection (estimated April 2019).

Who can I talk to?

If you have any questions concerning the research study, please contact the research team at: Primary Investigator: Jenny Holzapfel – jlgrant4@asu.edu, or Faculty Primary Investigator: Dr. Terence Tracey – ttracey@asu.edu. This research has been reviewed and approved by the Social Behavioral IRB at Arizona State University (IRB #STUDY00008540). You may talk to them at (480) 965-6788 or by email at research.integrity@asu.edu if:

- Your questions, concerns, or complaints are not being answered by the research team.
- You cannot reach the research team.
- You want to talk to someone besides the research team.
- You have questions about your rights as a research participant.
- You want to get information or provide input about this research.

This form explains the nature, demands, benefits and any risk of the project. By participating in this study, you agree knowingly to assume any risks involved. Remember, your participation is voluntary. You may choose not to participate or to withdraw your consent and discontinue participation at any time without penalty or loss of benefit. In participating, you are not waiving any legal claims, rights, or remedies. If you do not wish to participate, please exit your browser now.

APPENDIX B

SCREENING QUESTIONS

1. Are you 18 years old or older?
    a. Yes
    b. No
2. Please select which academic program you are currently completing:
    a. Counseling Psychology
    b. Clinical Psychology
    c. Counselor Education or Counselor Education & Supervision
    d. Clinical Mental Health Counseling
    e. Counseling or Mental Health Counseling
    f. Social Work
    g. Marriage & Family Therapy
    h. None of the above
3. Are you currently enrolled in or have completed at least one semester of clinical/counseling practicum AND you have had direct contact with clients as the primary therapist?
   Note: Client here refers to a real client who is seeking therapy services. Situations in which classmates, faculty, or other people role play as clients DO NOT count as direct contact.
    a. Yes
    b. No

APPENDIX C

LOW RISK CLIENT VIGNETTE & ATTENTION CHECK QUESTIONS

Instructions: You are going to read brief vignette. Image yourself as the therapist who has been assigned to work with this client and this is your first meeting together. The client is beginning to describe the reasons for coming to therapy. Please pay attention as you will be asked several questions about the vignette.

Vignette:
Client: My boyfriend and I broke up last week. We were together for almost 3 years. He told me he had been cheating on me for the past few months and wanted to be with her instead of me. I had no idea and never thought he would do something like that. I loved him and thought we had a future together. I've been a mess the past week. I've been crying a lot and feeling very sad and depressed. For the past few nights I've been wishing I just wouldn't wake up. That'd be easier than facing all this. I'm just feeling so sad and tired… I wish this wasn't happening… It hurts so much. I'm trying to stick with my normal routine, you know, wake up, go to work, go to my kickboxing class, but I get these moments where I feel really depressed and don't care about anything. It's been hard to focus at work. I feel so lonely without him. I know I can talk to my friends or my sister about what's going on, and my friends are taking me out this weekend to help cheer me up, which is nice, but sometimes all I want to do is cry. I miss him. I'm up for a job promotion next month and I don't want to mess it up, but I don't know how to focus on anything when I feel like this. It's overwhelming and I hope it will get better.

Attention Check Questions:

1. What was this client's main concern?
    a. Divorce of her parents
    b. Break-up with boyfriend
    c. Conflict with boss
2. Did the client mention any suicidal concerns?
    a. Denied suicidal concerns
    b. Wish to not wake up
    c. Slitting wrists or jumping off bridge
    d. Shooting self with firearm

APPENDIX D

HIGH RISK CLIENT VIGNETTE & ATTENTION CHECK QUESTIONS

Instructions: You are going to read a brief vignette. Imagine yourself as the therapist who has been assigned to work with this client and this is your first meeting together. The client is beginning to describe the reasons for coming to therapy. Please pay attention as you will be asked several questions about the vignette.

Vignette:
Client: My boyfriend and I broke up last week. We were together for almost 3 years. He told me he had been cheating on me for the past few months and wanted to be with her instead of me. I had no idea and never thought he would do something like that. I loved him and thought we had a future together. I've been a mess the past week. I've been thinking about shooting myself. Things would be so much easier if I wasn't here. I had the gun out last night and I was going to do it, but I wanted to leave him a note though to tell him how I much I love and miss him. I'm just feeling so sad and tired… I wish this wasn't happening… It hurts so much. … I've been sleeping a lot more, but I'm still so tired. I haven't been able to focus on anything and actually called off work the past few days because I couldn't bring myself to get out of bed and dressed. I didn't go to my kickboxing class either. I'm up for a job promotion next month, but I probably won't get it now since I haven't been at work. It doesn't matter. I probably won't be here anyway. I feel so lonely without him. I only really have one friend, but I haven't talked to her about it because I just don't care. My family isn't that close, and they never liked my boyfriend anyway, so I haven't talked to them. I miss him. I don't know how to focus on anything when I feel like this. It's overwhelming and this will never get better.

Attention Check Questions:

1. What was this client's main concern?
    a. Divorce of her parents
    b. Break-up with boyfriend
    c. Conflict with boss
2. Did the client mention any suicidal concerns?
    a. Denied suicidal concerns
    b. Wish to not wake up
    c. Slitting wrists or jumping off bridge
    d. Shooting self with firearm

APPENDIX E

SELF-EFFICACY QUESTIONS

Self-Efficacy
(Adapted from the PPCS; Binkley & Leibert, 2014)

1: Disagree
2: Somewhat disagree
3: Neutral
4: Somewhat agree
5: Agree

1. When I think about counseling this client, I feel confident.
2. When I think about counseling this client, I feel anxious. [Reverse coded]
3. I feel comfortable with the steps I should take in session to address this client's concerns.
4. I know what to say to this client.
5. I trust that I can help this client.
6. I have no idea what to do with this client. [Reverse coded]
7. I know how to wrap up the session with this client.

APPENDIX F

SUPERVISION VIGNETTE - STRUCTURED - LOW RISK & ATTENTION CHECK QUESTIONS

Instructions: You are going to read a brief vignette of a supervisory session. Imagine this person as your supervisor and yourself as the supervisee, and you are discussing the client you just read about. Please pay attention as you will be asked several questions after.

Vignette:
Supervisor: You're doing great work with this client. There's a lot going on for her, so I want to spend some time talking about what to do next. First, her saying that she didn't want to wake up is passive suicidal ideation. It can be scary to hear clients say things like this. I want you to continue to monitor these thoughts when you next meet with her. Next, we need to develop a solid conceptualization. It's clear she's experiencing some depressive symptoms, which seem like a normal reaction to the break-up, especially since it was unexpected. She also seems to be resilient in that even though she's been having difficulty focusing at work and her feelings of sadness and loneliness are impacting her, she has been maintaining her normal routine and is motivated to regain her focus to help her earn the job promotion. I would like you to address these strengths the next time you meet with her. I'm going to give you a handout on risk assessment and a book about break-ups, which I think will help give you some more information about these concerns. I hope you'll incorporate some of this information into your work with your client. You did a great job in session, and I'm here to support you moving forward with this client.

Attention Check Questions:

1. What did the supervisor recommend doing to address the client's risk?
    a. Hospitalization
    b. Safety Plan
    c. Monitor thoughts
2. What resources did the supervisor want to give you?
    a. Nothing
    b. Handout on risk assessment and book on break-ups
    c. Book about depressive symptoms

APPENDIX G

SUPERVISION VIGNETTE - STRUCTURED - HIGH RISK & ATTENTION CHECK QUESTIONS

Instructions: You are going to read a brief vignette of a supervisory session. Imagine this person as your supervisor and yourself as the supervisee, and you are discussing the client you just read about. Please pay attention as you will be asked several questions after.

Vignette:
Supervisor: You're doing great work with this client. There's a lot going on for her, so I want to spend some time talking about what to do next. It's clear she's experiencing depressive symptoms and has suicidal intent with a plan and access to a gun. She's been rehearsing and doesn't have many protective factors. It can be scary to hear clients say things like this. For her safety, we should admit her to a hospital. I want you to let her know that you're concerned for her safety and talk with her about going voluntarily to the hospital. If she agrees to go voluntarily, we'll prepare any paperwork we need, like release of information forms so we can coordinate with the hospital staff. We'll also work on getting her transportation there. If she doesn't want to go, you and I will talk about petitioning to have her involuntarily admitted. Later, I'm going to give you a handout on risk assessment and a book about break-ups, which I think will help give you some more information about these concerns. I hope you'll incorporate some of this information into your work with future clients. You did a great job in session, and I'm here to support you moving forward with this client.

Attention Check Questions:

1. What did the supervisor recommend doing to address the client's risk?
    a. Hospitalization
    b. Safety Plan
    c. Monitor thoughts
2. What resources did the supervisor want to give you?
    a. Nothing
    b. Handout on risk assessment and book on break-ups
    c. Book about depressive symptoms

APPENDIX H

SUPERVISION VIGNETTE - FACILITATIVE - LOW RISK & ATTENTION CHECK QUESTIONS

Instructions: You are going to read a brief vignette of a supervisory session. Imagine this person as your supervisor and yourself as the supervisee, and you are discussing the client you just read about. Please pay attention as you will be asked several questions after.

Vignette:
Supervisor: You're doing great work with this client. There's a lot going on for her, so I'd like to spend some time talking about your reaction to the client and what you think next steps are. This is important for a few reasons. First, it can be a way of releasing some of our own emotions and taking care of ourselves. I'm here to support you and want to know how you're doing. It's also important for us as clinicians to be self-aware and engage in self-exploration. You're learning how to become a competent and caring therapist, and one day you'll be your own supervisor so knowing yourself will help you handle situations in the future. It's clear she has some risk for suicide. What do you think we need to do to address her risk? I wonder how you're feeling after hearing about her passive suicidal ideation when she said she didn't want to wake up. It can be scary to hear clients say things like this. I also wonder what you think we can do next to help her reach her goal of being able to focus at work to stay on track for her job promotion? You did a great job in session, and I'm here to support you moving forward with this client.

Attention Check Questions:

1. Did the supervisor ask to talk about your reaction to the client?
    a. Yes
    b. No
2. What resources did the supervisor want to give you?
    a. Nothing
    b. Handout on risk assessment and book on break-ups
    c. Book about depressive symptoms

APPENDIX I

SUPERVISION VIGNETTE - FACILITATIVE - HIGH RISK & ATTENTION CHECK QUESTIONS

Instructions: You are going to read a brief vignette of a supervisory session. Imagine this person as your supervisor and yourself as the supervisee, and you are discussing the client you just read about. Please pay attention as you will be asked several questions after.

Vignette:
Supervisor: You're doing great work with this client. There's a lot going on for her, so I'd like to spend some time talking about your reaction to the client and what you think next steps are. This is important for a few reasons. First, it can be a way of releasing some of our own emotions and taking care of ourselves. I'm here to support you and want to know how you're doing. It's also important for us as clinicians to be self-aware and engage in self-exploration. You're learning how to become a competent and caring therapist, and one day you'll be your own supervisor so knowing yourself will help you handle situations in the future. It's clear she has some risk for suicide. What do you think we should do to address her risk? I wonder also how you're feeling after hearing her talk about killing herself. It can be scary to hear clients say things like this. You did a great job in session, and I'm here to support you moving forward with this client.

Attention Check Questions:

1. Did the supervisor ask to talk about your reaction to the client?
    a. Yes
    b. No
2. What resources did the supervisor want to give you?
    a. Nothing
    b. Handout on risk assessment and book on break-ups
    c. Book about depressive symptoms

APPENDIX J

COUNSELOR RATING FORM- SHORT VERSION

Counselor Rating Form-Short
(CRF-S; Corrigan & Schmidt, 1983)

Based on the supervisory vignette you just read, please indicate your perception of the style of this supervisor on the following descriptors.

Scale:
1: Not Very
2
3
4
5
6
7: Very

1. Friendly
2. Experienced
3. Honest
4. Likeable
5. Expert
6. Reliable
7. Sociable
8. Prepared
9. Sincere
10. Warm
11. Skillful
12. Trustworthy

APPENDIX K

TRAINEE EXPERIENCE LEVEL QUESTIONS

Trainee Development Questions
Based upon the work of McNeill, Stoltenberg, and Pierce (1985) & McNeill, Stoltenberg, and Romans (1992)

1. How many semesters of clinical placements (i.e., practicum, externship, internship, etc.) have you completed in which you had direct contact with clients as the primary therapist (including the current semester even if you have not yet completed it)?
   Note: One semester (or quarter) here means Fall, Spring, or Summer. Clients here means real people seeking therapy; situations in which classmates, faculty, and/or other people engaged in role plays with you DO NOT count.
2. How many semesters of clinical supervision have you received (including the current semester even if you have not yet completed it)?
   Note: One semester (or quarter) here means Fall, Spring, or Summer. Supervision here means supervision in which you were the supervisee.
3. How many semesters of graduate education in counseling/social work/marriage & family/etc., have you had (including the current semester even if you have not yet completed it)?
   Note: One semester (or quarter) here means Fall, Spring, or Summer. Please do not include time spent earning a degree that did not directly develop your ability to work with clients in a clinical setting (e.g., MBA).

APPENDIX L

DEMOGRAPHIC QUESTIONS

1. How old are you?
    a. [free response]
2. With which gender do you identify?
    a. Woman
    b. Man
    c. Transwoman
    d. Transman
    e. Prefer not to answer
    f. Not listed - please specify: [free response]
3. Which best describes your racial and/or ethnic background? (Select all that apply)
    a. Asian/Asian-American
    b. Black/African-American
    c. Hispanic/Latinx
    d. Middle Eastern
    e. Multiracial
    f. Native American, Alaska Native, or Pacific Islander
    g. White/European-American
    h. Prefer not to answer
    i. Not listed - please specify: [free response]
4. With which sexual orientation do you identify?
    a. Bisexual
    b. Gay
    c. Heterosexual/straight
    d. Lesbian
    e. Queer
    f. Prefer not to answer
    g. Not listed - please specify: [free response]
5. Are you an international student?
    a. Yes; please specify country of origin: [free response]
    b. No
6. What type of degree are you currently seeking?
    a. Ph.D.
    b. Psy.D.
    c. Ed.D.
    d. M.A.
    e. M.S.
    f. M.C.
    g. MSW
    h. Not Listed (please specify): [free response]
7. Is your current graduate program primarily online or in-person?
    a. Online
    b. In-person

8. Please select your current graduate program's accreditation. (Select all that apply.)
    a. APA – American Psychological Association
    b. CACREP – Council for Accreditation of Counseling & Related Educational Programs
    c. COAMFTE – Commission on Accreditation for Marriage & Family Therapy Education
    d. CSWE – Council on Social Work Education
    e. PCSAS – Psychological Clinical Science Accreditation System
    f. My program is not accredited
    g. Other accreditation – please specify): [free response]
9. In what region of the U.S. is your current graduate program located?
    a. Northeast – Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont
    b. Midwest – Kansas, Illinois, Indiana, Iowa, Michigan, Minnesota, Missouri, Nebraska, North Dakota, South Dakota, Ohio, Wisconsin
    c. South – Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, West Virginia
    d. West – Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, Wyoming
    e. My program is outside the U.S. – please specify country & city: [free response]
10. What is the highest degree you have earned?
    a. Doctoral or other professional degree
    b. Master's degree
    c. Bachelor's degree
    d. Not listed – please specify: [free response]
11. What type of clinical placement are you currently completing?
    a. First practicum
    b. Practicum/field placement/externship
    c. Master-level internship
    d. Pre-doctoral internship
    e. Other – please specify: [free response]
    f. I am not currently completing a placement
12. How many direct client hours do you have? Please do not guess, but provide your best response based on hour logs.
    a. [free response]
13. How confident are you in your response above about number of direct client hours?
    a. Slider from *0: Not at all confident* to *100: Completely confident*
14. How often do you work with clients who present with suicidal concerns?

    a. Slider from *0: Never* to *100: Exclusively*
15. How confident are you in your response above about how often you work with clients presenting with suicidal concerns?
    a. Slider from *0: Not at all confident* to *100: Completely confident*
16. How confident are you in your abilities to work with clients presenting with passive suicidal thoughts?
    a. Slider from *0: Not at all confident* to *100: Completely confident*
17. How confident are you in your abilities to work with clients presenting with active suicidal thoughts?
    a. Slider from *0: Not at all confident* to *100: Completely confident*
18. How confident are you in your abilities to work with clients presenting with suicidal intent?
    a. Slider from *0: Not at all confident* to *100: Completely confident*
19. How confident are you in your abilities to work with clients presenting with a suicidal plan?
    a. Slider from *0: Not at all confident* to *100: Completely confident*
20. How confident are you in your abilities to work with clients presenting with access to suicidal means?
    a. Slider from *0: Not at all confident* to *100: Completely confident*
21. Have you completed any training in suicide risk assessment and intervention? Please check all that apply
    a. Coursework
    b. Seminar
    c. Workshop
    d. Practicum related activity (e.g., “on-call” time or specific rotation)
    e. Crisis Hotline Work
    f. Volunteer Activity
    g. Other – please specify: [free response]
    h. No

APPENDIX M

FREE RESPONSE QUESTIONS

You will be asked several free response questions about the client and supervision cases. Please feel free to write as much or as little as you wish.

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior

1. According to the SAFE-T model of risk presented above, I would classify this client's risk level as:
    a. Low
    b. Moderate
    c. High
2. Was the supervisory session you read structured (i.e., supervisor provided direct feedback/guidance on what to do next; supervisor provided resources for more information)?
    a. Strongly Disagree
    b. Disagree
    c. Somewhat Disagree
    d. Neither Disagree nor Agree
    e. Somewhat Agree
    f. Agree
    g. Strongly Agree
3. Was the supervisory session you read facilitative (i.e., supervisor encouraged me to develop my ideas; supervisor encouraged me to talk about my own reactions to the client)?
    a. Strongly Disagree
    b. Disagree
    c. Somewhat Disagree
    d. Neither Disagree nor Agree
    e. Somewhat Agree
    f. Agree
    g. Strongly Agree
4. Based on the definitions above of structured and facilitative supervision, which do you think best described the supervision session?
    a. Structured
    b. Facilitative
5. What would you want to speak to your supervisor about regarding this client?
6. What would you do next with this client?
7. How would you feel about the approach the supervisor took if this was a real client you were working with and this was your real supervisor?

8. If you were to engage in risk assessment with this client, what steps would you take? Please select all that apply.
    a. Explore risk factors
    b. Explore protective factors
    c. Consider context & situational factors
    d. Explore previous suicide attempts
    e. Explore personal history of suicide or suicide attempts (e.g., family or friends)
    f. Reinforce coping skills
    g. Develop coping skills
    h. Alert friends or family members of the client
    i. No-harm contract
    j. Safety plan
    k. Suggest voluntary hospitalization
    l. Involuntary hospitalization
    m. Other – please specify: [free response]
9. How did you hear about this research?
10. Do you have any final thoughts or comments about this study?

APPENDIX N

TRAINEE & SUPERVISOR PILOT TESTING QUESTIONS – CLIENT CASE

Note: All questions, unless otherwise specified, were on a 7-point Likert scale from *1: Strongly Disagree* to *7: Strongly Agree*

Trainee Questions:

Please rate the following items using the scale below about the client case you just read.

1. I could picture myself working with this client.
2. This client seemed like someone who could walk into my counseling room.
3. The client's concerns seemed real.
4. The client's reactions to the situation seemed like they could really happen.
5. I could participate in this study imaging this person as my real client.
6. The client's concerns did not seem like something that could happen in real life.
7. The client presented with a high amount of suicidal risk.
8. I would not feel comfortable waiting until next week to see this client again based on their suicidal risk level.
9. I am not worried about this client's probability of attempting suicide.
10. According to the SAFE-T model of risk assessment below, I would classify this person's risk level as:

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior

    a. Low
    b. Moderate
    c. High
11. Do you have any feedback or comments regarding the client presentation you read?
    a. Free response

Supervisor Questions:

Please rate the following items using the scale below about the client case you just read.

1. I could picture one of my supervisees working with this client.
2. This client seemed like someone who could walk into one of my supervisee's counseling room.
3. The client's concerns seemed real.
4. The client's reactions to the situation seemed like they could really happen.
5. The client's concerns did not seem like something that could happen in real life.
6. The client presented with a high amount of suicidal risk.
7. I would not feel comfortable for my supervisee to wait until next week to see this client again based on their suicidal risk level.
8. I am not worried about this client's probability of attempting suicide.

9. Based on the SAFE-T model presented below, you would classify this person's suicidal risk level as:

RISK LEVEL	RISK / PROTECTIVE FACTOR	SUICIDALITY
High	Psychiatric disorders with severe symptoms, or acute precipitating event; protective factors not relevant	Potentially lethal suicide attempt or persistent ideation with strong intent or suicide rehearsal
Moderate	Multiple risk factors, few protective factors	Suicidal ideation with plan, but no intent or behavior
Low	Modifiable risk factors, strong protective factors	Thoughts of death, no plan, intent or behavior

   a. Low
   b. Moderate
   c. High
10. Do you have any feedback or comments regarding the client presentation you read?
   a. [free response]

APPENDIX O

TRAINEE & SUPERVISOR PILOT TESTING QUESTIONS – SUPERVISION SESSION

Note: All questions, unless otherwise specified, were on a 7-point Likert scale from *1: Strongly Disagree* to *7: Strongly Agree*

Trainee Questions:

Please rate the following items using the scale below about the supervisory session you just read.

1. I could picture myself working with this supervisor.
2. This supervisor gave lots of direction.
3. It is clear what the supervisor expected me to do in my work with the client.
4. The supervisor seemed like someone who could be a real supervisor at some point in my training.
5. This supervisor let me decide how to approach things.
6. This supervisor was supportive of me and my work.
7. The supervisor's suggestions were not things that a real supervisor would do.
8. The supervisor was interested in my thoughts and experience.
9. I could see myself working with this supervisor.
10. This supervisor validated my experience.
11. I could participate in this study imagining this supervisor as my real supervisor.
12. Was this supervisory session structured (i.e., supervisor provided direct feedback/guidance on what to do next; supervisor provided resources for more information)?
13. Was this supervisory session facilitative (i.e., supervisor encouraged me to develop my ideas; supervisor encouraged me to talk about my own reactions to the client).
14. Based upon the definitions above of structured and facilitative supervision, which would you rate this supervision as?
    a. Structured
    b. Facilitative
15. Do you have any feedback or comments regarding the supervisory session you read?
    a. [free response]

Supervisor Questions:

Please rate the following items using the scale below about the supervisory session you just read.

1. This supervisor followed ethical and legal guidelines regarding the client's risk level.
2. This supervisor gave lots of direction.
3. It is clear what the supervisor expected the trainee to do in his/her work with the client.
4. The supervisor seemed like someone who could be a real supervisor at some point in a trainee's training.
5. This supervisor let the trainee decide how to approach things.

6. This supervisor was supportive of the trainee and his/her work.
7. The supervisor's suggestions were not things that a real supervisor would do.
8. The supervisor was interested in the trainee's thoughts and experience.
9. This supervisor validated the trainee's experience.
10. The supervisor's clinical judgement regarding next steps for the client were appropriate.
11. I would make similar clinical recommendations if this was a real client one of my trainees was seeing.
12. Was this supervisory session structured (i.e., supervisor provided direct feedback/guidance on what to do next; supervisor provided resources for more information)?
13. Was this supervisory session facilitative (i.e., supervisor encouraged trainee to develop his/her ideas; supervisor encouraged trainee to talk about his/her own reactions to the client).
14. Based upon the definitions above of structured and facilitative supervision, which do you think best describes the supervision session?
    a. Structured
    b. Facilitative
15. Do you have any feedback or comments regarding the supervisory session you read?
    a. [free response]

APPENDIX P

SUPERVISOR PILOT TESTING QUESTIONS

Screening Questions:

1. Are you 18 years old or older?
    a. Yes
    b. No
2. Please select which academic program from which you graduated:
    a. Counseling Psychology
    b. Clinical Psychology
    c. Counselor Education
    d. Counseling or Mental Health Counseling
    e. Social Work
    f. Marriage & Family Therapy
    g. None of the above
3. Have you provided clinical supervision to trainees for at least 5 months?
    a. Yes
    b. No

Supervisor Experience Level Questions:

1. How much time in years and months have you worked with clients as the primary therapist (including time in your graduate program)?
    Note: "Clients" here means real people seeking therapy; situations in which classmates/faculty/other people engaged in role plays with you DO NOT count.
    a. ____ Years
    b. ____ Months
2. How much time in years and months have you provided supervision to trainees?
    a. ____ Years
    b. ____ Months
3. How many years of graduate education in counseling/social work/marriage & family, etc. did you completed? Note: Please do not include time spent earning a graduate degree that did not directly develop your ability to work with clients or trainees (e.g., MBA).
    a. [free response]

Demographic Questions:

1. What is the full name of the highest degree you received (e.g., Psy.D. in Clinical Psychology; Master of Counseling in Counseling)?
    a. Free response
2. What license(s) do you currently hold (e.g., Licensed Psychologist, Licensed Master Social Worker)? Note: Please DO NOT use abbreviations.
    a. I am not licensed
    b. I am completing post-doctoral training
    c. Free response
3. In what type of setting do you currently work?

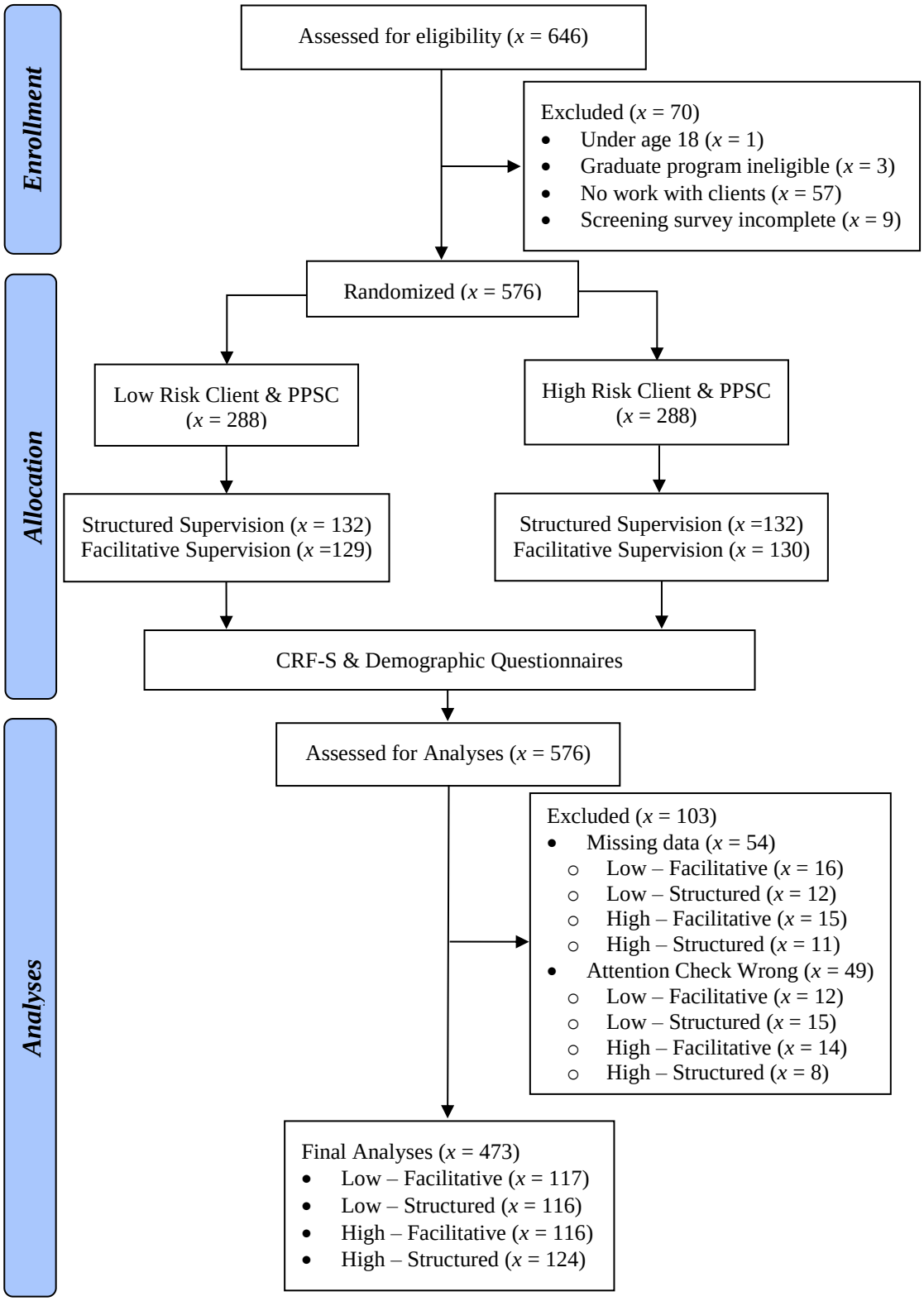
    a. Professional school
    b. University or college
    c. Community college
    d. University counseling center
    e. VA
    f. Hospital or other medical setting
    g. Private practice
    h. Community center
    i. Other: (Please specify)
4. What percentage of your work time per week is spent in providing supervision or other supervisory activities?
    a. 0-100% (slider)
5. How many supervisees have you had?
    a. _____
6. How confident are you in your response above about number of supervisees?
    a. 0-100% (slider)
7. How much experience do you have working with clients who have endorsed suicidal concerns (i.e., suicidal intent, plan, means, or thoughts)?
    a. 0-100% (slider)
8. How much experience do you have supervising trainees who are working with clients who have endorsed suicidal concerns (i.e., suicidal intent, plan, means, or thoughts)?
    a. 0-100% (slider)
9. How confident are you in your abilities to provide supervision when clients presenting with passive suicidal thoughts?
    a. 0-100% (slider)
10. How confident are you in your abilities to provide supervision when clients presenting with suicidal intent?
    a. 0-100% (slider)
11. How confident are you in your abilities to provide supervision when clients presenting with a suicidal plan?
    a. 0-100% (slider)
12. How confident are you in your abilities to provide supervision when clients presenting with access to suicidal means?
    a. 0-100% (slider)

Supervisor Free Response Questions:

1. If the client you read about was a real client that one of your supervisees was seeing, what would you want to speak to your supervisee about?
2. What would you recommend doing next with this client?
3. What would you hope your supervisee learned from working with this client?

APPENDIX Q

RESEARCH FLOWCHART


Enrollment
Assessed for eligibility (x = 646)
Excluded (x = 70)
Under age 18 (x = 1)
Graduate program ineligible (x = 3)
No work with clients (x = 57)
Screening survey incomplete (x = 9)
Allocation
Randomized (x = 576)
Low Risk Client & PPSC (x = 288)
High Risk Client & PPSC (x = 288)
Structured Supervision (x = 132)
Facilitative Supervision (x =129)
Structured Supervision (x =132)
Facilitative Supervision (x = 130)
CRF-S & Demographic Questionnaires
Analyses
Assessed for Analyses (x = 576)
Excluded (x = 103)
Missing data (x = 54)
Low – Facilitative (x = 16)
Low – Structured (x = 12)
High – Facilitative (x = 15)
High – Structured (x = 11)
Attention Check Wrong (x = 49)
Low – Facilitative (x = 12)
Low – Structured (x = 15)
High – Facilitative (x = 14)
High – Structured (x = 8)
Final Analyses (x = 473)
Low – Facilitative (x = 117)
Low – Structured (x = 116)
High – Facilitative (x = 116)
High – Structured (x = 124)

APPENDIX R

IRB APPROVAL LETTER

ASU Knowledge Enterprise Development

APPROVAL: MODIFICATION

Terence Tracey
CISA: Counseling and Counseling Psychology
480/965-6159
Terence.Tracey@asu.edu

Dear Terence Tracey:
On 11/20/2018 the ASU IRB reviewed the following protocol:

Type of Review:	Modification
Title:	Structure and Facilitation in Clinical Supervision when Clients Present with Varying Levels of Suicidal Risk
Investigator:	Terence Tracey
IRB ID:	STUDY00008540
Funding:	Name: Arizona State University (ASU), Grant Office ID: Graduate & Professional Student Association
Grant Title:	None
Grant ID:	None
Documents Reviewed:	• Informed Consent_Final Study.pdf, Category: Consent Form; • Final Study_Holzapfel_Dissertation_IRB Form.docx, Category: IRB Protocol; • Questions_TRAINEE_07.17.18.pdf, Category: Measures (Survey questions/Interview questions /interview guides/focus group questions); • Grant Email Award, Category: Sponsor Attachment; • Grant Application, Category: Sponsor Attachment; • Final Study_Recruitment Information.pdf, Category: Recruitment Materials;

The IRB approved the modification. When consent is appropriate, you must use final, watermarked versions available under the "Documents" tab in ERA-IRB. In conducting this protocol, you are required to follow the requirements listed in the INVESTIGATOR MANUAL (HRP-103).

Sincerely,
IRB Administrator
cc: Jennifer Holzapfel