Suicide and Depression Education Provided in Doctorate of Physical Therapy Programs

by

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Suicide and Depression Education Provided in Doctorate of Physical Therapy Programs

by

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has been approved

at the

Graduate Department of Clinical Psychology

George Fox University

as a Dissertation for the PsyD degree

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Suicide and Depression Education

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Laura H. Smith
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Abstract

As depression and suicide are prevalent issues in America, further efforts to screen patients for depression need to be made in order to provide treatment. Given the documented comorbidity between depression and chronic pain, looking at health professionals who treat chronic pain patients may be a viable option for depression screening. Physical therapists were chosen as potential screeners because of the amount of time they spend with chronic pain patients. To assess competency for depression screening, a survey was sent to accredited doctorate of physical therapy (DPT) programs in order to learn what education their students receive on depression and suicide. Results indicate 75% of DPT programs provide some sort of mental health education. Mental health professionals teach half of education provided; the other half is taught by physical therapists with no formal mental health training. This indicates the perception of education provided might be different than what is actually provided half of the time. Physical therapists are likely not receiving adequate training on depression to screen.
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Chapter 1

Introduction

Prevalence of Depression

Depression affects 14.8 million Americans per year or approximately 6.7% of adults in the United States (Kessler, Chin, Demier, & Walters, 2005). Depression is known as the leading cause for disability in America and has long-term affects of social isolation and an increased risk of suicide. In addition to the disability-related costs, depression can also lead to decreased productivity in the workplace, which further adds to its economic impact (The World Health Organization, 2004). Although effective treatments for depression exist in the United States, it is estimated that less than half of the people struggling with depression ever seek treatment (Rupp, Gause, & Reigier, 1998). Factors such as anhedonia, social isolation, social stigma, and lack of treatment awareness may contribute to individuals not seeking treatment. Unfortunately, there is an increased risk for suicide attempts and completions when depression is untreated. In 2004, 32,439 individuals died from suicide completion in the United States (Centers for Disease Control and Prevention, n.d.), 90% of which had a diagnosable mental disorder. The most common disorders among those committing suicide are depression (59%) and substance abuse disorder (43%; Conwell & Dent, 1995; Henriksson et al., 1993). Depression is even more prevalent among the elderly who commit suicide (75%; Conwell, 2001). These statistics emphasize the importance of identifying individuals with depression so they may seek treatment and avoid the adverse effects of depression.
Screening for Depression and Its Limitations

An attempt to improve the identification of depression was made when the United States Preventive Services Task Force (USPSTF) recommended that primary care physicians (PCP) screen adult patients for depression (United States Preventive Services Task Force, 2002). This strategy for identifying depressed clients has been somewhat effective but is limited due to time constraints. Mechanic, McAlpine, & Rosenthal (2001) estimated that the typical primary care visit lasts approximately 16 minutes. Most of the time of a primary care visit is devoted to a physical exam, discussion of treatment alternatives, education, and questions (McAlpine & Wilson, 2004). Common screening tools for depression only take a few minutes; however, a more in depth intake is required for proper diagnosis when a patient endorses depressive symptoms. Therefore, a physician’s patient load may prevent him or her from obtaining all the information necessary to discern between differential diagnoses (Mulrow et. al., 2002) Williams, Pignone, Ramirez, & Perez-Stellato, 2002). Consequently, physicians only detect between one third and one half of depression cases (Brody et. al. 1998; Simon & VonKorff, 1995). This relatively low detection rate is particularly problematic since most people with depression receive medical care from their PCP. One strategy for improving the diagnosis of depression is to screen for depression at multiple points throughout the treatment process. Such a strategy would be especially beneficial in areas that are frequently comorbid with depression.

Comorbidity of Depression and Chronic Pain

The affects of chronic pain on one’s psychological functioning have yet to be fully understood, however the connection between chronic pain and its comorbidity with depression has been well documented. For instance, Gatchel (2005) noted that when compared to the
general population, those with chronic pain have a greater risk of experiencing depression. The greater the pain, defined by duration, intensity, and frequency, the greater the level of depression (Fishbain, Cutler, Rosomoff, & Rosomoff, 1997). Furthermore, Fishbain et al. (1997) found that chronic pain patients have a higher risk of suicidal ideation, attempts, and completions compared to the general population. The increased risk for depression and suicide within the chronic pain population prompted the U.S. Surgeon General to rate chronic pain as one of the highest public health concerns in the country (Hanscom & Jex, 2001). Consequently, Gatchell (2005) concluded, “all pain management approaches, therefore, require a strong mental health component, which can be directed by a psychiatrist or clinical psychologist” (p. 268).

Because research shows a correlation between pain and depression, the medical field has begun to explore a more comprehensive biopsychosocial model of illness in order to understand and treat patients with chronic pain as well as enduring psychological, emotional, and interpersonal issues (Turk & Okifuji, 2002). However, the limited success rate of PCP for identifying depression suggests that alternative strategies need to be employed to identify depressed clients.

Physical Therapists as Screeners

Individuals who endure chronic pain are likely to have been treated by multiple professionals including physical therapists, chiropractors, and other health professionals. Gatchell (2005) found that pain management professionals and PCP’s who collaborate on the treatment of their patients are more likely to identify and prevent high risk patients from developing more chronic issues associated with pain or disability. Specifically, this close collaboration between PCP’s and pain management professionals might help prevent depression.
and suicide completions. Physical therapists, on average, see their patients from one to three 50 minutes sessions per week over a six-week period (K. Braden, personal communication, September 16, 2007). Given the extended amount of time that physical therapists spend with clients, especially compared to other health professionals, and that many clients experience some degree of pain, physical therapists may be ideal candidates for screening depression.

**Physical Therapists Education for Screening**

Aadland (2008) found that the majority of physical therapists view mental health issues, including depression, as relevant to physical therapy treatment. This finding is consistent with the well-documented comorbidity between chronic pain and depression. Furthermore, Aadland (2008) found that 21% of physical therapists report receiving no formal training on mental health issues. Physical training programs need to provide education covering the vast array of symptoms that physical therapists encounter and treatments that they utilize. This broad-based approach makes in-depth instruction on specific topics, such as depression and suicide, extremely difficult (J. Harle, personal communication, July, 19, 2010). In fact, a review of program materials found on school websites reveals very little training of mental health issues, particularly specific education focused on psychological disorders, symptoms of depression, or how to screen for depression.

To date, there has been no study or survey of the mental health education that physical therapy programs provide their students. Since physical therapists spend a significant amount of time with chronic pain clients, many of whom are likely to experience depressive symptoms and/or suicidal ideation, an examination of the type and amount of mental health training provided within physical therapy programs is warranted. Physical therapists, in collaboration
with PCPs, may be able to significantly decrease the number of individuals with untreated depression with the proper use of depression and suicide screening tools.

**Purpose of the Study**

The present study was a descriptive study examining the depression and suicide education offered in accredited doctorate of physical therapy (DPT) programs across the United States. The purpose of the study was to establish how depression and suicide instruction is provided within existing program curriculums. Additionally, the study examined the education and experience level of instructors providing the training. Ideally, the results from this study will be used to enhance the training physical therapists receive regarding depression and suicide, facilitate collaborative health care, and improve the identification of depression among patients, particularly patients dealing with chronic pain.
Chapter 2

Methods

Participants

All 201 DPT programs accredited by the American Physical Therapy Association (APTA) were included in this study. The APTA is the primary nationwide professional organization for accredited DPT programs and for practicing physical therapists. Program directors were initially contacted and asked to complete an online survey. The response rate to this request was 24% (n = 49). A follow-up survey was conducted as well. Thirty-seven percent (n = 18) of the program chairs that completed the first survey also completed the second survey.

Instruments

A survey was constructed to determine if accredited DPT programs provide education in depression and suicide risk assessment (Appendix A). Program directors were asked to indicate whether or not their programs include suicide and depression education and to provide information regarding the delivery of training in this area. Specifically, program directors were asked to provide information about the format of the training and the types of instructors used to provide the training. In addition, program directors were asked to rate the utility of suicide and depression education on physical therapy programs.

Procedure

Program directors were emailed with an introductory message explaining the purpose of the study. A direct link to the survey was included in the email. Two follow-up email messages were sent at two-week intervals to program directors who had not responded to encourage their
participation. A follow-up survey was emailed to program chairs that completed the first survey. The second survey was conducted to clarify how the training in suicide and depression is delivered in those physical therapy programs.
Chapter 3

Results

Forty-nine directors of DPT programs completed the initial survey. All program chairs either agreed (28) or strongly agreed (21) that depression and suicide are important factors in treating patients receiving physical therapy. According to responses to the follow-up survey, more than half of the programs began including education on depression after 2000. Only two program directors indicated that depression education was included in their curriculum prior to 1990.

Depression and Suicide Education

Overall, 75% of DPT programs that responded currently provide at least some education on depression and suicide in their respective curriculums. The settings in which students are provided education on depression, suicide risk assessment, and other psychological disorders vary. However, most program chairs (31) indicated that this information was distributed across courses (Table 1). In contrast, none of the programs used independent study or web-based training options for providing this information.

In response the content-related items, 94% of the program chairs indicated that depression education was focused on the signs and symptoms of depression as well as how to refer patients to a mental health professional. Approximately 75% of DPT programs include training with depression as a treatment variable. Similarly, nearly 75% of DPT programs
provide training on screening for depression. In contrast, only 37% of DPT programs address suicide risk assessment. The number and percentage of programs responding positively to depression education are presented in Table 2.

The primary outcome measure of depression and suicide education is exam scores (76.6% of the DPT programs). However, 20.8% of the programs do not assess depression and suicide education. Interesting, according to responses from the follow-up survey, all programs including depression and suicide education embed the material in required courses.

Although psychologists and other mental health professionals do provide some of the instruction on depression and suicide, physical therapists provide most of the training in this area (Table 3). This finding is not surprising since depression and suicide education is included in required courses within physical therapy programs. However, this finding did prompt the follow-up survey in order to examine the qualifications of the physical therapists who teach
Table 2

*Number of DPT Programs Including Content of Depression Education (n = 49)*

<table>
<thead>
<tr>
<th>Content</th>
<th>Number</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Signs and symptoms of depression</td>
<td>46</td>
<td>93.9</td>
</tr>
<tr>
<td>Depression as treatment variable</td>
<td>37</td>
<td>75.5</td>
</tr>
<tr>
<td>How to screen for depression</td>
<td>36</td>
<td>73.5</td>
</tr>
<tr>
<td>Suicide risk assessment</td>
<td>18</td>
<td>36.7</td>
</tr>
<tr>
<td>How to refer patients to mental health professional</td>
<td>46</td>
<td>93.9</td>
</tr>
</tbody>
</table>

about depression and suicide. The most common qualifications were clinical experience as a physical therapist, self-study, or an advanced degree (Table 4). Relatively few instructors providing instruction on depression and suicide have had either continuing education courses dealing with depression or a course in psychopathology.

Interest in providing additional education on depression and suicide was also examined. Approximately 39% of program directors (19) expressed interest in additional depression education and 47% (23) expressed interest in additional education regarding suicide risk assessment (Table 5). In contrast, almost half of the program directors indicated no opinion on additional education and a small percentage expressed no interest in depression (10) and suicide risk assessment (5).
Table 3

**Professional Background of Instructors Teaching about Depression and Suicide (n = 49)**

<table>
<thead>
<tr>
<th>Professional Teaching</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical therapist</td>
<td>38</td>
<td>77.6</td>
</tr>
<tr>
<td>Psychologist</td>
<td>23</td>
<td>46.9</td>
</tr>
<tr>
<td>Other mental health professional</td>
<td>9</td>
<td>18.4</td>
</tr>
</tbody>
</table>

Table 4

**Training of Physical Therapist Instructors Teaching about Depression and Suicide (n = 17)**

<table>
<thead>
<tr>
<th>Training of Physical Therapists Teaching Mental Health Education</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical experience as a physical therapist</td>
<td>8</td>
<td>47.1</td>
</tr>
<tr>
<td>Self Study</td>
<td>6</td>
<td>35.3</td>
</tr>
<tr>
<td>Continuing education</td>
<td>2</td>
<td>11.8</td>
</tr>
<tr>
<td>Course on psychopathology</td>
<td>1</td>
<td>5.9</td>
</tr>
<tr>
<td>Undergraduate degree</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Advanced Degree</td>
<td>8</td>
<td>47.1</td>
</tr>
</tbody>
</table>
Table 5

*Interest in Further Education About Depression and Suicide Risk Assessment (n = 49)*

<table>
<thead>
<tr>
<th>Interest in further depression education</th>
<th>Interested</th>
<th>Not Interested</th>
<th>Undecided or no opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>19 (38.8%)</td>
<td>8 (16.3%)</td>
<td>23 (46.9%)</td>
</tr>
<tr>
<td>Interest in further suicide risk assessment</td>
<td>23 (47%)</td>
<td>5 (10.2%)</td>
<td>22 (44.9%)</td>
</tr>
<tr>
<td>Interest in further training on how to refer to MHP</td>
<td>20 (40.9%)</td>
<td>14 (28.6%)</td>
<td>16 (32.7%)</td>
</tr>
</tbody>
</table>

**Other Mental Health Education**

In addition to depression and suicide education, program chairs were asked if and how other psychological variables were covered within their curriculums in order to obtain a broader perspective of mental health training in DPT programs. These responses were obtained in the follow-up survey. Fifty-nine percent of the programs include substance abuse, anxiety, mood disorders, and psychosis in a section of a course. Somatoform and fictitious disorders are less frequently addressed. The different methods for providing training for psychological variables other than depression are presented in Table 6.
Table 6

*Delivery Format of Other Psychological Variables Based on Responses to the Follow-Up Survey*

\( (n = 14) \)

<table>
<thead>
<tr>
<th></th>
<th>Substance Abuse</th>
<th>Anxiety</th>
<th>Mood Disorders</th>
<th>Psychosis</th>
<th>Somatoform &amp; Factitious Disorders</th>
</tr>
</thead>
<tbody>
<tr>
<td>Course</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>Section of Course</td>
<td>10 (58.82%)</td>
<td>10 (58.82%)</td>
<td>10 (58.82%)</td>
<td>10 (58.82%)</td>
<td>6 (35.29%)</td>
</tr>
<tr>
<td>Field Experience</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
<td>0 (0.00%)</td>
</tr>
<tr>
<td>Reading</td>
<td>2 (11.76%)*</td>
<td>2 (11.76%)*</td>
<td>2 (11.76%)*</td>
<td>1 (5.88%)#</td>
<td>1 (5.88%)#</td>
</tr>
<tr>
<td>Presentation/Guest Speaker</td>
<td>4 (23.53%)</td>
<td>3 (17.65%)</td>
<td>3 (17.65%)</td>
<td>4 (23.53%)</td>
<td>2 (11.76%)</td>
</tr>
<tr>
<td>Other</td>
<td>1 (5.88%)</td>
<td>1 (5.88%)</td>
<td>1 (5.88%)</td>
<td>1 (5.88%)</td>
<td>1 (5.88%)</td>
</tr>
</tbody>
</table>

* two schools indicated both section of a course and reading

# one school indicated both section of a course and reading
Chapter 4

Discussion

The purpose of the present study was to examine DPT program chairs’ perceived importance of depression and suicide in patients receiving physical therapy, assess if education on depression is provided in DPT programs, determine what content is included within the training, learn who is providing the education and their level of training (competency), and to estimate interest level among program directors for expanding the training in depression and suicide provided within their respective programs. Program directors from accredited DPT programs were surveyed. Nearly 25% (n = 49) of the program directors (N = 201) responded.

Perceived Importance

Overall, program directors perceive depression to be important and relevant to the treatment of patients receiving physical therapy. This perception is consistent with the relationship between chronic pain and depression. Chronic pain and depression are often comorbid. Therefore, physical therapy patients experiencing pain, especially chronic pain, are likely to also experience symptoms of depression. The negative manifestations of depression, such as reduced energy, unconstructive cognitions, and suicidal ideations, cannot only be detrimental to achieving physical therapy goals but also to the overall well being of the patient. Consequently, recognizing and treating depression is important for providing holistic care to physical therapy patients.
Education on Depression and Suicide Risk Assessment Provided in DPT Programs

Approximately 75% of respondents indicated that their DPT programs provide some sort of education on depression and mental health related issues. This finding is consistent with previous research indicating that 21% of practicing physical therapists report receiving no formal training on mental health issues (Aadland, 2008). Most of the education provided in these programs takes place within a section of a required course. The two most prevalent topics covered in these courses are signs and symptoms of depression (93.9%) and how to refer patients to a mental health professional (93.9%). Diagnostic criteria for depression and how to refer are the two most important topics for depression screening. In addition, the majority of DPT programs include depression as a treatment variable (73.5%) and explain how to screen for depression (73.5%). These programs, however, do not tend to include information on suicide risk assessment. Interestingly, some DPT programs also provide instruction on other mental health issues including anxiety, substance abuse, psychosis, mood disorders, somatoform, and factitious disorders. Therefore, it appears that DPT programs are attempting to address the spectrum of mental health issues that physical therapy patients may present.

Instructor and Student Competency

Although the inclusion of depression education in DPT programs is important, equally important is the adequacy of the instruction. Since depression and other mental health issues are included as a section within a required course, the instruction on these topics is often provided by a physical therapist. In fact, program directors indicated that approximately half of the instructors for mental health topics are physical therapists. Responses to the follow-up survey further indicated that approximately half of these instructors have no formal training on mental
health issues. Instead, these faculty members use their own clinical experience and self-study as reference points for their teaching on mental health issues. Clinical experience and self-study are certainly valuable but they do not necessarily lead to a sufficient level of competency required to teach students about depression and how to screen for it. Furthermore, students are typically assessed on this material with an exam. A competency-based assessment is generally not used. This point is particularly important given the recent emphasis by the American Psychological Association (APA) for competency-based outcome assessment.

**Interest in Further Depression and Suicide Risk Assessment Training**

Program directors report some interest in further education on mental health issues, however responses were quite mixed. Almost half of respondents indicated they would be interested in having suicide risk assessment training (47%) and the other half either indicated either having no opinion or no interest. Over a third of respondents indicated interest in further education on depression (38.8%), and the other two-thirds reported no opinion or no interest. These findings suggest that approximately half of the DPT program directors surveyed may be satisfied with the quantity and quality of the instruction they provide their students on mental health issues. Unfortunately, without additional training from qualified mental health professionals and competency-based assessment, it is unlikely that students in DPT programs receive adequate training to be proficient screeners of depression.

**Limitations of Study**

Although responses from 49 DPT programs should provide a reasonable description of training within those programs, the return rate was relatively low compared to the total number of DPT programs. Responses to the follow-up survey represented an even smaller number of
DPT programs. Ideally, the surveys should have been combined in order to obtain the most detailed amount of information from the largest number of programs.

**Further Recommendations**

Depression is a prevalent disorder with a variety of negative consequences. Unfortunately, depression is often not diagnosed by primary care physicians due to time constraints that prevent them from obtaining sufficient patient information to properly screen for depression. Therefore, it may be beneficial to screen for depression at multiple points throughout a patient’s care. Physical therapists may be ideal candidates for screening for depression since they tend to have significant contact with patients; and patients in need of physical therapy often experience pain, which is also associated with depression. Due to the model of disablement (Committee on Accreditation in Physical Therapy Education, 2010) that is used in physical therapy training, physical therapists are exposed to information about depression and other mental health issues. However, this exposure is somewhat limited, is typically not provided by mental health professionals, and is generally not assessed with proficiency-based outcome measures. Therefore, it may be necessary to either revise the training physical therapists receive in this area or create a system that incorporates psychologists into the treatment protocol. The former solution may require cross-disciplinary teaching assignments or standardized proficiency-based outcome assessments designed by psychologists for the training of health care professionals. The later solution is consistent with an integrative approach to health care (e.g., Boon, Verhoef, O’Hara, & Findlay, 2004). Under this model, a team of different health care professionals working in collaboration with each other ensures that a patient receives a thorough diagnosis and appropriate treatment. Additional research examining the
effective implementation of these solutions and the corresponding increase in treatment efficacy is required to determine which solution has the greatest positive impact on patient care.
References


Appendix A

Letter and DPT Program Director/Faculty Survey
Dear Program Director,

Many physical therapists have treated patients with mental health issues. It is well documented that chronic pain is comorbid with depression and increased suicide risk. Our goal is to learn the amount of education physical therapists receive in their respective DPT programs regarding mental health; specifically on depression and suicide. Enclosed you will find a link to a brief survey designed to look at the specifics of what your program offers or desires in regards to mental health education. This survey is part of a dissertation study for the Graduate Department of Clinical Psychology at George Fox University in Newberg, Oregon. The survey will take approximately 3 minutes to complete and results will be used for research purposes. The survey is available at the following web address. All responses are completely voluntary and will be kept confidential.

http://www.surveymonkey.com/s.aspx

In appreciation, your participation will automatically enter you into a drawing for 1 of 4 different $25 Target Gift Cards. Please complete the survey by April 20, 2010. Thank you again for your participation as your response will help to inform the relationship between mental health and the treatment you and your students provide. Feel free to use the contact information below if you have any questions.

Best regards,

Laura Smith, MA
George Fox University
lauramansfieldsmith@gmail.com
503-260-9910

Chris Koch, PhD
George Fox University
ckoch@georgefox.edu

http://www.surveymonkey.com/optout.aspx
DPT Program Director/Faculty Survey

Do you believe depression is a factor in treatment of patients receiving physical therapy?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

What education is currently offered to students in your DPT program? (Check all that apply):

- [ ] Signs and symptoms
- [ ] Depression as a treatment variable
- [ ] How to screen for depression
- [ ] Suicide risk assessment
- [ ] How to refer patients to a mental health professional
- [ ] Not Applicable

Would your program be interested if education on depression was potentially provided as a class or presentation in your program?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Would your program be interested if education on suicide risk assessment were potentially provided as a class or presentation in your program?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

Would your program be interested in potential training in how to refer patients to a mental health professional?

<table>
<thead>
<tr>
<th>Strongly agree</th>
<th>Strongly disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>3</td>
<td>4</td>
</tr>
<tr>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

If your program currently offers education on depression, in what venue is it offered? (Check all that apply):

- [ ] Course
- [ ] Seminar
- [ ] Guest Speaker
- [ ] Independent Study
- [ ] Web based training
- [ ] Disbursed throughout courses
- [ ] Not applicable
- [ ] Other: __________________________
Suicide and Depression Education

Who teaches it?

☐ Physical Therapist
☐ Psychologist
☐ Other
☐ Other mental health professional
☐ Not Applicable

What is the outcome measure of student knowledge of depression?

☐ Exam
☐ Competency
☐ No measure
☐ Other___________________________

Do you believe this training on depression is helpful?

Strongly agree  Strongly disagree  1  2  3  4  5

What percentage of faculty is currently seeing patients?

☐ 0-25%
☐ 26-50%
☐ 51-75%
☐ 76-100%

We would like to hear any comments or concerns you have related to this subject.

Demographics

Name:
Gender
Address
City
State
Zip code
Email address

Thank you for your participation! By filling out this survey and demographics automatically enters you into the drawing for one of the 4 $25 Target gift cards.
Appendix B

Follow-up Letter and Second DPT Program Director/Faculty Survey
Dear Program Director,

Thank you for participating in our survey on depression and suicide education in physical therapy programs. You might be interested to know that approximately 75 percent of DPT programs offer some sort of training in depression and suicide prevention. These results, however, have raised several questions related to depression and suicide prevention instruction. Therefore, we would appreciate your participation once more. Please complete a brief follow-up survey (link below). The survey should take approximately 3 minutes to complete. As before, all responses are completely voluntary and confidential.

http://www.surveymonkey.com/s.aspx

Completed surveys will be placed in a drawing for four $25 Target cards which will be drawn on May 5th. Additionally, if you are interested, we can provide you with the findings from both surveys. Indicate your desire for this information via an email message.

Once again, thank you for your participation!

Laura Smith, MA  
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Dissertation Chair  
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http://www.surveymonkey.com/optout.aspx
DPT Program Director/Faculty Follow Up Survey

1. What other mental health variables are taught in your program?

<table>
<thead>
<tr>
<th>Course</th>
<th>Section of course</th>
<th>Reading</th>
<th>Presentation/guest speaker</th>
<th>Other</th>
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</thead>
<tbody>
<tr>
<td>Substance Abuse and Dependence</td>
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<tr>
<td>Mood Disorders</td>
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<td>Anxiety Disorders</td>
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<td>Psychosis</td>
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<td>Somatoform/Factitious Disorders</td>
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2. If training is offered in a single course, what is the title of that course?

3. In what manner is the above course offered

- [ ] Required
- [ ] Elective

4. What training does the faculty member teaching possess?

- [ ] Clinical experience as a physical therapist
- [ ] Undergraduate degree in psychology
- [ ] Course on psychopathology
- [ ] Advanced degree in mental health field
- [ ] Continuing education on depression
- [ ] Other ___________________________
- [ ] Self study

5. When did your program begin to offer education on depression?

   Date: _________________________
Appendix C

Curriculum Vita
LAURA H. SMITH
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Beaverton, OR 97007
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EDUCATION:

2004-Present
George Fox University, Newberg, Oregon
Graduate School of Clinical Psychology: APA Accredited
Doctor of Clinical Psychology (PsyD) Expected December 2010

2004-2006
George Fox University, Newberg, Oregon
Graduate School of Clinical Psychology: APA Accredited
Master of Arts in Clinical Psychology (MA)

1999-2003
George Fox University, Newberg, OR
Bachelor of Science, Psychology, (BS)

PROFESSIONAL TRAINING IN CLINICAL PSYCHOLOGY:

2009-2010
Pre-doctoral Psychology Intern
Linn County Mental Health, Albany, OR

• Providing outpatient psychological services to a diverse population of adults, families, and couples. Direct services include intake assessments, diagnosis, treatment planning, case management, individual therapy, group therapy, couples therapy, and comprehensive psychological assessments.
• Second rotation providing crisis intervention by phone, walk in clinic, conducting evaluations in three local hospital ERs and CCUs, consulting with doctors, and providing hospitalization if necessary. Conducting pre-commitment investigations and providing testimony in court. Additional experience conducting intake assessments and psychological evaluations to inmates in county jail.
• Third rotation spent assessing and working with clients with severe and persistently mental illness, consulting with ACT team, psychiatrists, and primary care physicians, providing case management, individual, and family therapy.
• Supervisors: Julie Evans, PhD and Christine Wung, PsyD, Licensed Psychologists
2007-2008  
Clinical Psychology Pre-intern  
Lifeworks NW, Beaverton, OR  
- Clinical experience providing outpatient psychological services to a diverse population of adults, families, and couples. Direct services include intake assessments, diagnosis, treatment planning, individual therapy, consultation with psychiatrists and nurse practitioners.  
- Supervisor: Ken Ihli, PhD, Licensed Psychologist.

2007-2008  
Supplemental Clinical Psychology Pre-intern  
Evergreen Clinical, Portland, OR  
- Practicum experience providing outpatient psychological services to uninsured and underinsured adults in non-profit clinic. Direct services include intake assessments, diagnosis, treatment planning, and individual therapy.  
- Supervisor: Brian Goff, PhD, Licensed Psychologist

2006-2007  
Clinical Psychology Practicum II  
Archer Glen Elementary School, Sherwood, OR  
- Practicum experience providing outpatient psychological services to elementary aged children in school setting. Direct services include intake assessments, classroom observation, consultations with parents and teachers, intellectual and cognitive assessments, and teaching in multiple classrooms on violence prevention.  
- Supervisor: Hannah Stere, PsyD, Licensed Psychologist

2005-2006  
Clinical Psychology Practicum I  
The Wellness Project, Vancouver, WA  
- Practicum experience in a free clinic providing psychological services to a diverse population of uninsured adults. Direct services included providing intake assessments, diagnosis, treatment planning, case management, individual therapy, group therapy, and personality assessments.  
- Supervisor: Colin Joseph, PhD, Licensed Psychologist

2005  
Clinical Psychology Pre-Practicum  
University Counseling Center, George Fox University, Newberg, OR  
- Pre-practicum experience providing intake assessments, diagnosis, treatment planning, and individual therapy to undergraduate students.  
- Supervisor: Sally Hopkins, PsyD, Licensed Psychologist
RELATED EXPERIENCE:

2008
GAU Care Coordinator/Behavioral Health Specialist
Greater Lakes Mental Health Care
• Clinical experience providing and coordinating mental health care, community referrals, and facilitating high level of continuity of care to a diverse population of adults in multiple medical clinics. Direct services include intake assessments, diagnosis, treatment planning, crisis services, brief individual therapy, consultations with primary care physicians and psychiatrists. Providing education and behavior activation, monitoring symptoms, and response to medication and/or psychotherapy using structured instruments, gaining experience as a mental health professional in a primary care setting.

2007
Congressional Lobbying, Salem, OR
• Consulting with senators and representatives’ regarding Mental Health Parity

2007
Multicultural trip to Guatemala, George Fox University
• Investigating history and mental health effects of the civil war in Guatemala; specifically focusing on how people of the indigenous culture continue to cope with trauma by looking at the emotional, social, financial and spiritual implications.
• Interviewing surviving family members, ex-guerrillas, human rights organizations, and forensic teams who exhume mass graves. Participating in a home-stay with a local family.
• Supervisor: Pat Stone, PhD, Licensed Psychologist

2005
Congressional Lobbying, Salem, OR
• Consulting with senators regarding mental health parity

2003-2004
NW Psychological Center, Clackamas, OR
• Assistant manager of front office managing all billing and collections for two psychologists and two licensed clinical social workers. Making initial contact with clients to conduct screening interviews.

RESEARCH EXPERIENCE:

2005-Present
Doctoral Dissertation, Graduate School of Clinical Psychology, George Fox University
• Subject: Suicide and Depression Education Provided in Doctorate of Physical Therapy Programs
• Chair: Chris Koch, PhD, George Fox University
• Provisional Pass 6/2010
2004-2008
Research Vertical Team Member, Graduate School of Clinical Psychology, George Fox University
• Meet bi-weekly to discuss and evaluate the progress methodology, design, procedures, and various issues related to a wide range of research projects that are being conducted or proposed by students and faculty
• Supervisor: Chris Koch, PhD

SUPERVISION EXPERIENCE:
2007-2008
George Fox University, Newberg, OR
• Providing oversight supervision to doctoral level practicum students for professional development, case conceptualization, intervention, and report writing
• Supervisor: Paul Stolzfus, PsyD

UNIVERSITY INVOLVEMENT:
2006-2008
Psychodynamic Group, George Fox University

2005-2008
Peer Mentor: Clinical Psychology Peer Mentoring Program
• Offer guidance in professional development and peer support to doctor of psychology student

2005-2008
GSCP Multicultural Club, George Fox University

PROFESSIONAL AFFILIATIONS:
2005 to present American Psychological Association
2006 to present Oregon Psychological Association
2007-2009 Washington State Psychological Association

ADDITIONAL CLINICAL TRAINING:
01/10
Civil Commitment Investigator/Examiner Training
Keith Breswick, MA, Civil Commitment Specialist: Salem, OR
06/07
*Domestic Violence*
Chris Huffine, PsyD & Chris Wilson, PsyD, Licensed Psychologists: Portland, OR

05/07
*Treating Patients with Chronic Pain*
Beth Darnall, PhD, Licensed Psychologist: Eugene, OR

10/06
*Motivational Interviewing Clinical Colloquium.*
William Miller, PhD, Licensed Psychologist: Newberg, OR

6/06
*ADHD in Children and Adolescents Nature, Diagnosis, and Management.*
Russell Barkley, PhD, Licensed Psychologist: Portland, OR

04/06
*Psychodynamic Case Conceptualization*
Chuck Weissen, PhD, Licensed Psychologist: Vancouver, WA

09/05
*Suicide.*
Kay Bruce, PsyD, Licensed Psychologist: Vancouver, WA

05/05
*Using the Millon Scales in Clinical Practice.*
Seth Grossman, PsyD, Licensed Psychologist, Newberg, OR