Preventing Burnout: The Role of Personality and Awareness in Early Career Mental Health Professionals in Acute Settings

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Mental Health Professionals in Acute Settings

by

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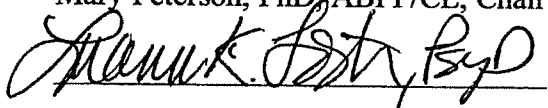
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Abstract

Burnout among health professionals had been increasing over the last decade, but amidst the global impact of COVID-19, burnout has contributed to a national health care crisis (Bednar, 2019; Sklar et al., 2021). Due to increased demand and patient acuity, entry-level mental health professionals (MHPs) in acute settings are specifically at risk (Morse et al., 2012; Simpson et al., 2018). Moreover, unique variables related to personality disposition and emotional vulnerability from trauma can create a predisposition for burnout (Alarcon et al., 2009). This study explored the impacts of personality and emotional awareness curriculum on managing stress amidst crisis work and minimizing burnout. This study used the Big Five Inventory-2-Short Form (BFI-2-S) personality measure and curriculum in the context of a semester long graduate level course that included emotional awareness training, stress-management strategies, and peer-to-peer process groups, to explore if clinical psychology doctoral students at a private university could increase emotional awareness and applicable stress management skills. The intervention group participated in the 15-week course, was tested pre- and post-intervention and at 4 month follow-

up of work in rural emergency departments using the Difficulty in Emotion Regulation Scale (DERS-18) and Emotional Self Awareness Scale (ESAS) and a qualitative questionnaire to assess for long-term efficacy. Results showed statistically significant differences in the total score of the ESAS, and in subdomains for Contextualization and Decision-Making with small to very large effect sizes. However, the changes were in the opposite direction than hypothesized. It appears that students reported more confidence in their emotional self-awareness at the beginning of the intervention than at the conclusion. We failed to find a significant difference in participants' ability to regulate difficulty emotions (DERS-18) and yielded only small to no effect size. The paired sample t-test comparing subjective reports found statistically significant increase in their confidence to manage emotions with a large effect size between T1 and T2. A repeated measures ANOVA failed to find significant difference, suggesting that changes between T2 and T3 were not retained. Although not statistically significant, results showed a moderate effect size in their confidence to maintain the use of the coping strategies.

Keywords: emotional regulation, emotional awareness, mental health professional burnout, burnout prevention.

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Chapter 1

Introduction

Burnout: A National Health Crisis

Burnout is characterized by chronic emotional, physical, and psychological distress due to persistent strain associated with high-intensity careers (Armon et al., 2012; Grossi et al., 2015). Health care professionals are inevitable candidates for burnout due to the long hours, understaffed settings, and the incessant need for their expertise (Gillespie et al., 2003; Moukarzel et al., 2019; Nelson et al., 2009). Research suggests that the presence of burnout is considered a "national health crisis" due to it impacting as many as 50% of health care professionals within recent years (Bednar, 2019; Panagioti et al., 2018; Shanafelt & Noseworthy, 2016). This number is asserted to be increasing amidst the global impact of Covid-19 (Sklar et al., 2021). Burnout places health care professionals at higher risk for substance abuse, mental health difficulties and suicide in comparison to other professionals (Panagioti et al., 2018). Provider burnout can compromise patient care in multiple ways including increased medical errors, fatigue, and decreased productivity which impacts provider availability during times of need (2018; Shanafelt & Noseworthy, 2016). Therefore, the significant impacts of health care professional burnout have caught the attention of healthcare systems across the globe.

Although no one is exempt from experiencing burnout, mental health professionals (MHPs) are at a unique risk among the health care professions (Simpson et al., 2018). By nature of their work, MHPs are at the forefront of caring for their patients' mental health concerns

which bears a unique burden on their own health. Research conducted within the last decade

suggests that between 21-67% of MHP's experience burnout (Morse et al., 2012). MHP's

vulnerability to burnout is multifaceted; for example, they are threatened by maladaptive stigmas

of "helpers not needing help" (Di Benedetto et al., 2015), false assumptions that they must not

have their own mental health histories, and that they must be held to an inaccurately high

standard (Saddicha et al., 2012 as cited in Simpson et al., 2018). Identifying that MHPs are just

as human as their patients, unfortunately, is often met with inaccurate ethical concerns about

their ability to practice instead of strategies to support their mental health care (Di Benedetto et

al., 2015). This misunderstanding often serves as a barrier to MHPs seeking their own mental

health treatment when problems arise. Additionally, other variables influence MHPs

vulnerability to burnout.

Other Variables in Mental Health Professionals

It takes a unique person to pursue mental health care as a profession considering the

known demands of the work. Previous research has shown a strong correlation between

personality characteristics and predisposition for burnout (Alarcon et al., 2009). For example, the

Big Five Inventory (BFI) looks at five core personality factors (Extraversion, Agreeableness,

Conscientiousness, Neuroticism, and Openness to Experience; Costa & McCrae, 1992), along a

high-to-low scale and has been proven effective for correlating personality traits and burnout

among working professionals (Armon et al., 2012). Research suggests that on average MHPs

rank higher in personality scales of Conscientiousness and Agreeableness which may serve as a

protective factor against initial stress but may also be a variable contributing to internalized

stress and burnout over time (Simpson et al., 2018). It is argued that some of the core

personality traits captured in the personality factor of Agreeableness are characteristic of

effective MHPs—i.e., a sense of increased empathy for others—may be influential in their experience of chronic emotional and physical fatigue (Connor-Smith & Flachsbart, 2007, as cited in Armon et al., 2012; Barnett et al., 2007). Moreover, people who score high in these personality traits may self-select high intensity roles (i.e., acute settings) because of the demanding need—and because of their desire to "help" address this need—which invites further concern regarding MHP personality and burnout (Garden, 1989, as cited in Armon et al., 2012).

People who have adverse childhood experiences (ACES) or other life difficulties enter helping professions in increased numbers (Galvin & Smith, 2015 as cited in Simpson et al., 2018). Research asserts that MHPs are more likely to have experienced their own traumas or mental health difficulties before entering the field. Although this altruism rooted in MHPs' own experiences is inspiring to note, it also sheds light on the reality of life-traumas impacting MHP's resilience amidst stressful work settings (Dyrbye et al., 2010). According to their personality, incoming MHPs may be more eager to help in crisis settings and yet be predisposed to vicarious trauma or chronic stress associated with these work environments (Galvin & Smith, 2015 as cited in Simpson et al., 2018). This inevitable naïveté and potential predisposition raise questions as to the unique emotional vulnerability of early career MHPs in acute settings.

The Impact of an Acute Environment

Work environment significantly impacts a person's experience of burnout. A MHP's work environment plays a specific role, such that providers in acute settings are at an increased risk for burnout compared to their colleagues in less acute settings (Moukarzel et al., 2019). Acute settings, such as hospital emergency departments (ED), place an unparalleled demand on MHPs because the demands are high as they grapple with at-risk populations; Nelson et al., 2009). The necessity of the fast-paced environment in these settings is characterized by

inevitable stress for practitioners (Sende et al., 2012, as cited in Moukarzel et al., 2019).

Therefore, the strain of acute settings is twofold: firstly, the intensity of the environment often

requires split-second clinical judgment, and secondly, it tests the MHP's own ability to

emotionally regulate the stress with efficiency.

Considering what we know about the prevalence of ACES among MHPs, from a trauma-

informed lens, we can infer that effective stress regulation in these environments may prove

more challenging for them than for people without ACES backgrounds (Galvin & Smith, 2015,

as cited in Simpson et al., 2018). Effective work in these settings require a specialized skill set of

MHP's, one that often takes years of practice and necessary support to develop. Research

suggests that seasoned mental health professionals have acquired skills that buffer against

burnout in comparison to their entry-level colleagues (Wilkerson & Bellini, 2006 as cited in Lim

et al., 2010). Yet, where does this leave incoming, early-career MHPs in acute settings who have

not yet had years to develop the essential skills like their seasoned colleagues? Early career

MHPs are at a unique risk for burnout in acute clinical settings—at no fault of their own—but

due to their inevitable lack of experience as they begin their professional careers. Furthermore,

there is increased strain for early career MHP's based on the unique populations seeking service

in acute settings.

The Impact of Working with an Acute Population

Despite MHP vulnerability, entry level direct service is essential work amidst increasing

incidence of mental health diagnoses within the US. This recent increase has impacted hospital

settings, especially as underserved populations seek acute settings as their primary support for

mental health concerns due to resource barriers (Miller et al., 2017; Center for Disease Control,

2018). By nature of this accessibility, populations that access emergency departments tend to be

higher risk including those experiencing increased resource disparity, chronic substance use, active psychosis, and suicidal and/or homicidal ideation (Betz et al., 2015; Rabu et al., 2016). In comparison to populations seeking mental health treatment through private clinical practices, there is often an immediacy, increased risk and complexity associated with the ED population's mental health treatment (Moukarzel et al., 2019; Nelson et al., 2009). On many occasions, patients are even brought into the ED involuntarily by law enforcement or ambulance due to their imminent risk and immediate need for care. Mental health symptom severity is higher in the ED versus less acute settings and MHPs are impacted by the persistent exposure to suffering and trauma (Rabu et al., 2016). Further research suggests that professionals working in settings with persistent human suffering are more likely to experience emotional exhaustion, compassion fatigue and depersonalization in their work, which can lead to decreased empathy for the acute patient population overall (Ortiz-Fune et al., 2020; Suping et al., 2015). This invites questions as to how MHPs can be more readily equipped to effectively process the strain of caring for at-risk populations—and themselves in the process.

Although the immediacy of care for at-risk populations is paramount, the unique acuity of this patient population inevitably adds to the stress of MHPs working in these settings. Many early career MHPs begin in acute settings due to the growing need, yet as previously mentioned, they do not have the necessary years of cultivated clinical skill to effectively withstand the stress of working with high-risk populations (Nelson et al., 2009). Systematically and financially, there is a need for entry-level MHPs in these essential roles. Considering this, the inevitable risk of entry level MHPs working with high-risk populations is unavoidable and merits further research.

Relevant Programs and Need for Current Research

As aforementioned, health care professional burnout has become increasingly prevalent. Out of necessity, programs have begun to develop addressing treatment and prevention of burnout among a variety of mental health professionals. Large healthcare institutions such as the Mayo Clinic (Shanafelt & Noseworthy, 2016) and Providence Medical group (Nelson et al., 2009) have published literature with workplace strategies and even launched peer-to-peer physician support programs to address the current crisis. Oregon Health Sciences University launched the Relationship Leadership Institute in 2017 (https://relatelab.org) to address systemic factors and build interprofessional teams to mitigate burnout.

The American Medical Association (AMA) created "Steps Forward" which is curriculum designed for healthcare teams to address current burnout and engage in preventative care, with significant success as to date (American Medical Association, 2020). Recent research on workplace thriving has shown effective program implementation for seasoned medical practitioners facing burnout with promising results of increased quality and satisfaction in their work (Sinsky et al., 2013). A common thread throughout the literature refers to the necessity for professionals to increase self-awareness and develop skills in emotional regulation to facilitate sustainability. Healthcare systems have developed curriculum around emotional awareness training, stress reduction and mindfulness rooted in the evidence-based interventions of Acceptance and Commitment Therapy (ACT; Di Benedetto et al., 2015). Programs such as "RISE" by Kripalu center for yoga and health, have begun implementing interventions for physician stress reduction and resiliency building through mindfulness, yoga and positive psychology curriculum as well (Kripalu Center for Yoga and Health, 2020). Amidst the current crisis of burnout, evidenced-based programming is continuing to develop with promising results

for health care professionals. Although research has been conducted on physicians and seasoned MHPs, there is a dearth of research regarding incoming MHPs and the importance of preventative care for their health. As aforementioned, entry-level MHPs in acute settings are a unique population amidst health care professions. Therefore, there is a need for bolstered research on the impacts of preventative training and skills development for this specific population.

Considering this, the current study piloted a curriculum rooted in evidence-based interventions to explore the role of emotional awareness, regulation, and personality disposition in preventing burnout among entry level MHPs in acute settings. The population for this study included Master's level clinicians pursuing their Doctor of Psychology (PsyD) degree at a private religious university in Oregon. This university has a unique contract with two rural hospitals by offering crisis consultation in collaboration with a county mental health care team. Graduate students offer weekday after-hour (5pm-12am) and full weekend coverage (6am-12am) for patients presenting to the emergency departments (ED) for suicidal or homicidal risk. These doctoral students undergo several months of shadowing procedures: shadowing qualified MHPs, and then being reverse shadowed before operating independently. Once cleared through the shadowing procedures, students have an on-call supervisor available for consult while on shift and ultimately operate independently in the ED. For many students, this is among their first few years of clinical work, and it involves high acuity patients among EDs and intensive care units (ICUs). Within this study, the entry-level MHPs were given psychoeducation about their personality in relation to burnout and engaged in curriculum focused on evidenced-based interventions as outlined in previous literature to mitigate burnout as they developed within their early professional career.

The purpose of this study was to research if training curriculum including psychoeducation and applied practice in emotional regulation and emotional self-awareness increased students' ability to manage the stress associated with service provision of crisis consultation in an acute setting.

Hypotheses

- H1: Participants will show a decrease in Difficulty in Emotion Regulation Scale (DERS-18) scores and an increase in Emotional Self-Awareness Scale (ESAS) scores from pre to post-test implying an improved ability to regulate emotions and an increase in emotional awareness from pre to post test and at 4 month follow up.

- H2: Participants will show significant improvement in knowledge relative to coping strategies and emotional awareness from engagement in course curriculum, and this improvement will be significantly greater from pre to post test and at 4 month follow up.

Exploratory Analyses

- EA1: Are the Conscientiousness and Agreeableness traits on the Big 5 elevated for student seeking training to provide mental health risk assessments in acute settings?

- EA2: Is the Emotional Instability (Neuroticism) lower for these students?

- EA3: What are the intercorrelations among the Big 5 traits with these students?

- EA4: Which component of the training, curriculum and/or the process groups did the students find most helpful to their learning both personally and professionally

Chapter 2

Methods

Participants

Participants for this study included Masters level clinicians pursuing their doctorate in clinical psychology (PsyD) from a private religious institution in Oregon. Participants were comprised of the incoming crisis consultation team members for the 2021-2023 contract, an anticipated population of 16 students. All participants applied to join the consultation team and supervisors reviewed applications and selected participants according to pre-established criteria. Participants were required to complete the 15-week academic curriculum and clinical training as part of the requirements for Qualified Mental Health Professional (QMHP) licensure with the local county, including multiple phases of shadowing other QMHPs and ultimately being approved by the team of licensed supervising psychologists.

The initial design included two other comparison groups of participants. The first comparison group was to be comprised of doctoral students who began their training the previous year and had been providing the crisis consultation services for approximately six months. The purpose of this comparison group was to explore the differences between participants who engaged in this study versus students from the previous year cohort (2020-2022) who participated in the former model of training. The second comparison group was to be another group of students in the same year of training as our participants but who chose not to apply for the crisis consultation training and practicum experience. However, despite multiple attempts, we were unable to recruit the comparison group members. The lack of participation

was due to a variety of factors, most notably the stress and exhaustion caused by the global pandemic. Thus, we needed to revise the design. We maintained the integrity of the training for the intervention group including the pre, post and follow-up assessment but had to eliminate the comparison groups.

Thus, the final participant pool included 5 male and 11 female students who all identified as being of European-American descent. Participants' age varied from 22 to 36 years of age, with a mean of 27 years of age. Of the final 16 participants, three expressed prior experience with crisis work. Two of the three students expressed supporting 3 and 4 clients amidst prior crisis work, and one student communicated prior experience supporting 500+ clients. Thirteen of our participants expressed no prior experience with crisis work before engagement in the risk assessment course or crisis consultation team.

Measures

All participants completed the informed consent (Appendix A), and were then provided the following measures:

Pre-Test Qualitative Questionnaire

The Pre-Test Questionnaire (Appendix B) asked participants to indicate their uniquely assigned random number generated ID tag to maintain their confidentiality amidst data collection. The questionnaire asked participants' age, gender identity, ethnicity, current year in the crisis consultation team program as well as their prior experience with crisis work. Participants were asked to scale perceived emotional awareness, perceived confidence in ability to regulate their emotions, and current frequency of intentional strategies used to mitigate burnout. Furthermore, participants were asked to identify what strategies they use, how

frequently they used them and their confidence in ability to maintain these strategies over their career.

Big Five Inventory 2 Short Form (BFI-2-S)

The BFI-2-S (Appendix C) is a consolidation measure designed to identify the big five core personality factors of Neuroticism, Extroversion, Openness, Conscientiousness, and Agreeableness initially assessed in the work of McCrae and Costa (2004). This shortened version of the personality inventory presents thirty Likert continuum questions (six for each personality factor) regarding participants' level of agreement to self-identified personality characteristics given through adjective statements about attitude and behavior. The BFI-2-S Likert scale ranges from 1-5 for varying agreement to presented statements, 1 meaning *Disagree Strongly* and 5 meaning *Agree Strongly* with corresponding subsequent numbers in between. The measure items are organized into subscales of Extraversion, Agreeableness, Conscientiousness, Neuroticism, and Openness to Experience, which are tallied through scoring or reverse scoring according to the measure key (Soto & John, 2017). The Five Factor model has been an effective measure in understanding participants' personality structure (Arterberry et al., 2014; Soto & John, 2017) and has been proven statistically reliable with retesting (0.83- 0.91) and has shown strong internal consistency. The BFI-2-S has been utilized for its successful identification of personality structure while also providing greater fidelity and predictive power than the original BFI.

Difficulty in Emotion Regulation Scale (DERS-18)

The DERS-18 (Appendix D) comprises 18 Likert continuum questions related to participant emotional regulation and attends to the constructs of identifying, accepting, and managing emotions (Victor & Klonsky, 2016). The DERS-18 is derived from the original 36 item scale developed by Gratz & Roemer (2004 as cited in Victor & Klonsky, 2016) and was

shortened to decrease participant burden. The scale ranges from 1-5, 1 meaning *Almost Never* and 5 as *Almost Always* with corresponding percentage values. The DERS-18 items are organized into subscales to attend to constructs such as Awareness, Clarity, Goals, Impulse, Nonacceptance, and Strategies. The DERS-18 has internal consistency within subscale alphas ranging from .77 to .90, for Awareness and both Goals and Impulse, respectively. Overall score alpha for the DERS-18 is .91.

Emotional Self-Awareness Scale (ESAS)

The ESAS (Appendix E) is made up of 33 Likert continuum questions assessing for emotional self-awareness along a 5-point scale (Kauer et al., 2012). This 5-point Likert scale ranges from 0-4, 0 meaning *Never* and 4 meaning *A Lot*. This screener poses a series of questions regarding emotional awareness that are scored both at Likert-value and reverse-scored according to the question for a total ESAS score ranging from 0 to 132. The ESAS combines three previous screeners to more robustly identify the self-awareness constructs including Recognition, Identification, Communication, Contextualization, and Decision-Making. The ESAS exhibited strong internal consistency: Cronbach Alpha = .83.

Post-Test Qualitative Questionnaire

The Post-Test Qualitative Questionnaire (Appendix F) included the same content from the Pre-Test Qualitative Questionnaire (Appendix B) as well as further exploratory analysis questions. These questions asked about the individual participants' personal takeaways from the course curriculum as well as its impact on their professional development as a psychologist. The post-test questionnaire also invited open-ended feedback about the course curriculum and areas for perceived improvement.

Procedure

Participants in the 2021-2023 crisis consultation team cohort enrolled in the standard crisis consultation weekly class-trainings beginning in Spring 2021. All students in the study (whole class) created a unique identifier that served in place of their name on all questionnaires and data. All course participants engaged in 15 weeks (including testing days) of bi-weekly evidence-based curriculum and oriented towards personality and emotional regulation amidst acute settings utilizing ACT therapy constructs. On alternating week, participants engaged in peer-to-peer and group processing on various topics related to crisis intervention. Outline for curriculum found in Appendix G.

Week 1: (Pre-Intervention; Time 1)

The participants created their own unique identifier that was used for each measure and questionnaire they completed. At the start of the semester, all 16 participants completed the pre-test measures: informed consent, demographics questionnaire, BFI-2-S a personality questionnaire based on the Big 5, DERS-18, ESAS and qualitative questionnaire (Time 1).

Weeks 2-15: (Intervention 1)

The intervention group utilized the last 30 minutes of bi-weekly class time to engage in curriculum oriented towards personality awareness, emotional awareness, and mindfulness—according to evidence-based research on effective burnout curriculum. Every other week, students engaged in peer-processing groups and full class discussion to encourage emotional exploration surrounding topics related to working in crisis settings.

Week 16: (Post-Intervention; Time 2)

The DERS-18, ESAS, and posttest qualitative questionnaire were completed.

Four Month Follow Up: (Post-Intervention; Time 3)

To further assess for long-term implications, the DERS-18, ESAS, and Post-Test

Qualitative Questionnaire were completed again following four months of post-training

experience for the intervention group. Data were analyzed using the SPSS software program.

Chapter 3

Results

As described in Chapter 2, our initial research design included a comparison group of experienced consultation team members and another comparison group of students who had self-selected to not participate in the crisis consultation team or risk assessment course. Unfortunately, despite extensive efforts to gather data from each of these groups, there were not enough responses to provide a robust comparison. Therefore, our results show the changes reported by the intervention group with implications explored in our Discussion.

Hypothesis 1 Results

Hypothesis 1 of this study predicted participants in the intervention group would exhibit a decrease in their total Difficulty in Emotion Regulation Scale (DERS-18) scores and an increase in their Emotional Self Awareness Scale (ESAS) scores from pre to post-test implying an improved ability to regulate emotions and an increase in emotional awareness overall.

Difficulty in Emotion Regulation Scale (DERS-18)

The results of a paired sample *t*-test comparing participants responses on the DERS between Time 1 (pre-test) and Time 2 (post-test) immediately following the intervention, failed to show a significant decrease in difficulty in emotional regulation, with only a small effect size on the one scale showing the desired lower score for difficulty in emotional regulation (Awareness, see Table 1). The repeated measures (ANOVA) comparing scores at Time 1, Time

2 and Time 3 also failed to show a significant difference between scores at Time 1 or Time 2 in

comparison to Time 3.

Table 1

Results of the Paired Sample T-Test for the DERS-18

Subscales	Time 1		Time 2		t	p	d'
	M	SD	M	SD			
Awareness	6.81	2.25	6.44	1.93	0.92	.371	0.23
Clarity	4.69	1.30	5.13	1.36	−1.60	.130	0.40
Goals	8.00	2.44	9.13	3.64	−1.39	.183	.38
Impulse	3.88	1.5	4.25	3.02	−0.80	.432	0.2
Nonacceptance	6.69	2.65	6.69	3.02	0.00	1.00	00
Strategies	4.44	1.15	5.25	1.91	−2.08	.055	0.52

Note. The sample size (n = 16) was identical for both the pre-test at Time 1 and the post-test at Time 2.

Emotional Self Awareness Scale

In contrast to the results of the DERS-18, the results of a paired sample t-test comparing

participants responses on the ESAS between Time 1 (pre-test) and Time 2 (post-test)

immediately following the class showed a significant decrease in the total scores assessing

Emotional Self-Awareness, and the subscale scores for Contextualization and Decision-Making

(see Table 2). These results were in the opposite direction of our hypotheses indicating that

students reported have less emotional self-awareness following the intervention. The potential

implications of this change are found in the discussion section. Results failed to find significant

differences between the subscales of Recognition, Identification or Communication. The

ANOVA comparing the scores at Time 1, Time 2, and Time 3 (4 months post intervention) failed

to show a difference between scores at Time 3 with either Time 1 or Time 2.

Table 2

Results of the Paired Sample T-Test for the ESAS

Subscales	Time 1		Time 2		t	p	d'
	M	SD	M	SD			
ESAS Total	64.94	8.24	57.17	15.71	2.19	.042	0.52
Recognition	13.67	2.14	14.11	2.49	−0.95	.354	0.20
Identification	12.12	1.94	11.39	1.65	1.56	.137	0.37
Communication	12.72	3.10	12.67	2.85	0.08	.941	0.00
Contextualization	13.67	2.85	10.94	1.06	4.32	<.001	1.04
Decision-Making	14.22	1.63	10.83	1.34	11.56	<.001	2.72

Note. The sample size ($n = 16$) was identical for both the pre-test at Time 1 and the post-test at Time 2.

Hypothesis 2 Results

Hypothesis 2 explored participants' subjective reports using a set of non-standardized

questions developed for the purpose of this research. Five questions were included as part of the

pre and post intervention survey. The first three questions were scored on a Likert type scale:

(Please scale from 1-5; 1 = Low Awareness & 5 = High Awareness); (1). At this current time in

your training, how emotionally aware are you as you engage in clinical work in acute settings?

(2) At this current time in your training, how confident do you feel in your ability to regulate

your emotions in acute settings? (3) At this current time in your training, do you engage in

strategies to intentionally minimize your stress surrounding clinical work in acute settings?).

The results of the paired sample *t*-test for the combined sample for the first three questions failed

to show a statistically significant difference between participants' answers at Time 1 and Time 2

(see Table 3). However, there was a large effect size for changes in confidence to regulate

emotions (Question 2).

Table 3

Results of the Paired Sample T-Test for Changes in Subjective Report

Subscales	Time 1		Time 2		t	p	d'
	M	*SD*	*M*	*SD*			
Emotional awareness	3.78	0.67	3.89	0.60	−1.21	.234	0.18
Confidence in ability to regulate emotions	3.56	1.13	4.33	0.71	−1.81	.08	0.93
Engagement in intentional strategies	3.33	0.71	3.44	0.88	−0.41	.687	.11
Frequency of engagement in preferred strategy	1.63	1.06	1.25	0.46	−1.11	.05	0.35
Confidence in ability to maintain strategy	3.67	1.12	4.33	0.71	−0.86	.231	0.56

Note. The sample size ($n = 16$) was identical for both the pre-test at Time 1 and the post-test at Time 2.

Question 4 expanded on the previous question by inquiring what top three strategies

participants utilized, and how frequently they utilized these specific strategies each week: *(If you*

do engage in intentional strategies, what top 3 strategies/activities do you currently engage in at

this time in your training? How frequently do you engage in these specific strategies per week?).

Our results found that 9 of 16 participants (56%) reported utilizing mindfulness and/or deep

breathing as their most preferred strategy. Furthermore, they reported a statistically significant

increase in the use of this strategy between T1 and T2 (see Table 3) with a small effect size.

Question 5 sought to inquire about participants' confidence in long-term application of strategies: (*Please scale from 1-15; 1=* Low Confidence *& 5 =* High Confidence*: At this current time in your training, how confident do you feel in your ability to maintain these strategies/activities throughout your career in psychology? (i.e., over the next 20+ years of clinical practice).* Although there was not a statistically significant difference in participants' reported confidence to maintain strategies over time, the moderate effect size suggests that the sample size may have affected the statistical results.

Following the analysis of the data for Time 1 and Time 2, we used a repeated measures Analysis of Variance (ANOVA) to explore changes between Time 1, Time 2, and Time 3 for the smaller pool of participants who completed the assessments the time-delayed follow-up (see Table 4). Those results showed a statistically significant increase in participants' reported confidence to maintain the use of strategies over the course of their career. Additionally, the results showed large effect sizes in the confidence in their ability to regulate their emotions in acute settings both now and in the future.

Open-Ended Questions

Following the quantitative questions at T2 and T3, participants responded to open-ended questions after engagement in the intervention curriculum: *(1) Was there anything that was surprising to you about your reactions/sensations once you started your training in the ED?* (2) *After engagement in the bi-weekly burnout prevention curriculum please answer the following questions. What part of the bi-weekly burnout prevention curriculum was most beneficial to your professional training*; (3) *What part of the bi-weekly burnout prevention curriculum was most beneficial to your personal development? (4) What could have made the bi-weekly burnout*

Table 4

Repeated Measures Analysis of Variance

Subscales	Time 1		Time 2		Time 3		ANOVA		
	M	SD	M	SD	M	SD	F(1, 6)	p	η_p^2
Emotional awareness	3.86	0.69	3.86	0.69	3.86	0.69	0.00	1.00	0.00
Confidence in ability to regulate emotions	3.29	1.13	4.29	0.76	4.14	0.69	2.87	0.09	0.32
Engagement in intentional strategies	3.43	.53	3.43	0.98	3.86	0.69	1.35	0.29	0.18
Frequency of engagement in preferred strategy	1.71	1.11	1.29	1.29	2.00	1.41	0.80	0.47	1.18
Confidence in ability to maintain strategy	3.71	.95	4.29	0.76	4.14	0.90	1.22	0.33	0.17

Note. The sample size ($n = 7$) was identical for all three time points.

prevention curriculum more effective? Or, include any additional comments about your

experience with the curriculum. (For example, maybe more time in groups? different topics or

activities? Anything else?)

Findings for Question 1

Regarding question one, a few participants reported feeling "comfortable" in acute

settings because of familiarity, and/or were unsurprised by their experience training in the

emergency room because they anticipated feeling anxious. Conversely, many participants

reported being surprised by the "physiological reaction" of being in an acute setting: participants

reported feeling "distracted," "overstimulated" and even "triggered " by the environmental

sounds. Other participants expressed feeling surprised about their "physiological arousal" and

increased "anxiety" in the acute environment. A handful of participants were surprised by the

work being more "emotionally taxing than [they] expected," and further noted themes of

empathetically "holding pain" or experiencing physical pain (i.e., "back pain") after their shifts.

One participant reported feeling surprised by being previously "out of touch" and expressed

increased awareness of their emotional experience after beginning their training. Moreover,

others noted that they have grown more "confident with time" and even feel "calm in the room"

while completing risk assessments. General themes gathered from these open-ended responses

suggested surprise around the physiological arousal (loud sounds/busyness) and emotional

arousal (stress/anxiety) of working with patients in acute settings as well as general awareness of

increased coping with time.

Findings for Question 2

The second question inquired about participants' perceived benefit to their professional

training. Global themes gathered from participants' responses included the helpfulness of the

trainings' techniques and practical tools, the recognition of burnout and the removal of stigma as

well as the significance of the BFI individualized feedback. Many participants reported that the

practical tools offered in the curriculum—mindfulness, values-based work, and coping

strategies—were "beneficial" and helped participants understand and apply ACT theory to their

own lives. One participant stated that it helped them "better understand [their] own style and how

it could affect the way [they] think and act at work which could affect [their] long-term

performance." Moreover, participants also spoke to the impact the curriculum had on fostering

recognition of burnout and prompting them to both be pre-emptive of its impacts and de-

stigmatize the prevalence among MHPs. One participant specifically stated that the curriculum

made them be "aware of how common burnout is" and another stated it helped them "not feel

bad about feeling overwhelmed in the work [they] do." Lastly, a common theme among

participants also included the perceived benefit of the individualized BFI personality profile on their professional development, and participants specifically named this in their qualitative responses.

Findings for Question 3

Question 3 prompted participants to reflect on what aspects of the curriculum most benefited their personal development. Overall, participants reported similar themes to question 2, expressing that what benefited their personal development was learning to implement strategies, normalizing the prevalence of burnout as well as the individualized BFI profiles. More specifically, multiple participants reported that the specific emphasis on their personal values was helpful with "recognizing why [they're] doing this" and inspired "motivation" and "gave [them] energy" amidst fatiguing work. Qualitative data suggests that participants found the individualized aspects of the curriculum—values-identification, unique BFI profiles, and specific emphasis to engage in their own self-care routines—as formative to their personal development.

Findings for Question 4

Our last qualitative questions invited participants to give unstructured feedback on their experience and invite ideas for improvement. Overall, the most consistent theme woven between participants' responses included them finding the curriculum "very helpful," "fruitful" and "worthwhile." Multiple participants expressed that it was "something [they] looked forward to." More specific feedback for improvement included themes of increasing time in groups for processing as well as more specific strategies according to the BFI profile types and coping skills. One participant recommended starting the training with "emotional simulations" to encourage more practice with the physiological arousal associated with this work and to more effectively "introduce the concepts." Themes emerged around the time of the course negatively

impacting students experience—after a long academic day—reportedly made it more difficult to engage the curriculum topics.

Exploratory Analysis

This study explored the personality profiles of the consultation team members using the Big Five Inventory (an abbreviated measure of the Factor Five assessment). The five factors include Openness, Conscientiousness, Extraversion, Agreeableness and Neuroticism. Previous research noted healthcare providers typically show elevations on Conscientiousness (hard working, responsible, and reliable) and Agreeableness (altruistic, warm, and cooperative) (Armon et al., 2012). Consistent with prior research, our intervention group participants showed a similar pattern with, 12 of 16 (75%) scored within the higher range of Conscientiousness and 15 of 16 (94%) scored within high ranges of Agreeableness. The next question explored the level of Negative Emotionality (Neuroticism) of the intervention group. Results showed 15 of 16 (~94%) of the intervention group members scored within the medium range for Negative Emotionality, with 1 of 16 (~6%) scoring within the low range. A final question explored the intercorrelations between the five personality factors. Consistent with our expectations, the only significant correlation occurred between Conscientiousness and Agreeableness (16) $r = .447, p =.002$. In further exploratory analysis, none of the demographic variables (gender, age, ethnicity, years of experience) correlated with any of the outcome measures assessed as part of the previous hypotheses.

The last portion of our exploratory analysis sought to unearth which aspects of the course curriculum participants reported contributing most to their learning. Per qualitative data gathered at Time 2 and Time 3 for the intervention group, students reported that the specificity of attending to burnout based on their own personality style was advantageous to their learning as

well as increased conversation around the prevalence of burnout among MHPs. Participants noted that increased conversation around burnout and practical strategies to address it were beneficial to their learning. In questions that invited open feedback on course curriculum, students spoke of their desire to have increased time in small groups and as a whole class to discuss the curriculum topics and apply practical burnout prevention strategies. The course was structured so that students had bi-weekly peer process groups but not specifically related to the topics of the burnout prevention curriculum. In this way, it appears that if changes are to be made to the course curriculum, perhaps combining the bi-weekly peer process groups and the burnout prevention curriculum together would meet the student's reported desire to have increased time to dialogue and implement the burnout prevention curriculum.

Chapter 4

Discussion

Contributions to Current Research

According to research, entry-level mental health professionals MHP's are at unique risk for burnout due to a multitude of factors both personally and in their professional contexts (Morse at al., 2012; Simpson et al., 2018). Therefore, our bi-weekly burnout prevention curriculum was designed to mitigate burnout by addressing these factors in practical ways: identifying personality predispositions, increasing emotional awareness, normalizing burnout, identifying triggers, and increasing agency in mitigating the effects. The results from the Difficulty in Emotion Regulation-18 (DERS-18) and Emotional Self-Awareness Scale (ESAS) reported results different than we hypothesized—we found no statistically significant differences in the expected direction on either of the standardized assessment measures.

The decreased scores in emotional self-awareness implies the content of our curriculum touched on relevant developmental themes of "unconscious incompetence." A core component of our curriculum was contextualizing the emotional experience of working acute settings and learning to identify and graciously respond to these experiences in oneself. In this way, participants may have initially scored themselves as being more emotionally aware, and as training progressed, they came to identify the multiplicity of the role and how emotionally unaware they previously were. We assert that this is a developmentally appropriate response to the demands of the work. The large to very large effect sizes in the opposite direction within

domains of Contextualization and Decision-Making may imply that students became increasingly aware of the difficulty of decision-making in the context of an acute environment. These results bolster the implication that students may have attempted to present themselves favorably initially, and they grew in acknowledgement of the emotional demands in specific settings (acute environment) and their need to push for participant's growth in strategies to care for themselves.

The results of the qualitative questions between Time 1 and Time 2 demonstrated a significant increase in their use of a preferred strategy to intentionally mitigate burnout. Furthermore, there was a large effect sizes for subjective reports on confidence in ability to regulate emotion in acute settings as well a moderate effect size for their reported ability to continue using strategies. However, when we ran an ANOVA to consider these subjective reports at Time 1, 2 and 3, we failed to find a statistically significant increase in participants' confidence to regulate emotions or in their confidence in their ability to maintain the strategy. One possible explanation for these results is found in the literature on the impact of contextual moderators on habit formation (Mergelsberg et al., 2020). Part of our curriculum was encouraging students to engage strategies around burnout prevention, and regardless of the reported helpfulness of these strategies, the decrease in significant numbers is most likely due to students struggling to implement these strategies consistently enough to become a habit—the context for implementation was not reinforcing enough, or public enough, etc. to promote habit formation. In this way, our findings align with research in that people have difficulty maintaining new behaviors, and this mixed with MHPs predisposition to burnout and co-morbid personality traits—ex: "Helpers not needing help"—they may be less likely to engage strategies for help, and struggle to make these strategies a priority in their day to day lives enough to become a habit (Di Benedetto et al., 2015).

Additionally, the results of our BFI scales for this population of MHP's was consistent

with the research in that those in helping professions score high on scales of *Agreeableness* and

Conscientiousness (Armon et al., 2012). As previously noted, these two personality traits are

exceptionally high in helping/service-oriented populations because there is an innate altruism and

dutifulness which caters well to work that encourages diligence in task while also pulling for

empathic attunement to others. Furthermore, the research suggests that this combination of traits,

although innately helpful amidst an MHP's professional work, can lead to burnout in the long-

term due to the tendency to people-please and wrestle with personal boundary setting (Simpson et

al., 2018). Furthermore, the intercorrelations found between Conscientiousness and

Agreeableness traits in our participants align with the research in the general population of health

care providers who may be predisposed to burnout. In this way, our student sample was a good

representation of their professional peers considering the personality traits of MHP's, and the

understanding of personality predisposition impacting burnout.

The previous section showed how our results converged with previous research however,

our results failed to align with research in several areas. According to previous research on

burnout prevention among health professionals through peer engagement and increased emotional

awareness training (amongst other curriculum focuses), we anticipated to see change among our

intervention group. Amidst using the DERS-18 and ESAS scales, unfortunately, our global scores

between all three intervention times were not statistically significant nor did the change occur in

the desired direction. The ESAS was implemented as part of our research to capture the emotional

self-awareness of participants. We had anticipated that as students engaged in bi-weekly burnout

prevention curriculum they would increase in their ability to identify and therefore attend to their

emotional experience as it may fluctuate in a crisis setting, and respond with increased

confidence. Interestingly, our results suggested that students may have assumed a level of

emotional self-awareness at the beginning of the training that was later challenged by their experiences in the acute setting.

Our use of the DERS-18 scale was intended to capture difficulty in emotional regulation which we proposed should decrease as students engaged in the curriculum strategies and grew more accustomed to the ED environment. Research suggests that people increase their distress tolerance with practice which serves to mitigate burnout specifically within acute/crisis settings (Wilkerson & Bellini, 2006, as cited in Lim et al., 2010). We anticipated that students would show a decrease in scores between Time 1, 2 and 3, yet there were no statistically significant changes. This lack of statistical significance for the total DERS-18 scores may be due to our small sample size, but more likely it was a function of the lack of sensitivity and specificity of the measure to assess change in this specific population. In the post-intervention qualitative responses, participants attested to their increased confidence in emotional regulation amidst working in the ED as well as awareness of their increased comfortability in the environment over time. In this way, the DERS-18 results did not align with the more qualitative findings, or what we anticipated based on the research. Although the standardizes measures failed to show the expected results, we cannot conclude statistical significance based on our numerical findings, the qualitative responses shed light on participants' growth amidst curriculum engagement.

Implications

Research suggests that burnout is a national health crisis and furthermore, that MHP's are at a unique risk (Bednar, 2019; Panagioti et al., 2018; Shanafelt & Noseworthy, 2016; Simpson et al., 2018). Therefore, effective preventative intervention is an important part of an MHP's preparation for crisis work in acute settings. The implications of our research, based on qualitative data gathered, is that entry-level MHPs are identifying with the predisposition to burnout and are

interested in increasing their understanding and application of strategies to support their longevity.

Furthermore, the statistically insignificant changes in global DERS -18 and ESAS scores across all data collection times may be due to the participants' personalities. Research suggests that entry level MHPs feel obligated to engage in impression management to minimize risk of being perceived as incompetent (Saddicha et al., 2012, as cited in Simpson, 2018), and this paired with the noted high BFI Agreeableness score may have resulted in a desire to present positively. In this way, as participants engaged in our measures there may have been a desire for impression management which would have produced falsely high ESAS scores and falsely low DERS at Time 1. Additionally, as participants engaged in the burnout prevention curriculum and increased their awareness around universal emotional distress and burnout for MHP's, they may have become more honest in their responses. If this were the case, this could have contributed to an opposite effect than we were hoping to capture; participants may have recognized that they were not as emotionally aware as they thought they were, and they acknowledged that it was more difficult than they thought to regulate emotions in acute environments and answered accordingly at post-test report.

Furthermore, our scores at post-test report may have been inaccurately captured due to students' low morale amidst contextual stress. At this time, students were completing their school semester and entering finals week—a notoriously stressful time—while also entering into crisis consultation shadowing during a record increase in crisis call volume. Furthermore, this training and shadowing was occurring amidst the global stress of Covid-19 and hybrid learning formats. Students were emotionally taxed and being put to the test. These contextual factors may have impacted participants' scores as they reported increased difficulty in regulation and decrease in emotional awareness as a "cry for help" amidst their legitimate contextual stress. Unfortunately,

we were unable to control for all notable impacting factors that may have influenced our participants' responses. This postulation around our participants' emotional experience with the measures is multifaceted and as such requires additional research.

Limitations

A prominent limitation of our study was the sample size and attrition of participants at each follow up. Ideally, it would have been advantageous to engage more participants in this curriculum to gather more robust and accurate data on its effectiveness or ineffectiveness. Unfortunately, the small class-size and attrition of some of these students served as an inevitable barrier to robust results. Moreover, a further limitation of this study was the lack of a comparison group. Our intent was to engage graduate students who were not participating in the crisis consultation course as a comparison group, yet we were unable to get enough participation from these students to make a significant comparison. We also had intended for the experienced consultation team members to serve as another comparison group and were unable to gather enough participant responses. Therefore, this inability to compare our intervention group to a true comparison group makes for a significant limitation on the implications of our research. Moreover, as evidenced by the variability between participants' reported experiences and the DERS-18 & ESAS scores, another limitation was the lack of specificity these measures offered to capture our participants' changes throughout curriculum engagement. In this way, we appeared to not gather the changes that were reportedly occurring, and therefore needed measures more sensitive to the content of the course curriculum.

Suggestions for Future Research

Engagement in mental health care in acute settings invites inquiries about the long-term wellness of practitioners—how does one stay well amidst work that is high-intensity/high-acuity? As previous research suggests, there are a multitude of factors that impact people's self-selection

into this level of work, and moreover, serve as mitigating factors in either buffering against or inviting burnout. Amidst the increased need for health and mental health professionals during the global distress of Covid-19, conversations around provider health and longevity are paramount. Future research around burnout prevention curriculum in health care workers would benefit from continued exploration on the personality and disposition of the workers. As discussed, these individuals self-select into these careers and therefore highlighting the role of personality, the pros and the cons, can increase awareness around their long-term health and happiness in their career field. Moreover, we can start by increasing awareness of the prevalence of burnout among mental health providers and working to humanize the experience of serving others as taking a toll on ourselves when not balanced well. Therefore, further research in emotional awareness training as well as efforts to increase self-care habits could be advantageous for determining long-term health of providers. More specifically, future research surrounding emotional awareness, regulation and burnout prevention could be benefitted by more sensitive measures that capture the nuance of providers' emotional experiences.

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Appendix A

Informed Consent for Research Participants
George Fox University Graduate School of Clinical Psychology

Description of Study and Your Involvement

The following research is being conducted on entry-level mental health professionals working in acute and non-acute settings. Involvement includes filling out questionnaires and potentially engaging in curriculum related to the unique clinical work in acute settings within the Consultation Team elective course. Some participants will not be involved with the Consultation Team. The timeline for this research will span over the Spring 2021 semester and include follow up data gathered through questionnaires after the MHP's begin working independently in their acute settings (roughly August 2021). By agreeing to participate, students are allowing their de-identified questionnaires scores, qualitative data and basic demographic information to be made accessible for future research. Involvement is voluntary, and participants can ask to have their data removed from the study at any point up until it is being analyzed along with other participants.

Possible Risks and Benefits of This Study

Risks involved in this research include potential emotional discomfort as patient's explore their experience surrounding their personality and predispositions. Benefits of engaging in this research include potential growth in personal awareness as a developing clinical. There are no consequences for withdrawing from the study, including no academic repercussions for students' course grade if they should decide to not participate. clinician and the advancement of program development for GFU's BHCC curriculum.

Compensation

No financial award or differentiation of treatment will be allotted to participants who choose, or do not choose, to participate.

Confidentiality

All participants will be given a random-number-generated code to uniquely identify their questionnaire responses and their data will be deidentified before given to the researcher. Information that will be collected includes: demographics of participants, year on BHCC team, previous history working with populations in acute settings, qualitative data regarding participants' perceived experience with curriculum and their personal growth.

Questions or Concerns

Questions or concerns can be directed to:
Primary researcher: Whitney J. Standal, M.A, QMHP, wstandal17@georgefox.edu
Supervisor: Mary Peterson, PhD, ABPP, mpeterso@georgefox.edu
IRB Approval Number for Research: 2201126

By signing below, I agree to the description articulated above, and am voluntarily choosing to participate. I understand that my information will be de-identified and kept confidential throughout the research process and will be made accessible for future research.

X_____
(Participant's Name)

X_____
(Participant's Signature)
Date: _____

Appendix B

Pre-test Qualitative Questionnaire

1. *(Informed consent) See appendix A.*

2. Please create a unique code for your responses by answering the following questions: What was/is the name of your/your family's first pet & what month were you born? For example: "Zazu" & "October" = Zazu10 or "Missy" & "May" = Missy05

3. What is your gender identity?

4. What is your age?

5. What crisis consultation cohort are you currently in?

6. Do you have previous experience with crisis work prior to joining the BHCC team?

7. If you answered "yes" to having previous experience with crisis work, please answer the following question accordingly. If you answered "no," please answer "0" or "N/A". Approximately how many people/patients have you provided crisis work for prior to consultation team?

8. *Please scale from 1-5; 1= Low Awareness & 5 = High Awareness:* At this current time in your training, how emotionally aware are you as you engage in clinical work in acute settings?

1	2	3	4	5
Low Awareness		Moderate Awareness		High Awareness

9. *Please scale from 1-5; 1= Low Confidence & 5 = High Confidence:* At this current time in your training, how confident do you feel in your ability to regulate your emotions in acute settings?

1	2	3	4	5
Low Confidence		Moderate Confidence		High Confidence

10. At this current time in your training, do you engage in strategies to intentionally minimize your stress surrounding clinical work in acute settings? (For example, mindfulness, exercise, habits before going into the ED, etc.)

1	2	3	4	5
Not at all	Occasionally	Typically	Often	Always

11. If you do engage in intentional strategies, what top 3 strategies/activities do you currently engage in at this time in your training?
    a. Strategy 1: _____
    b. Strategy 2: _____
    c. Strategy 3: _____

12. If you do engage in intentional strategies/activities, how frequently do you engage in these strategies per week?

Frequency of Strategy 1 per week:

0	1	2	3	4	5
N/A	<1x per Week	1x per Week	2x per Week	3x per Week/Every Other Day	Nearly Every Day

Frequency of Strategy 2 per week:

0	1	2	3	4	5
N/A	<1x per Week	1x per Week	2x per Week	3x per Week/Every Other Day	Nearly Every Day

Frequency of Strategy 3 per week:

0	1	2	3	4	5
N/A	<1x per Week	1x per Week	2x per Week	3x per Week/Every Other Day	Nearly Every Day

13. *Please scale from 1-15; 1= Low Confidence & 5 = High Confidence:* At this current time in your training, <u>how confident</u> do you feel in your ability to maintain these strategies/activities throughout your career in psychology? (i.e. over the next 20+ years of clinical practice).

1	2	3	4	5
Low Confidence		Moderate Confidence		High Confidence

14. Additional comments {text box}

Appendix C

The Big Five Inventory–2 Short Form (BFI-2-S)

Here are a number of characteristics that may or may not apply to you. For example, do you agree that you are someone who *likes to spend time with others?* Please write a number next to each statement to indicate the extent to which you agree or disagree with that statement.

1 Disagree strongly	**2** Disagree a little	**3** Neutral; no opinion	**4** Agree a little	**5** Agree strongly

I am someone who...

1. ___ Tends to be quiet.
2. ___ Is compassionate, has a soft heart.
3. ___ Tends to be disorganized.
4. ___ Worries a lot.
5. ___ Is fascinated by art, music, or literature.
6. ___ Is dominant, acts as a leader.
7. ___ Is sometimes rude to others.
8. ___ Has difficulty getting started on tasks.
9. ___ Tends to feel depressed, blue.
10. ___ Has little interest in abstract ideas.
11. ___ Is full of energy.
12. ___ Assumes the best about people.
13. ___ Is reliable, can always be counted on.
14. ___ Is emotionally stable, not easily upset.
15. ___ Is original, comes up with new ideas.
16. ___ Is outgoing, sociable.
17. ___ Can be cold and uncaring.
18. ___ Keeps things neat and tidy.
19. ___ Is relaxed, handles stress well.
20. ___ Has few artistic interests.
21. ___ Prefers to have others take charge.
22. ___ Is respectful, treats others with respect.
23. ___ Is persistent, works until the task is finished.
24. ___ Feels secure, comfortable with self.
25. ___ Is complex, a deep thinker.
26. ___ Is less active than other people.
27. ___ Tends to find fault with others.
28. ___ Can be somewhat careless.
29. ___ Is temperamental, gets emotional easily.
30. ___ Has little creativity.

Please check: Did you write a number in front of each statement?
BFI-2 items copyright 2015 by Oliver P. John and Christopher J. Soto.

Appendix D

Difficulty in Emotion Regulation-18

Name/ID: _____   Date: _____

DERS-18

Response categories:

1	2	3	4	5
Almost Never (0-10%)	Sometimes (11-35%)	About Half the Time (36-65%)	Most of the Time (66-90%)	Almost Always (91-100%)

1. _____ I pay attention to how I feel.

2. _____ I have no idea how I am feeling.

3. _____ I have difficulty making sense out of my feelings.

4. _____ I am attentive to my feelings.

5. _____ I am confused about how I feel.

6. _____ When I'm upset, I acknowledge my emotions.

7. _____ When I'm upset, I become embarrassed for feeling that way.

8. _____ When I'm upset, I have difficulty getting work done.

9. _____ When I'm upset, I become out of control.

10. _____ When I'm upset, I believe that I will remain that way for a long time.

11. _____ When I'm upset, I believe that I'll end up feeling very depressed.

12. _____ When I'm upset, I have difficulty focusing on other things.

13. _____ When I'm upset, I feel ashamed with myself for feeling that way.

14. _____ When I'm upset, I feel guilty for feeling that way.

15. _____ When I'm upset, I have difficulty concentrating.

16. _____ When I'm upset, I have difficulty controlling my behaviors.

17. _____ When I'm upset, I believe that wallowing in it is all I can do.

18. _____ When I'm upset, I lose control over my behaviors.

Original DERS (36 item) Citation: Gratz, K. L., & Roemer, L. (2004). Multidimensional assessment of emotion regulation and dysregulation: Development, factor structure, and initial validation of the difficulties in emotion regulation scale. *Journal of Psychopathology and Behavioral Assessment*, *26*(1), 41-54.

DERS-18 (18 item) Reference: Victor, S. E., & Klonsky, E. D. (2016). Validation of a brief version of the Difficulties in Emotion Regulation Scale (DERS-18) in five samples. *Journal of Psychopathology and Behavioral Assessment, in press.*

Appendix E

Emotional Self-Awareness Scale (ESAS)

All items are on a 5-point likert scale ranging from zero to five (0 = Never, 1 = Very Little, 2 = Sometimes, 3 = Often, 4 = A lot). Subscales range from 0 to 20. Total scale ranges from 0 – 132.

Subscales

Recognition: Items 4, 18, 20, 21, 22, 24. Divided by 6. Multiplied by 5.

Identification: Items 1, 3, 8, 17, 29. Divided by 5. Multiplied by 5.

Commuication: Items 6, 12, 13, 15, 27, 30, 3. Divided by 7. Multiplied by 5.

Contextualisation: 5, 7, 10, 11, 14, 16, 19, 28, 32, 33. Divided by 10. Multiplied by 5.

Decision-Making: 2, 8, 23, 25, 26. Divided by 5. Multiplied by 5.

Total ESA score: The sum of all subscales.

Item	Question
1	My moods are hard to describe *(reverse)*
2	I examined my feelings and then decided what to do
3	It's important to me to understand what my feelings mean
4	It's hard for me to tell what mood I'm in *(reverse)*
5	I analyse my personality to try to understand why I'm upset
6	Expressing emotion is easy
7	I usually know why I feel the way I do
8	I often have trouble deciding what will improve my mood *(reverse)*
9	I know how I feel about most things
10	I don't know why I feel the way I feel *(reverse)*
11	I go away by myself and think about why I feel a certain way
12	I like to write down what I'm feeling and analyze it
13	I can talk about mood to others
14	I don't really think about why I behave as I do *(reverse)*
15	I often 'self-talk' to think about feelings
16	I'm often confused about how I feel about things *(reverse)*
17	I'm often aware of being emotional, but I can't describe the emotion
18	I frequently take time to reflect on how I feel

19	I often know what caused my mood
20	I'm usually aware of my emotions
21	I like to go someplace alone to think about my feelings
22	I don't often think about my feelings *(reverse)*
23	I often think about ways to make myself feel better
24	I know exactly how I'm feeling
25	Sometimes I can't figure out how to make myself feel better *(reverse)*
26	When feeling bad, I try to deal with my problems and concerns
27	I can verbalise my feelings
28	I usually have clear idea about how my feelings affects my behaviour
29	It's difficult to make sense of the way I feel about things *(reverse)*
30	I find it easy to write down how I feel
31	It's difficult to communicate what I feel *(reverse)*
32	I often think about the way I feel about things
33	I analyse recent events to try to understand why I'm upset

Note: Reverse scored items are indicted by *(reverse)*

Appendix F

Post-Test Qualitative Questionnaire

Survey began same as above including: informed consent, pre-test qualitative questions,
DERS-18 & ESAS scales as well as the following questions. BFI-2-S questions were blocked.
Given at Time 2 and Time 3. Questions #1-95.

96. What is your ethnicity?

97. If you DID NOT participate in the Spring 2021 Risk Assessment course, please write "N/A"
    in the box below.Was there anything that was surprising to you about your
    reactions/sensations once you started your training in the ED?

98. If you DID NOT participate in the Spring 2021 Risk Assessment course, please write "N/A"
    in the box below.After engagement in the bi-weekly burnout prevention curriculum please
    answer the following questions. (I am looking for 1-2 sentences for each question)What part
    of the bi-weekly burnout prevention curriculum was most beneficial to your professional
    training?

99. If you DID NOT participate in the Spring 2021 Risk Assessment course, please write "N/A"
    in the box below.What part of the bi-weekly burnout prevention curriculum was most
    beneficial to your personal development?

100.   If you DID NOT participate in the Spring 2021 Risk Assessment course, please write
    "N/A" in the box below.What could have made the bi-weekly burnout prevention curriculum
    more effective? Or, include any additional comments about your experience with the
    curriculum. (for example, maybe more time in groups? different topics or activities? Anything
    else?)

Appendix G

Weekly Course Curriculum Outline

Week 1: Pre-test administration of questionnaires & Overview of Curriculum
- Quick Overview: Prevalence of burnout, Role of personality and predisposition in burnout, Impact of setting/ population
- How do we prevent it?
    - Awareness & building emotional regulation!
- Data collection—Pre-Test Data Collection

Week 2: Guided Imagery Class Exercise
- Partnered guided imagery exercise

Week 3: Personality
- Look over individual BFI-2-S results
- Talk about personality traits and impacts
    - Scale high or low?
    - What does this mean for you?
    - Anything surprising?

Week 4: Peer-Process groups
- Choose a partner
- Questions to process related to content

Week 5: Construct curriculum: Awareness/recognition & Clarity/Identification
- Role of simple awareness/recognition of emotional response
- Guided awareness activity: "Observing Self Activity"
    - Neutral environment:
    - Play ED sounds
    - Do you have any reactions? Do you have reactions to your reactions? (Embarrassment? Guilt?)
- Role of identifying specific emotional experience
    - Can you label your emotions? (Emotion vocabulary & emotion wheel)
    - What else occurred today or in your past that might get activated?
    - Can you clearly lay out what is coming up for you?
- Self-care: bring in importance of routine care/mindfulness BEFORE

Week 6: Peer-Process groups
- Same partner
- Questions to process related to content

Week 7: Construct curriculum: Acceptance of emotions
- Hx of "helpers not needing help"; psychoeducation about MHP's tendency to minimize
- What does it mean to "accept" who we are, our personalities and what that means in the room?
- Perspective-taking / Self-compassion exercise
- How do we then communicate what we need?
    - Examples: giving yourself the full hour to respond to call, asking for help from your secondary person, calling another team member for support?

- Self-care: related to accepting emotions

Week 8: Peer-Process groups
- Same partner
- Questions to process related to content

Week 9: Construct curriculum: Strategies to cope/regulation in high intensity contexts
- What habits do you currently use?
- What habits/ strategies have been proven helpful
  - Social Support
  - Mindfulness
- Self-care: What are your personal take-aways?
  - Motivational Interviewing to engage in values-based care for self
  - (habits extended beyond day on call: exercise, eating well, emotional support?)

Week 10: Spring Break/no class

Week 11: Construct curriculum: Decision-making/ engagement in goals; purposely and routinely engaging for burnout prevention
- Psychoeducation about decision making under stress in ED
- Emotional regulation helps us keep to our goals and make the necessary decisions (and impulse regulation in process)
- Role of personal values in decision-making:
  - ACT "Choice Point" exercise
  - Role of values in maintaining engagement in work
  - Emotional preparedness: How can you "fill your cup" when you're not "on" to prepare you for the times when you are "on"?

Week 12: Peer-Process Groups
- Same partner
- Questions to process related to content

Week 13: Data Collection
- Post-Test Data Collection with Intervention Group

Week 14: Peer-Process Groups
- Same partner
- Questions to process related to content

Week 15: Finals Week

Appendix H

Curriculum Vitae

Whitney J. Standal Schollars

Education

Doctorate in Clinical Psychology (PsyD) *APA-Accredited   **2018—Present**
George Fox University, Newberg, OR
- Track Specialty: Primary Care Psychology
- Health Resources and Services Administration (HRSA) Grant Student Recipient
  - Engaging in specialized training with rural hospital patients with chemical dependency, chronic pain, and other medical complexities.
  - Participating in increased clinical hour requirements with hospital consultation, primary care psychology, and interprofessional trainings.
- Academic chair: Mary Peterson, PhD, ABPP/CL
- Dissertation: "Preventing Burnout: The Role of Personality and Awareness in Early Career Mental Health Professionals in Acute Settings."
  - Final oral defense completed: October 29th, 2021.
- Expected graduation: May 2023.

Master of Arts in Clinical Psychology (MA) *APA-Accredited   **2018—2020**
George Fox University, Newberg, OR
- Academic chair: Mary Peterson, PhD.
- Successful completion of SFE and CIAE competency exams.
- Dissertation: Preliminary defense completed October 2020.

Bachelor of Science in Psychology (BS) *Cum Laude   **2013—2016**
Azusa Pacific University, Azusa, CA
- Academic chair: Kathryn Ecklund, PhD.
- Degree: Bachelor of Arts in Psychology.
- "Outstanding Senior" Award in Psychology.
- Pew College Society Student Affiliate.

Clinical Experience

Pre-Internship: Behavioral Health Intern/ Primary Care Therapist   **2021—Present**
Providence Medical Center, Bethany, OR
- Supervisor: Jeri Turgesen, PsyD, ABPP, MSCP; Savannah Hamilton, PsyD.
- Population:
  - Urban medical clinic patients ranging from child to geriatric and varying in sexual, gender, ability, and religious identities.

- Effectively utilize evidence-based treatments to support behavioral and mental health concerns in short-term modalities: ~30-minute sessions/4-6 visits, intakes, psychotherapy, consultation, warm-handoffs, and interdisciplinary collaboration.
- Utilization of patient-centered safety plans (for SI), PHQ-9 depression screeners, GAD-7 anxiety screeners and psychodiagnostic interviewing to determine client diagnoses and needed level of care.
- Experience with communication, collaboration, and treatment planning with health care professionals as a vital part of an interdisciplinary care team.

Practicum II: Behavioral Health Intern/ Primary Care Therapist   2020—2021
Providence Medical Center, Newberg, OR
- Supervisor: Jeri Turgesen, PsyD, ABPP, MSCP.
- Population:
  - Rural medical clinic patients ranging from child to geriatric and varying in sexual, gender, ability, and religious identities.
- Provided risk assessments/safety plans, warm handoffs, intakes, interdisciplinary consultation, psychotherapy, psychiatric evaluations, ADHD evaluations, MOCA memory assessments, and psychodiagnostics test administration.
- Engaged in clinical training rotation in family medicine providing on site consultation for patients struggling with chemical dependency.
- Participated in group trainings with chemical dependency psychiatrist and individual supervision.
- Opportunity to complete four integrative assessment reports (one full neurological assessment report) with patients ranging in diagnoses: ADHD, GAD, other specified neurocognitive disorder, and major neurocognitive disorder secondary to traumatic brain injury.

Behavioral Health Crisis Consultation Team   2020—2021
Providence Hospital, Newberg, OR
Willamette Valley Medical Center, McMinnville, OR
- Supervisors: Luann Foster, PsyD; Mary Peterson, PhD, ABPP/CL; Bill Buhrow, PsyD.
- Population:
  - Community members accessing the rural hospital emergency department in Newberg and McMinnville varying in age and their sexual, gender, and religious identities.
- Provided after-hour crisis intervention assessments for patients presenting with suicidal and/or homicidal ideation.
- Collaborated inter-professionally with attending physicians, nursing staff, supervising psychologists and county mental health services towards inpatient hospitalization, outpatient treatment and/or approved discharge.
- Managed cases, patients' families, and triaged connection to inpatient hospital care within interdisciplinary hospital settings.

Practicum I: University Health and Counseling Center Therapist   2019—2020
George Fox University, Newberg, OR

- Supervisors: Luann Foster, PsyD; Bill Buhrow, PsyD.
- Population:
  - Undergraduate students at George Fox University varying in racial, sexual, gender, and religious identities.
- Provided intakes, consultations, risk-assessment, and psychotherapy to college students ranging from trauma processing, PTSD, sexual assault, racial/cultural identity processing, transgender care, sexual orientation exploration, grief processing, interpersonal distress, religious/spirituality exploration, anxiety and depression, panic disorders, personality disorders, adjustment disorders, and disordered eating.
- Exhibited ability to work within short-term modalities (2-4 sessions) and longer-term modalities (15+ sessions) in collaboration with supervised treatment plans and client's goals for care.
- Participated in weekly group trainings and individual supervision ranging in topics from theoretical orientation, treatment planning, diagnoses, grief/loss, risk assessment, academic support, etc.

Pre-Practicum: Student Therapist   **2018—2019**
George Fox University, Newberg, OR
- Supervisors: Glena Andrews, PhD, ABPP; Laurie Meguro, MA.
- Population:
  - Graduate and undergraduate students at George Fox University varying in age, gender identity, sexual orientation, and spiritual identities.
- Provided supervised clinical interviewing, intakes, and psychotherapy to students with specific emphasis in Rogerian, Person-Centered psychotherapy.
- Provided 10 weekly, recorded sessions to two undergraduate students with weekly supervision of recordings.

Behavioral Technician II/ Technician Trainer   **2016—2018**
Center for Autism and Related Disorders, Temecula, CA & Beaverton, OR
- Supervisors: Ariel Denny, MA, BCAT; Natalia Garrido, MA, BCAT.
- Certifications: BCAT licensure, CPR certification.
- Population:
  - Children, ranging from two years old to 18 years old, with Autism Spectrum Disorder (ASD) and other developmental disorders, physical disabilities, and neurocognitive decline after seizures.
- Designed and execute Applied Behavioral Analysis (ABA) programs for children, managed clinical meetings for parents and primary caregivers, worked as liaison of families and supervisors to ensure efficacious services for children.
- Trained and supervised incoming behavioral therapists through formative and summative feedback methods, active shadowing, and final evaluations.

Children's Program Intern   **2015**
Door of Hope domestic violence shelter (secured location), CA
- Supervisors: William Whitney, PhD; Gema Chow, BA.

- Population:
  - The children and mothers of families escaping domestic violence (DM) ranging in SES, cultural/ethnic heritage, and primary language.
- Managed after school program for children at the domestic violence safe home, fostered relationships with mothers, facilitated food donations from local grocers, and assisted with behavior management during group therapy for children (provided by a licensed professional).

Supervision, Teaching & Program Evaluation Experience

Supervisor to Practicum I Students   **2021—Current**
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Supervisors: Daniel Rodriguez, PsyD; Rodger Bufford, PhD.
- Providing supervision to two doctoral students in their first clinical training sites under the structure of the Supervision & Management PSYD course curriculum (taught by Dr. Bufford, supervised by Dr. Rodriguez).
- Providing individual supervision, ~3 hours/week, around areas of personal and professional development: supporting theoretical orientation development, offering evidence-based treatment recommendations, and exploring their growth in the client/therapist relationship.
- Experience providing formative and summative feedback to supervisees after clinical presentations in alignment with competency-based evaluation measures (supervised be Dr. Rodriguez).

Teaching Assistant (TA): Substance Abuse (PSYD 582)   **2021—Current**
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
- Course Educator: Jory Smith, PsyD. (Psychologist at Hazelden Substance Use Treatment Center in Oregon)
- Fostering course curriculum for a trauma-informed approach to substance use conceptualization and treatment.
- Offering support and indirect supervision to students as they inquire about trauma-informed approaches for clients with substance use disorders.
- Managing logistics of course curriculum and announcements to enrolled students.

TA: Risk Assessment (PSYD 585) / Program Evaluation   **Spring 2021**
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
- Course Educator: Luann Foster, PsyD.
- Created and presented evidence-based bi-weekly curriculum to entry-level mental health professionals preparing for crisis consultation work in rural hospitals as part of dissertation.

- Provided curriculum rooted in personality awareness (Big 5 Personality Factors), mindfulness, ACT therapy, and motivational interviewing as part of burnout prevention.
- Facilitated process groups around curriculum content in conjunction with my dissertation research.
- Program Evaluation: Utilized exploratory analyses to gather themes on students' perceptions of course success and need for program changes.

Training of Behavioral Health/ Primary Care Therapists   **Summer 2021**
Providence Medical Center, Newberg, OR
- Supervisor: Jeri Turgesen, PsyD, ABPP, MSCP.
- Provided shadowing and training to incoming behavioral health therapists at a primary care clinic as well as within warm-handoff consultations within chemical dependency rotation at Family Medicine clinic.
- Trained incoming clinicians with EMR, charting, scheduling management and evidence-based interventions within short-term modalities.

Training of Behavioral Health Crisis Consultants   **Spring 2021**
Providence Hospital, Newberg, OR
Willamette Valley Medical Center, McMinnville, OR
- Supervisors: Luann Foster, PsyD; Mary Peterson, PhD, ABPP/CL; Bill Buhrow, PsyD.
- Provided training of risk assessment intakes, professional consultation, and crisis triaging to doctorate-level students training for crisis consultation roles in rural hospitals for patients with SI/HI.
- Shadowed incoming consultants to ensure effective preparation of independent work in crisis consultation role, in collaboration with licensed supervisors noted above.

TA: Integrative Approaches to Psychology and Psychotherapy (PSYD 571)   Fall 2019
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
- Course instructor: Mark McMinn, PhD; Megan Anna Neff, PsyD, MDiv.
- Provided co-led weekly process groups to doctoral students around topics of religious integration, spiritual embodiment, and therapeutic application using the book "Embodied Hope" by Dr. Kelly Kapic.

Assessment and Screener Experience

Cognitive Assessments
- Wechsler Adult Intelligence Scale-IV (WAIS-IV)
- Wechsler Intelligence Scale for Children-V (WISC-V)

Achievement Assessments
- Wechsler Individual Achievement Test-III (WIAT-III)
- Wide Range Achievement Test, Fifth Addition (WRAT-5)

Neuropsychological & Memory Assessments
- Wechsler Memory Scale-IV (WMS-IV)
- Delis-Kaplan Executive Function System (D-KEFS) (*all subtests*)
- Montreal Cognitive Assessment (MoCA) (*virtual and in person*)
- Booklet Category Test
- Test of Memory Malingering (TOMM)
- Tactical Performance Test (TPT)
- Rey-Osterrieth Complex Figure (Rey-O)
- California Verbal Learning Test-II (CVLT-2)
- Iowa Gambling Task
- Jordan Left-Right Reversal Test—3rd Edition
- Grooved Peg Board
- C-TONI
- Wisconsin Card Sort. Test (WCST)
- Boston Naming Test

Personality Assessments
- Minnesota Multiphasic Personality Inventory-II (MMPI-2; 2-RF)
- Personality Assessment Inventory (PAI)
- Millon Clinical Multiaxial Inventory-fourth edition (MCMI-IV)

Behavioral Assessments
- Continuous Performance Test (CPT-3)
- Behavioral Assessment Scale for Children—Third Edition, Parent Report (BASC-3 PRS-C)
- Behavioral Assessment Scale for Children—Third Edition, Teacher Report (BASC-3 TRS-C)
- Behavioral Assessment System for Children—Third Edition (BASC-3) Self-Report Scale— Adolescent (SRS-A)

Risk Assessments
- Columbia Suicide Severity Rating Scale (C-SSRS) (expanded into full SI/HI assessment interview)

Screeners
- Generalized Anxiety Disorder-7 (GAD-7)
- Patient Health Questionnaire-9 (PHQ-9)
- Patient Activation Measure (PAM)
- Pediatric Symptom Checklist (PSC-17)
- Weiss Functional Impairment Scale, Self-Report (WFIRS-S)
- Adult Self-Report Scale for ADHD (ASRS)
- PTSD Civilian Checklist (PTSD-CL)
- Wender Utah Rating Scale for ADHD (WURS)

Research Experience

Research Vertical Team (RVT)   **2019—Current**
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Supervisor: Mary Peterson, PhD, ABPP/CL.
- Dissertation research: "Preventing Burnout: The Role of Personality and Awareness in Early Career Mental Health Professionals in Acute Settings."
  - Pre-liminary defense completed: October 2020
  - Final defense completed: October 29th 2021
- Active engagement in vertical research team comprised of 1st through 4th year doctoral level trainees.
- Assist in collaboration and development of dissertation and supplemental research projects. Support includes direct feedback, collaborative support in developing areas of interest, development of methods and completion of individual projects.
- Team-based areas of research interest include integrated care, opioid-use disorders and MAT treatment providers, co-regulation and biofeedback, anti-stigma training around HIV in health care settings, and trauma-informed resiliency training for pregnant mothers.

Research Assistant   **2018—2019**
Graduate School of Clinical Psychology
George Fox University, Newberg, OR
Supervisor: Rodger Bufford, PhD.
- Evidence of integration understanding in graduate students.

Research Assistant   **2016**
Azusa Pacific University, Azusa, CA
Department of Psychology
Supervisor: Teresa Pegors, PhD.
- Race/ethnicity effects on sequential attractiveness judgments.
- Effects of virtual reality (VR) on clients with PTSD.
- Aesthetics of Chinese calligraphy to non-Chinese speaking students.

Research Lecture and Poster Presentations

Paxton, J., Peterson, M., **Standal, W.,** & Buckles Z. (2020, August). *The Effectiveness of Biofeedback on Post-Surgical Outcomes: A Qualitative Analysis.*
- Poster presentation at the (virtual) American Psychological Association (APA) Annual Conference; Washington D.C.

Shim, P., Peterson, M., **Standal, W.,** Owen, E., & Harberts, J., (2020, August) *The Impact of a Biofeedback Relaxation Intervention on General Self- Efficacy.*
- Poster presentation at the (virtual) American Psychological Association (APA) Annual Conference; Washington D.C.

Bufford, R., **Standal, W**., & Wingerter, R. (2019, March) *Learning Integration: Does Integration Knowledge Grow as a Result of Completing an Integrative Course?*
- Lecture presentation at the Christian Association of Psychological Studies (CAPS) annual conference; Dallas, TX

Professional Trainings

Clinical Team   **2018—Present**
George Fox University, Newberg, OR
Licensed Supervisors: Daniel Rodriguez, PsyD. (2021-2022); Rodger Bufford, PhD. (2020-2021); Luann Foster, PsyD. (2019-2020); Elizabeth Hamilton, PhD. (2018-2019).
- Meet weekly as part of a vertical training learning model with a licensed psychologist to discuss clinical cases, receive supervision, and practice skills pertaining to an interdisciplinary team of psychologists.
- Experiential learning as a supervisor-in-training by giving summative and formative feedback to second-year doctoral trainees in presence of licensed psychologist.
- Successful preparation and completion of the SFE Examination in March 2020 & CIAE examination in March 2021.

Fall 2021 Grand Rounds   **October 2021**
George Fox University, Newberg, OR
Elisabeth Esmiok Wilson, PhD.
- "Erotic Transcendence: Integrating Faith with What's Next in Sex Research"

HRSA Training: Opioid Use Disorders/ MAT   **May 2021**
George Fox University, Newberg, OR
Brett Kaylor, M.D.
- "Opioid Use Disorder and Medication Assisted Treatments"

HRSA Training: Native Culture and Individuals   **May 2021**
George Fox University, Newberg, OR
Pilar Peltier
- "Treatment for Native Culture and Individuals"

HRSA Training: Cultural-Specific trauma   **May 2021**
George Fox University, Newberg, OR
Eleanor Gil-Kashiwabara, PsyD.
- "Expanding Interpretive Power to Increase Understanding of Systemic Racism and Related Traumas"

HRSA Training: Telehealth   **May 2021**
George Fox University, Newberg, OR
Jeff Sordahl, PhD.
- "Tele-Behavioral Health"

Spring 2021 Grand Rounds   **March 2021**
George Fox University, Newberg, OR
Chloe Ackerman, PsyD.
- "Gender Diversity & Transgender Healthcare"

Spring 2021 Colloquium   **February 2021**
George Fox University, Newberg, OR
Janelle Kwee, PhD.
- "Saying Yes to Your Embodied Life: An Invitation to Psychotherapists"

Fall 2020 Colloquium   **November 2020**
George Fox University, Newberg, OR
Jason Steward, PhD
- "Complex PTSD: Advanced Case Conceptualization, Assessment, and Treatment Approaches in Trauma Population"

Fall 2020 Grand Rounds   **October 2020**
George Fox University, Newberg, OR
Justin Lee, PhD
- "The Role of Neuropsychology within the Pediatric Cancer Setting"

Primary Care Track Training: **February 2020**
George Fox University, Newberg, OR
Amy Stoeber, PhD
- "Trauma Informed Care in Primary Care Settings"

Spring 2020 Colloquium   **February 2020**
George Fox University, Newberg, OR
Amy Stoeber, PhD
- "Child Adverse Events to Adults with Substance Use Problems"

Interprofessional Primary Care Institute   **January 2020**
George Fox University, Newberg, OR
Patti Robinson, PhD. & Bruce Arroll, PhD.
- "Interprofessional Solutions for Treating Depression in Primary Care"

FACT Training   **December 2019**
George Fox University, Newberg, OR
Kirk Strosahl, PhD.
- "Focused Acceptance and Commitment Therapy (FACT)"

Fall 2019 Grand Rounds   **October 2019**
George Fox University, Newberg, OR
Cheryl Forster, PsyD.
- "Intercultural Communication"

Fall 2019 Colloquium   **September 2019**
George Fox University, Newberg, OR
Everett Worthington, PhD.
- "Promoting Forgiveness"

Spring 2018 Grand Rounds   **March 2018**
George Fox University, Newberg, OR
Douglas Marlow, PhD.
- "Foundations of Relationships Therapy—The Gottman Model"

Spring 2018 Colloquium   **February 2018**
George Fox University, Newberg, OR
Diomaris Safi, PsyD; Alex Millkey, PsyD.
- "Opportunities in Forensic Psychology"

Fall 2018 Grand Rounds   **October 2018**
George Fox University, Newberg, OR
Scott Pengelly, PhD.
- "Old Pains in New Brains: Working with Patients with Chronic Pain"

Fall 2018 Colloquium   **September 2018**
George Fox University, Newberg, OR,
Lisa McMinn, PhD; Mark McMinn, PhD.
- "Spiritual Formation & the Life of a Psychologist: Looking Closer at Soul-Care"

Additional Related Trainings

CPR/BLS Certification   **2018—2022**
George Fox University, Newberg, OR
- CPR & AED certified in accordance with the American Heart Association.

Additional Relevant Work Experience

Hadlock Student Center: Climbing Wall Coordinator   **2019—2020**
George Fox University, Newberg OR
- Managed a small team of students ensuring safety and community of larger GFU student body through boulder, top-tope and lead climbing.
- Served as manager of gym resolving student concerns, enforcing health policies, and promoting safety and a welcoming environment for all guests.

Product Specialist, **APPLE**   **2018—2019**
Apple Bridgeport Village, Tualatin, OR
- Coordinated appointments for technical repair services, facilitate customer purchases and inform customers of product features, connect business and end-users with essential services, facilitate inventory procedures.

Residence Life Coordinator **2014**
Azusa Pacific University
High Sierra Study Abroad Semester, Yosemite National Park, CA
- Oversaw student body, facilitated resident activities, and worked as liaison for student body and program management.

Honors and Awards

HRSA Scholarship Recipient **2020—Current**
George Fox University, Newberg, OR
- Recipient of competitive health services grant amidst engagement in Providence Medical Group/ Primary Care Psychology Track.

Outstanding Senior Award in Psychology **2016**
Azusa Pacific University, Azusa, CA
- Distinction for influential involvement, leadership, and scholarship in psychology courses.

Senior Chapel Speaker **2016**
Azusa Pacific University, Azusa, CA
- Honor given to speak at APU chapel as graduating senior.

PEW College Society Scholarship **2016**
Azusa Pacific University, Azusa, CA
- Fiscal scholarship for students showing trajectory for graduate school.

President's Academic Scholarship **2013—2016**
Azusa Pacific University, Azusa, CA
- Merit-based fiscal scholarship.

Dean's List **2013—2016**
Azusa Pacific University, Azusa, CA
- Consecutively maintaining a 3.5+ GPA.

Violet Richardson Scholarship
2013
El Dorado Country, CA
- Award for outstanding leadership and community service.

Girl's State Government/Leadership Camp
2012
American Legion, California Chapter
- Competitive government/leadership camp for high school seniors.

Professional Affiliations

American Psychological Association   **2018—Current**
Graduate Student Affiliate

Pew College Society   **2016—Current**
Lifetime Affiliate