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Building Competence: Trainee Counselors' Supervision Journey with Self-Injury and Suicidality

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Abstract

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Keywords

Counseling supervision, Non-suicidal self-injury, Suicide, Risk-communication, Supervision model

Author's Notes

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This grounded theory study examines the supervision needs of counselors-in-training (CITs) addressing clients with non-suicidal self-injury and suicidal ideations. The qualitative research question focused on counselor-in-training perception of their counseling program and practicum supervision preparation. Four key themes emerge: Supervision Facilitation, Secure Base Provision, Clinical Identity Development, and Sufficient Preparation. CITs express readiness concerns and a need for enhanced support in supervision for NSSI and SI. CITs also clarify logistical and emotional support that addresses their needs to serve NSSI and SI clients effectively.

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Counseling students become an army of crisis assessors upon launch to practicum, after just one year of theory and skills introduction through role-play with relatively stable peer classmates (Council for Accreditation of Counseling and Related Educational Programs [CACREP], 2017). They are at the least prepared moment of their clinical career to manage their own expected anxiety, with a high degree of responsibility to accurately assess and manage risk in otherwise underserved clients. Recent research shows that CACREP program graduates continue to report they are insufficiently prepared to support high-acuity clients such as those struggling with non-suicidal self-injury and suicidal ideation, or postvention stabilization treatment (Cureton et al., 2020, 2021). The current study therefore sought to understand what pre-licensed counselors-in-training report about what worked and what doesn't work in preparation to support NSSI and SI clients.

Counselors-in-training (CITs) may be among the first to know clients' emotional anguish, ranging from stress to distress to *psychache* (Cheng et al., 2021; Pachkowski et al., 2019; Shneidman, 1993). *Psychache,* coined by suicidologist Edwin Shneidman, is the unrelenting mental, emotional, and/or spiritual suffering often found at the root of suicidal ideation (Shneidman, 1993). Suicidology research and practice have evolved toward proactively engaging this psychache with risk communication, which the current authors posit is part of what manualized treatment for non-suicidal self-injury may sometimes miss.

Risk communication is the manner in which a counselor assesses and proactively prevents action that increases risk with their clients. This includes and transcends risk assessment through inquiry about internal and external threats to well-being and developing clients' protective factors (Soper et al., 2022). Effective risk communication helps keep

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clients' emotional baseline slightly above a neutral resting point despite life's inherent suffering (Soper et al., 2022). Risk communication engages directly with clients' thoughts, feelings, social supports, and an existential sense of purpose in a continual process of tracking clients' emotional baseline. It leverages internal and external protective factors whenever possible to support client autonomy while intervening more directly with wraparound support when necessary to keep clients safe and stable.

Effective ongoing risk communication de-stigmatizes honest transparency about thoughts and acts of harm to self, which alone reduces some risks by reducing social isolation with emotional pain (Soper et al., 2022). Effective risk communication also helps the counselor know what level of intervention is required across the spectrum, from outpatient to intensive outpatient to inpatient (Liu et al., 2019; Roush et al., 2020). Effectively performing risk communication requires role-modeling and repetitive supervised practice with a variety of clinical presentations over time. Given CITs are often merely introduced to these skills in one course before practicum placement, the actual development of risk communication skills with real clients who are actually suffering is predictably highly stressful without sufficient time to reflect, integrate, and generalize to varied presentations.

Effective risk communication therefore requires that CITs be in close ongoing, supportive supervision of client risk and protective factors for multiple reasons. First, the inexperienced counselor is not isolated with the emotional demand of client safety. Second, close supervision protects clients from risk-to-self. Third, supportive supervision protects CITs from burnout and compassion fatigue.

CITs are commonly overwhelmed by this new responsibility which is couched in the extensive discernment and trauma-informed pacing required to effectively perform a variety of risk assessments, rule-outs, and evidence-based interventions, all while maintaining rapport. The resulting anxiety, coupled with the inherent lack of experience, complicates the decision-making process about where to start, proceed, determine clinical severity, and when to ask for help (De Stefano et al., 2012).

Such work-related anxiety and inexperience can lead to over-reactions, over-simplification or conflating of presenting data, under-reporting to supervisors, and misunderstanding of clinical severity. This increases the risk of danger to clients, as well as burnout and compassion fatigue in counselors (Davies et al., 2020; Davis, 2019; Novoa, 2021; Substance Abuse and Mental Health Services Administration [SAMHSA], 2021). These skills are arguably more difficult to develop and replicate effectively in online training and practice due to the over-reliance on verbal reports as opposed to more complete access to non-verbal communication.

A prime example of where CITs must learn on the job when the stakes are high is discerning between non-suicidal self-injury (NSSI) and suicidal ideation (SI) or attempts. Even experienced clinicians may not know the key differences and overlapping risks between NSSI, SI, and attempts. Further, it is not uncommon for seasoned clinicians to be confused about how to effectively support clients experiencing these presentations (Shook, 2019; Westers, 2021). Over- or under-reacting can lead to critical rapport breaches or increased danger for clients, especially if a supervisor is not duly informed to help effectively (Novoa, 2021; Shook, 2019). Therefore, this research team performed grounded theory research to understand what CITs have found most and least helpful in their pre-licensure training to prepare them for structured assessment, intervention, and referral of NSSI and suicidal clients, both in-person and online. Our research question was: How does instructional training prepare counselors-in-training and new professionals to work with non-suicidal self-injurious and suicidal clients? The preliminary results of our study have strong implications for informing CACREP-accredited programs on how to best train CITs to work with NSSI, SI, and SA. In particular, CITs who were trained only online report how essential their post-graduation in-person shadowing of live sessions has been to learn life-saving interventions that were not taught to them during their programs. The authors further propose that skilled scaffolding is even more essential when CITs are working through an unresolved attachment

trauma history that negatively impacts their self-regulation and help-seeking from authority figures, which may not be known to faculty or supervisors.

Variance in Site and Supervision Resources

While NSSI itself is not suicidal behavior, the longer one engages in NSSI, the more increased their risk for suicide attempts (Westers, 2021). It is generally not appropriate for trainees to retain outpatient clients with this level of clinical severity given their restricted availability and scope of competence, but accurately identifying the needs and making appropriate referrals to full-time counselors within a network of care is. Rural or globally placed trainees are working where there is often no such available referral network, therefore have increased pressure to retain and treat these clients.

Grounded theory results of the current study seek to understand what CITs most need from their training to effectively assess and serve clients presenting with NSSI, SI, and/or SA. CITs consistently reported they did not get introduced to theory or skills practice for assessing, intervening, or referring NSSI or SI clients where indicated, either online or in-person. CITs report a wide variance of referral access to networks of care from their sites, and in supervisor preparedness to support CITs in risk communication. Therefore, counselor education needs to prepare *all* CITs for effective risk communication before clinical placement, online and in-person.

Present Study

Method

The authors completed a grounded theory tradition because it allowed us to discover, develop, and describe the complex experiences of CITs entering into their clinical work with NSSI and SI populations while generating a theory based on their experiences (Charmaz, 2014). The use of grounded theory kept us close to the data and participant voice during theory formulation (Hays & Singh, 2012). We selected a constructivist paradigm, including assumptions of subjectivity; knowledge is co-created; and collaboration between researchers and participants is essential to the process (Charmaz, 2014; Hays & Singh, 2012).

The Research Team

In accordance with grounded theory, the research team is an instrument in data collection, analysis, and exploration of the findings. Additionally, the research team must address subjectivity and reflexivity during the study (Hays & Singh, 2012). The research team was composed of four counselor educators and one master's-level graduate student. All members of the research team identify as cisgender women with diverse racial and ethnic identities. The first three authors are all licensed counselors, the fourth author is a pre-licensed counselor and the fifth author is a student trainee. Additionally, the counselor educators have all taught crisis and trauma counseling courses, as well as practicum and/or internship courses. The first and second authors are licensed as supervisors with additional certifications in crisis-focused clinical work.

Participants and Procedures

We secured approval from our institutional review board prior to recruiting participants. Purposive and snowball sampling was used to recruit participants who met the inclusion criteria, which were: 1) to be a pre-independently-licensed counselor (i.e., dependently licensed counselor, counselor associate) or counselor-in-training (i.e., practicum or internship student), 2) in current clinical placement, 3) with some experience assessing and intervening on SI, NSSI, and/or step-down postvention of crisis clients. Exclusion criteria were: 1) post-licensed counselors (i.e., independently licensed counselors and counselor supervisors) and 2) pre-licensed counselors-in-

training without crisis assessment or intervention experience.

We chose this sampling method and inclusion criteria with the assumption that CITs and new professionals would rely heavily on supervision to effectively assess and intervene in self-directed violence in their clients. By recruiting a diverse sample of participants, we hoped to acquire an account of information that provided both high- and low levels of awareness of how to serve clients engaging in self-directed violence. We also hoped for a diversity of experiences with faculty, supervisors, and the supervision process across a variety of programs, clinical acuity, support networks, and geographically diverse clinical settings.

We initially posted a recruitment call on several counseling-affiliated listservs and sent a recruitment email to fellow counselor educators at universities across the United States. The first call for participants yielded 15 participants, while the remaining six participants were recruited through mutual relationships between one member of the research team and the participants, and from an additional call on listservs.

We simultaneously collected and analyzed data by continuously completing, transcribing, and coding participant interviews, and reaching saturation by our 19th participant. The first author completed 16 interviews, the second author completed two interviews, the third author completed two interviews, and the fourth author completed one interview. The first and fifth authors transcribed the interviews verbatim. The first four authors completed individual coding, with two authors coding each transcription. All authors were involved in the consensus coding process (Flynn & Korcuska, 2018).

A diverse sample of CITs and new professional counselors (i.e., licensed under supervision, pre-licensed counselors, and counseling associates) participated in this study (N = 21) with respect to age, race/ethnicity, and state of training. Participants ranged in age from 24 years old to 45 years old (M = 31.19, SD = 5.91). 12 participants were currently enrolled in a counselor education program, completing their practicum (n = 2) or internship (n = 10), while nine participants graduated within the last year. In the present study, 20 of the 21 participants identified as cisgender female (95%) and one participant identified as cisgender male (4%); 12 participants identified as White (57%), four as multicultural or biracial (19%), three as Asian (14%), one as Hispanic (4%), and one as Native American (4%). Participants came from 14 different states in the United States, including California (n = 3; 14%), Ohio (n = 3; 14%), Florida (n = 2; 9%), Illinois (n = 2; 9%), Washington (n = 2; 9%), Colorado (n = 1; 4%), Indiana (n = 1; 4%), Kansas (n = 1; 4%), Mississippi (n = 1; 4%), Nevada (n = 1; 4%), New Mexico (n = 1; 4%), North Carolina (n = 1; 4%), Georgia (n = 1; 4%), and Virginia (n = 1; 4%).

Data Collection

Data were collected through individual, semi-structured interviews (Charmaz, 2014). Participants completed an informed consent and demographics questionnaire before participating in the interview. The interviews were audio recorded with participant permission and lasted 60 to 90 minutes. Each recording was immediately deleted after being transcribed to ensure privacy. The demographics questionnaire included nine multiple-choice and write-in questions to ensure that participants met the inclusion criteria. Questions identifying age, race/ethnicity, gender, training experiences, and state of training were included.

The initial interview protocol consisted of 5 open-ended questions, with 15 potential semi-structured sub-questions grounded in knowledge of clinical work NSSI and SI. Participants were asked if they would like to add a question that was not included in the protocol. Sample protocol questions include “What has your training been regarding clinical work with NSSI and SI?”; “What have your clinical experiences been like with NSSI and SI clients?”; “When seeking support for your clinical practice, how have your supervisory experiences been?”; and “What information or processes do you

believe you still need to learn regarding your clinical work with NSSI and SI clients?"

Interviews were transcribed using Otter.AI and checked verbatim by the lead and fifth author to ensure accuracy. Participants were invited to review, revise, redact, and add information to their transcripts. Twenty participants chose to acknowledge their review of their transcript; one participant did not respond. Of the twenty participants, three clarified information on their original transcript (Hays & Singh, 2012).

Data Analysis

The research team began data analysis with the initial coding of each transcript to identify keywords, phrases, and processes related to the phenomenon of interest (Charmaz, 2014). Transcripts were independently coded line-by-line by two members of the research team, rotating between the first four authors on the research team. Next, the research team met to discuss and agree on the operational definition of the initial codes while building an initial codebook. The first and second researchers attended every coding meeting for consistency, while the third through fifth researchers attended coding meetings as their schedules permitted (Hays & Singh, 2012). Consensus coding yielded 69 codes, which were further collapsed into four themes with nine sub-themes during axial coding (Hays & Singh, 2012). The final step in data analysis was to organize the themes and subthemes into a theoretical model and create a figure to represent the relationship between the themes (Figure 1).

Trustworthiness

Multiple strategies were used to ensure credibility, transferability, confirmability, authenticity, sampling adequacy, ethical validity, substantive validity, and creativity (Hays & Singh, 2012). The research team utilized reflexive journaling to bracket assumptions; memos to describe and analyze findings; member checking with all participants to ensure the accuracy of transcripts and appropriate representation of their experiences; triangulation of researchers during data collection and analysis; thick descriptions to detail the research process and outcomes as well as participant experiences. We maintained an audit trail as evidence of research procedures (Hays & Singh, 2012).

Findings

Data analysis yielded four superordinate themes: (1) Facilitation of Supervision, (2) Secure Base Provision, (3) Development of Clinical Identity, and (4) Sufficient Preparation. The CITs spoke of these themes in bifurcated terms; either their faculty, supervisor, and site were or were *not* consistently able to anticipate and provide what was needed in a developmentally appropriate way. The resulting anxiety and attitude toward assessing and intervening with NSSI and SI appeared informed by the faculty, supervisor, and site's ability to provide what was needed in good timing. Only when CITs perceived that their developmental needs were met in good timing did CITs report working within their evolving scope of competence. A key indicator of this perception was that CITs would seek appropriate help to keep clients safe and mitigate their predictable work-related stress.

Facilitation of Supervision

Subthemes for Facilitation of Supervision included (a) Accessibility (e.g., quantitative and qualitative) and (b) Sensitivity of Attunement (e.g., Compassion Satisfaction/Fatigue, cultural competence, and ethically sound). Supervisors who were perceived as accessible both physically and emotionally tended to instill a sense of appropriate (not inordinate) confidence and growing competence in CITs. CITs with this perception reported following the order of operations in assessment and intervention until they needed more live supervision and shadowing to scaffold further skills development. P2 shared the positive experiences they had with live supervision:

> I seemed to have not what a lot of other students had, which was a very attentive, very accessible supervisor. I can't think of a time when I didn't feel like I could reach out and she was there to help me figure it out, talk to her, process through it, make sure that I followed the right [steps] and I would always double-check, "hey, did I do this right?" She was always there. She was always consistent.

Supervisors who anticipated CIT and client needs tended to demonstrate more Compassion Satisfaction and were perceived as more culturally competent and ethically sound. This allowed CITs to trust them more, to seek them out with less anxiety, and be open to their guidance with less internal conflict, even if they didn't completely align with their supervisor's modality or intervention suggestions. P5 reflected on how difficult sessions may be, and the importance of leaning into their support, particularly supervisors: "There can be certain situations that can be really hard, where I'll have to take a breather after a session, it was really hard and it hit home. There's other times where I really lean into it to provide a bridge of empathy and connecting, "okay, we're not alone in this." P1 expressed their gratitude towards their supervisor for offering clarity and support:

> …When you're in the real world, there's a lot at stake here. And you just want to be extremely careful… to do what is best for the client. You also want to be sure about the ethical needs, then policy needs… to make sure that you're checking all the boxes. That can be intimidating when you're still training and learning. So if it weren't for my supervisor, I think it would have been very confusing.

P7 provided an example of their supervisory experiences:

> I'm lucky to have two very different supervisors. They're both very skilled in different areas. They have different approaches, it's challenging at times, but it also gives me more of an ability to see from different angles. I think of how different providers might approach [clinical work]. My group supervision has been really nice to hear from the other students and interns as well because there's a lot of learning together that we have. But individual supervision has also been really helpful for active resourcing. These are the questions we need to ask. These are things we need to take action on. So I think it's been a good combination.

Supervisors who did not anticipate CIT and/or client needs proactively tended to demonstrate more signs of Compassion Fatigue, and/or were perceived to be less culturally competent or ethically sound. P20 shared their experiences with microaggressions experienced in their supervision:

> One of my biggest complaints was that they really valued whitewashed experiences. And anytime I would say, "hey, I'm struggling with imposter syndrome," I would get an email saying that they were concerned about me. So I don't feel like I am safe [here].

Such experiences resulted in CITs not seeking supervisors out as readily, finding supervision to be a chore rather than a benefit, and being less open to supervisor influence. P13 reflected on their discomfort in asking their supervisor for more support: "With that particular supervisor, I didn't ever address it directly with her. It was understood by many of the clinicians that worked for her that she did not receive constructive criticism well at all, or any form of feedback. And so I didn't say anything in response." This also resulted in ethical dilemmas and escalating client crises. P18 shared of obstacles they experienced with accessing their supervisor:

> … so the only person I actually have contact [information] for is my supervisor if any immediate danger in my counseling session [occurs]. I have her phone number and an email. And this has been an issue, sometimes I have a question about something with my current client, and I texted her and she hasn't responded. So that's also problematic because I can't leave my client to go to her office and grab her because she might also be with a client, which is a whole other conversation.

P18 also stated the limited communication of the standard operating procedures of their agency:

> … the interns, we're not allowed to take crisis calls… so when they refer it [a crisis call] to an intern, [it] has happened once before where I got a crisis call, my supervisor was in session, so she was not available. So I was trying to figure out what to do, it was very stressful. And I didn't realize that I wasn't allowed to take a crisis call until after the situation had ended. So I just wish I would have been more aware of the protocol for crisis as an intern, and communication, and all of those important things when a crisis occurs, because I felt very stressed that this client was just waiting in a crisis situation, and I was not able to provide the help they needed. Not because I didn't want to, because I didn't know how to, and I didn't know I wasn't allowed to.

P19 shared a lack of secure base provision because of their supervisor's unavailability:

> It's a little bit challenging because the size of her caseload, we probably only have supervision really for a half an hour. And then she'll [say], "as long as there's nothing else," because we just go over, "This is what I need you to do. Is there anything else you need to talk about?" And talking with another intern who has the same supervisor, she says the same thing… I feel like I'm not gaining enough because of that lack of time. But also, I understand that she doesn't have a lot of time, and she has a lot of clients too. She probably wants to use that time to catch up on paperwork...

Secure Base Provisions

Subthemes for Secure Base Provision included (a) Quality of Support (e.g., supervision support, interdisciplinary consultation, high morale) and (b) Quantity of Knowledge and Resources (e.g., anticipation of needs). CITs' needs appear grafted onto human attachment needs for secure base provision while adjusting to organizational change and work-related stress (Feeney et al., 2013; Harms, 2011; Johnstone & Feeney, 2015; Kahn, 1995). When CITs perceived that the quality of emotional and supervisory support that they needed was available, their general sense of competence was increased and they were more clear about what they could do independently vs. when they needed help. CITs also noted that collaboration on interdisciplinary teams increased their support network and resulted in higher positive morale in the workplace. P5 stated:

> My supervisors have always been really helpful in those moments. And using supervision has been a big help to process them. Anything like self-injury and suicide is a very tough subject for some people where it's taboo, or sometimes one that people often come with 'walking on eggshells' kind of feeling. And so making sure I have the support system with my supervisor, and sometimes even just talking with other students or professionals has been really helpful to get through the feelings of walking around eggshells, or just making sure I did everything right because there's also a gravity of responsibility.

P10 reflected on their collaboration with interdisciplinary systems while providing care:

> I was providing services for clients at a school setting…there are always other people around, I was very rarely alone with somebody who would self-injure. We were able to have debriefing sessions, and they were team-oriented. There's a lot of team-oriented problem-solving, brainstorming of how to prevent this self-injury, because a lot of it was communicating a need that wasn't being met. So I got support from both my coworkers who were doing the same thing. We had access to occupational therapists, and physical therapists to all collaborate together.

When CITs perceived that their faculty, supervisor, and site could offer the quantity of knowledge and resources necessary to stabilize high-acuity clients, this clarified the order of operations to follow to keep clients safe and seek help in good timing. Alternatively, when CITs perceived that either the quality of support or quantity of knowledge and

resources were lower, they were less likely to seek help as indicated and had a more negative attitude toward serving high-acuity clients. It appears that systemic strengths and shortcomings are transmitted to CITs adjusting to those systems and that this necessarily impacts service provision. P12 shared their positive experiences compared to the experiences of their peers:

> …I've heard some of my classmates in internship right now, what they're going through at their site. I must have hit the jackpot or something with my supervision because I have a very supportive supervisor. Some of my peers are still wondering about this and that at their site, not really providing that insight about self-injuries or suicidal ideations. I'm just feeling lucky to have the support I have at my site.

P3 provides examples of low attachment to their supervisor, as well as legal and ethical limitations they have experienced in supervision, including using an unlicensed supervisor:

> …the program director supervised me until this person was fully licensed. But even then, she would schedule things during my supervision time, and then not tell me until the day-of sometimes. I had expressed that I was disappointed that my supervision was going to be transferred to this other [unlicensed] person when I had no idea when I accepted the position that this was going to be the case. And so the program director agreed to meet with me for a half hour each week. And while I take full responsibility for not initiating that request, she has not followed through on that at all or even mentioned it. She's just pulled in too many directions. And so even now, my supervision is probably a half hour a week instead of an hour, which is not great.

Development of Clinical Identity

Subthemes for the Development of Clinical Identity included (a) Self-Awareness (e.g., embodied emotional maturity, professional experiences, sufficient preparation) and (b) Personal Experiences (e.g., countertransference, unresolved trauma, stigma). Embodied emotional maturity was further operationalized by: self-care practices, self-regulation capacity, and pre-existing security. CITs' personal experiences with NSSI and SI, either as the sufferer or with loved ones having struggled with self-directed violence, resulted in reactions to their high acuity clients that sometimes caught them by surprise. CITs who signed up to work with NSSI and SI clients consistently noted how widespread these clinical presentations are and expressed a desire to grow in expertise to train others in skillful assessment and intervention. P13 shared:

> The countertransference I've had was more about [loss]. I've lost about six friends at this point to suicide… between the ages of 18 and…32. The countertransference that I've experienced was sort of twofold… countertransference in session, struggling to be present because I'm so lost. This was really early on, feeling lost in imposter syndrome … being a young therapist, someone who is very green in the field. And also, not feeling good enough. The other piece of that countertransference was projecting onto clients in a moment, "no, you can't go down the same rabbit hole that my friends went down." So I definitely have to check that in the moment, [and that] is a difficult thing to do.

These CITs also tended to express gratitude for the support they've been given thus far and exhibited positive attitudes towards working with the support systems of their clients. P9 shared their experiences having a step-by-step process to support minor clients experiencing suicidality:

> … my supervisor's help. I felt not getting anxious in the moment was helpful. Just being with a client and informing the authorities, and if the client is a minor, informing the parents is very crucial. I did have a client who was doing drugs, and the parents didn't know, he was below 18 years old. And he just said, "I have a plan in mind. And I'm suicidal." Parents didn't know and were in the lobby. So I had to bring the parents in and talk to them. And we had to refer him to an inpatient unit.

P15 reflected on their self-care practices:

> … sometimes I just start listening to audiobooks. [I] let my mind go to this other world completely where I don't have to worry about anything else…when I really need to disconnect from what's happening with my clients, especially with suicidal ideations.

CITs who did not necessarily intend to specialize in NSSI or SI had more mixed attitudes about continuing to do so. It appears that the quality of their training experience informed their attitude about deepening skills for high-acuity clients. P4 expressed that their lack of personal and social exposure working with NSSI and SI resulted in more dismissive responses toward their clients:

> I didn't have self-harm tendencies when I was younger. I came from maybe a motherly instinct. I wanted to hug everyone and [say], "your life is okay. It's just hard right now. Please don't hurt yourself."

The researchers noticed very few of the CITs volunteered information about using personal counseling (n = 2) to help cope with the stress of serving high acuity clients, having dismissive supervisors, or managing their personal histories likely to contribute to countertransference. This stigma regarding committing to personal healing work is of concern, especially for counselors serving high-acuity clients. We wondered what quality of role-modeling many of the CITs have received regarding the use of personal counseling as part of a holistic self-care plan for counselors whether or not one serves high-acuity clients.

Sufficient Preparation

Subthemes for Sufficient Preparation included (a) Pre-launched Training (e.g., scaffolding needed), (b) Post-launched Supervision (e.g., scaffolding provided), (c) Scope of Competence (e.g., high acuity care for NSSI/SI, awareness of limitations, referral-up process, awareness of chain-of-command). There was an overarching awareness of *cultural variance,* grappling with how to navigate oppressive systems. More specifically, we noticed how degrees of cultural competence within supervisors impacted CITs' experience of supervision, an agency, and their willingness to seek help depending on the expectations of their authority figures. P6 identified the importance of cultural norms regarding high acuity suffering in clients, and how CITs need to be trained around the world:

> In China, there are legal regulations, if you're not a national, and you can't work in a hospital system, you can't work with anybody who's diagnosed with psychosis, or bipolar or anything like that. And here [U.S.] all of a sudden, I have access to that population. So I am working with [clients who have] bipolar and schizophrenia [diagnoses]. And I'm working a little more here with history of suicidal attempts.

Regarding pre-launched training, CITs very regularly stated that their counseling programs barely introduced the concept of risk, perhaps had them read one article or chapter, if that; this resulted in very low student learning knowledge outcomes re: NSSI and SI for many CITs. P12 stated their observations of the comfort level their faculty lacked when addressing NSSI and SI: "I honestly just think it comes down to they're not comfortable with it, so it just doesn't get covered." P8 shared their experiences learning more at their internship site than their program:

> … lecture-wise, we only have a few classes talking about suicides, and crises; but not really specific to NSSI. But then training or in the field, I was shadowing some colleagues from the crisis team. They provided me with some assessments they were using just for crisis. A couple of times I was just learning how to do these assessments, what should I be looking for? What are the signs and risk factors? Just do an overall crisis assessment. But that's only limited to one setting or one internship experience. Other than that, I will say I have not had more.

P14 addressed the importance of repetition to demystify gray areas:

> And then there's also gray areas even in suicidal ideation because a couple of times students have said how they had suicidal ideation in the past, but not anymore. Or for CPS, they've been abused in the past, but not anymore. And so, do I still have to make that call? Do I still have to go through the questions and talk to a parent or a CPS person? So I wish we had talked more about that at my school, those kinds of gray areas.

Also of great concern is how very few CITs were required to practice assessment and intervention skills through fishbowl demonstrations followed by structured role-play and debriefing. Many of the CITs interviewed could not recall <u>any form</u> of program preparation before meeting their first client exhibiting NSSI or SI. P11 shared their experiences practicing assessments and role plays:

> I wish that I had been paired up with another student three weeks later and tried it again, throughout the course of the whole class, instead of it just being one. We tried this once … I feel like you could know all of the questions to ask or all of the information you need to gather, but no person presents the same.

This resulted in confusion about how to start and what to do. Those who perceived their supervisors to be responsive tended to ask for help in good timing; those who did not perceive the goodness of fit or whose agency failed to provide clear standard operating procedures tended to try to figure out on their own what to do. CITs therefore demonstrated a spectrum of initiative in seeking out further scaffolding; those who had more scaffolding provided in their counseling programs could operate within an appropriate scope of competence more confidently, and seek out more scaffolding in good timing as necessary. P16 demonstrated holding more preparation of how to use skills such as scaling questions and risk communication:

> So some kids you see have a six or seven on a suicidal ideation, it's unfortunately normal for them. It doesn't mean they're at an imminent risk, whereas for others, that's really, really concerning when they get that high. So you have to know them a little bit to make that decision. Always err on the side of caution, if you don't know. So just pulling them outside saying, "Hey, I noticed you have defined the high numbers, tell me about what's going on in your life. What kind of support do you need? What are your plans for it, if these emotions become unmanageable? Do you have a safety plan in place that we need to complete or refresh?" And basically making sure that they feel like they have what they need to show up the next day.

P21 addressed their lack of awareness surrounding the subject and severity of assessing NSSI, expressing their need for more training:

> NSSI is the bigger gap for me. That is a clinical presentation that would make me pretty nervous because, again, I don't want to assume that there is a suicidality to the NSSI. This is an emotion, this is a regulation issue. And this person is using this coping skill. But sending somebody home, knowing that they are likely to harm themselves, as they're still working on building alternative coping skills would be a bit frightening for me and I don't know where the line is, this is something that might be more appropriate for a higher level of care. That's something that I need a lot more training and experience with.

Contrary to these participants, P17 shared their positive communication with their practicum professors: "And my professor for my practicum class has been very helpful in assess[ing] things that come up as they are needed. And if we're unable to contact our supervisor about a question, he has been available, which has been really helpful as well." Those who had less scaffolding in their programs appeared not to have a healthy expectation of such support being offered, and thus often did not seek it out. One CIT was a clear exception to this pattern; this CIT's program did not introduce or develop skills for NSSI or SI assessment or intervention. Despite these programmatic shortcomings, she sought out specialized training with NSSI and SI due to personal loss and a clear need in her community for skilled intervention, thus her

integration of personal experience resulted in higher motivation and she was thankfully afforded a very responsive supervisor who skillfully filled in the gaps in her training. P13 shared of these experiences:

> I have instead sought out consultation with others for the purpose of double checking [if] I am making any assumptions here that are unfair or unwarranted. In this situation, am I misunderstanding the ethics of something that perhaps she knows more about? And if I didn't know the questions to ask to understand better from her side. The biggest thing I've done to address what I was experiencing on my side of it is just double-check.

Emergence of Theory

The researchers reflected on the themes' interaction patterns and how they fit within known models of clinical supervision, clinical development, and human development. We identified a timeline trajectory of realistic expectations for what CITs can know upon program arrival and need to get from their counseling programs. We discussed how a CIT needs to be accompanied across this timeline trajectory from beginning their counseling program, through launch to Practicum, through completion of Internship, and movement toward more independent practice. We identified which authority figure must hold which primary responsibility, and when, to ensure that CITs develop appropriately to effectively serve clients with NSSI and SI. Based on the interaction of these themes, we developed the *Bridge to Safety Model*, which conceptualizes how these pillars must be integrated to sufficiently prepare CITs to work with NSSI and SI clients.

Bridge to Safety Model

We visualize this model as the Bridge to Safety. The ordinal pillars upholding this bridge from beginning to end are Facilitation of Supervision, Secure Base Provision, and Development of Clinical Identity. When these three pillars are grounded in a solid foundation and each is kept whole, the result is Sufficient Preparation to support the CIT to cross from pre-launched training towards more independent practice within a solid referral network and capable of leveraging their clients' support systems effectively to keep clients safe and stable. When any component of a pillar is not provided, that support may begin to crumble and reduce the stability of the Bridge to Safety. This negatively impacts clients and their support systems, CITs, and agency morale as a whole.

Facilitation of Supervision

The most essential element for the Facilitation of Supervision is that the CIT perceives that their supervisor is physically available, then emotionally available. The supervisor's sensitivity of attunement will then impact the CIT depending on their embodiment of Compassion Satisfaction/Fatigue, cultural competence, and ethical decision-making. The more availability and skilled sensitivity the supervisor can provide, the more stable the CIT will feel in starting their clinical skills development, which in turn impacts the development of their clinical identity. For CITs before the Practicum launch, this supervisor is their faculty member/s providing training on risk communication and interventions through an iterative, scaffolded process of knowledge, and skills development without the pressure of actual client needs yet.

Upon launch to Practicum, the primary responsibility for skills development then passes to the CIT's site supervisor, even though there continues to be overlap in consulting with training faculty. If training faculty have failed to provide the necessary and sufficient preparation for a CIT's launch to Practicum, the site supervisor will have to run back to the beginning of the bridge and pick up the baton for primary responsibility there. Thus, counseling programs that are not proactively preparing CITs end up burdening supervisors and sites with more distance to cover, potentially risking client lives if this is not assessed and addressed effectively prior to clinical launch. We suggest supervisors ask CITs the following questions to

assess their preparedness: 1) How prepared do you feel to work with clients experiencing a crisis? 2) What is your understanding of the steps to take when a client is experiencing non-suicidal self-injury or suicidality? 3) In the event of an emergency and I am inaccessible, do you know who to contact? These examples of questions are to be used as guides to further explore the CIT's competence to work in crisis and trauma situations, as well as increase the supervisor's awareness of how they can provide support to the CIT before starting clinical sessions.

Secure Base Provision

In counseling programs and clinical sites where CIT and client needs are anticipated and proactively provided for, there is a perception of high-quality support and a high quantity of knowledge and resources. This results in Secure Base Provision for CITs serving NSSI and SI clients. High-quality support includes supervisor responsiveness, respectful interdisciplinary consultation, and high agency morale. A high quantity of knowledge and resources includes anticipatory onboarding with training and reference material for standard operating procedures, clarity about the chain of command and order of operations to follow when assessing and intervening on NSSI and SI, and clear referral processes such that CITs know exactly what to tell clients when referral-up is indicated. This allows CITs to get grounded in assessment measures, documentation expectations, processes to trigger live supervision and shadowing of risk communication interventions, and how referral-up occurs according to site standards. This Secure Base Provision allows CITs to trust in the processes deemed necessary by their site, and maintain positive attitudes about serving high-acuity clients.

Development of Clinical Identity

The foundation for the Development of Clinical Identity is CIT self-awareness. Critical building blocks for this self-awareness include embodied emotional maturity and integration of professional experiences. Potential challenges or threats to this self-awareness include personal unresolved trauma and stigma around personal counseling and/or high acuity clients resulting in problematic countertransference that has no proper place to be processed effectively. For instance, CITs that have sufficient professional support to help digest the stress of serving high-acuity clients are likely to keep doing so without undue duress impacting any of their self-care or relationships. However, CITs that do not have or seek sufficient professional and therapeutic support to help digest the stress of serving high-acuity clients are likely to carry over work stress and have more potential for problematic responses that they may not be aware of.

The Johari Window Model (Luft & Ingham, 1955) and its four quadrants aptly organize how a CIT's self-awareness may be categorized by (1) what they and others see in the open arena, (2) what is seen or hoped for by the CIT but not seen by others, and therefore is hidden or a façade, (3) what is not seen or known by the CIT but is seen by others in their blind spot, and (4) what no one sees in the complete unknown. Supervisors must be mindful of CIT's lack of awareness/insight, and all the unknowns that may impact how CITs operate under duress. If CITs can be counted on to turn to appropriate authority figures as indicated to seek help in good timing, clients are likely to be kept safe, but this is predicated on supervisors being perceived as responsive and available. Any pre-existing or current threat to CITs using the chain of command at the right time can result in the escalation of client risk. S

Threats to using the chain of command can include insecure attachment history or other unresolved trauma that may result in a disorganized, anxious, and/or avoidant response by the CIT when what is needed from them is organized, proactive seeking of help. Such threats can also include supervisors who are not perceived as appropriately responsive and available or a system that may be perceived as punitive or dismissive. The more self-awareness CITs have about when they might become disorganized, and the more support they have for these risks, the more effectively supervisors can provide the necessary

responsiveness to reduce those risks. CITs engaging in personal counseling around these stressors may be in less need to seek that support from their sites or supervisors, yet may be more likely to respond to the support available in their placements and programs.

Sufficient Preparation

When the Facilitation of Supervision, Secure Base Provision, and Development of Clinical Identity have been afforded and integrated, the result is Sufficient Preparation for CITs to assess and intervene effectively with NSSI and SI more independently by the end of their internship. CITs can then begin to focus their skills development on sensitively attuned assessment and intervention, including safety planning with client support systems and ongoing risk communication to track how clients are responding to treatment. Such preparation protects clients' lives, as well as CITs' professional quality of life, and maintains positive morale in agencies serving high-acuity clients.

Discussion

The findings in this study indicate that overall, CITs feel a lack of preparation to work with clients experiencing NSSI and SI, and need more support in their high-acuity supervision experiences. Overall, a majority of the CITs who reported having positive supervisory experiences expressed more realistic confidence in their work with high-acuity clients. Comparatively, CITs who experienced lower support from their supervisors reported learned helplessness. Our themes are congruent with existing literature, such as the need for proper risk assessment training (Soper et al., 2022), the experience of compassion fatigue early without secure-base provisions (Novoa, 2021), and the over- or under-reaction of CITs when working with clients experiencing NSSI or SI (Novoa, 2021).

The findings emphasize the significance of accessible and attuned supervisors to facilitate positive learning experiences for CITs. Accessible supervisors foster a sense of confidence and competence among CITs, enabling them to navigate the complexities of clinical practice effectively (Soper et al., 2022). This provides a safety net for CITs and encourages open communication and confidence in clinical care. On the other hand, when the quality of support and quantity of knowledge and resources available to CITs is low, CITs may hesitate to seek support when needed, and their attitudes toward high-acuity clients may become negative.

The findings also predictably reveal that personal experiences may have a profound influence on the experiences and clinical identity of CITs, manifesting as countertransference or bringing about unresolved trauma in clinical practice and supervision. These experiences can sometimes catch CITs without secure base provision by surprise, influencing their reactions and decision-making when working with high-acuity clients. As indicated by our findings, CITS must engage in self-care practices, including seeking their own counseling, to cope with the stressors of the profession.

A significant concern from our findings revealed a disparity in the level of pre-launched training provided by counseling programs. Many CITs reported minimal exposure to the concepts and skills required to address NSSI and SI cases effectively. Comparatively, post-launched supervision emerged as a critical component in addressing the training gap, however, there is also concerning variance in how often that supervision is truly effective and secure (Cureton et al., 2020, 2021). Regularly scheduled, structured supervision sessions that include role-play and debriefing can be instrumental in bridging the divide between theoretical knowledge and practical application. As evidenced by the Bridge to Safety model, CITs who feel that they have a strong foundation supporting them as well as hold a self-awareness of their needs and experiences, are more likely to feel prepared to provide care to high-acuity clients, or ask for support when needed.

Implications

This grounded theory study's participants exhibited a spectrum of preparedness for CITs serving clients exhibiting NSSI and SI that clarifies how essential iterative, scaffolded knowledge, and skills development in risk communication is for counselor education. Based on that spectrum of readiness, we propose all counseling programs incorporate curricular changes to help build a Bridge of Safety in collaboration with all clinical placement sites including:

1) Introduce risk communication as a concept in the preliminary Counseling Skills class; clarify that this concept will be further developed and skills will be scaffolded in identified classes in the curricular sequence. Assign related reading to introduce necessary knowledge outcomes and give time for reflection and integration prior to future skills practice (see suggested readings below). Prompt CITs that personal counseling related to the topic is responsible self-care to protect the counselor's quality of life and client welfare, in addition to anti-stigma role-modeling for clients.

2) Develop risk communication skills for NSSI and SI through multiple, varied fishbowl demonstrations followed by weekly role-play practice in the Trauma and Crisis Counseling or Advanced Counseling Skills class (see Appendix A for practice prompts and suggested demonstration videos). Provide feedback via live supervision and on two recorded sessions at mid-term and one final signature assignment. Require that students demonstrate how they activate the chain-of-command as indicated in order to pass the class.

3) Develop NSSI and SI knowledge and skills in Practicum by facilitating structured class discussions starting in Week 1. Require each student to produce a copy of their site's standard operating procedures related to risk assessment including preferred assessment measures, chain-of-command contacts, and order-of-operations to follow in response to risk communication resulting in appropriate concern. Ensure each student completes their supervisor safety contract and keeps copies accessible before beginning with clients.

4) Develop risk communication skills in the Internship through method-acted role-play anchored to the case study now that CITs are beginning to serve NSSI and SI clients directly and facilitate debriefings re: strengths and growing edges related to the use of questions, reflections, empathic conjecture, use of silence, culturally-affirming approaches, ethical decision-making, and trauma-informed care. The current authors propose faculty communicate the need for supervisors to use a step-by-step guide to scaffold risk communication skills development.

Limitations

Several key limitations are critical to address for future studies. This study is qualitative only and did not collect objective quantitative data on how much training, or how much direct experience with the clinical population each CIT received. This study gathered data only from the CITs themselves; a 360-degree review (Morgesen et al., 2005) would give a more well-rounded picture of how well the CITs' training was conducted, received, and perceived by those with a different perspective on their Johari window. To reduce the risk of trauma activation, direct questions about CIT personal experiences with NSSI and SI were not asked; while some volunteered personal information about a related history, we have no objective measure of how those histories may have impacted CIT perception or application of their training.

Future Research

The research team has identified several areas needed to develop the evidence base on preparing CITs to work effectively with high acuity populations such as NSSI and SI. One area would be to explore how CACREP standards for NSSI and SI are addressed in counseling curricula. Further, the development of a standard operating procedure for supervisees to use with supervisors to feel secure in their steps to take when working with high-acuity clients is essential. Additionally,

evidence-based iterative scaffolding is needed to support CITs in both academic settings and clinical practice.

References

Council for Accreditation Counseling and Related Educational Programs (CACREP). (2017). http://www.cacrep.org/wp-content/uploads/2017/08/2016-Standards-with-citations.pdf

Charmaz, K. (2014). *Constructing grounded theory* (2nd ed.). Sage Publications Ltd.

Cheng, Y., Zhao, W., Chen, S., & Zhang, Y. (2021). Research on psychache in suicide population: A bibliometic and visual analysis of papers published during 1994-2020. *Frontiers in Psychiatry, 12*, 1-13. https://doi.org/10.3389/psyt.2021.727663

Cureton, J.L., Clemens, E.V., Henninger, J., & Couch, C. (2020). Pre-professional suicide training for counselors: Results of a readiness assessment. *International Journal of Mental Health and Addiction, 18*, 27–40. https://doi.org/10.1007/s11469-018-9898-4

Cureton, J. L., Clemens, E. V., Henninger, J., & Couch, C. (2021). Readiness of counselor education and supervision for suicide training: A CQR study. *Journal of Counselor Preparation and Supervision, 14*(3), 1-36. https://digitalcommons.sacredheart.edu/jcps/vol14/iss3/1

Davies, S. M., Sriskandarajah, S., Staneva, A. S., Boulton, H. C. M., Roberts, C., Shaw., S. H., & Silverio, S. A. (2020). Factors influencing 'burn-out' in newly qualified counsellors and psychotherapists: A cross-cultural, critical review of the literature. *British Association for Counselling and Psychotherapy*, *22*, 64-73. https://doi.org/10.1002/capr.12485

Davis, M. K. (2019). *Counselors' knowledge, attitudes, and practices in treating nonsuicidal self-injurious behaviors* (Publication No. 27544721) [Doctoral dissertation, Capella University]. Proquest Dissertation & Theses Global. https://www.proquest.com/docview/2317592671?pq-origsite=gscholar&fromopenview=true

Feeney, B. C., Collins, N. L., Van Vleet, M., & Tomlinson, J. M. (2013). Motivations for providing a secure base: Links with attachment orientation and secure base support behavior. *Attachment & Human Development*, *15*(3), 261-280. https://doi.org/10.1080/14616734.2013.782654

Flynn, S.V & Korcuska, J.S. (2018). Grounded theory research design: An investigation into practices and procedures. *Counseling Outcome Research and Evaluation, 9*(2), 102-116. https://doi.org/10.1080/21501378.2017.1403849

Harms, P. D. (2011). Adult attachment styles in the workplace. (2011). Management Department Faculty Publications. 81. https://digitalcommons.unl.edu/managementfacpub/81

Hays, D. G., & Singh, A. A. (2012). *Qualitative inquiry in clinical and educational settings*. The Guilford Press

Johnstone, M., & Feeney, J. A. (2015). Individual differences in responses to workplace stress: The contribution of attachment theory. *Journal of Applied Social Psychology*, *45*(7), 412-424. https://doi.org/10.1111/jasp.12308

Kahn, W. A. (1995). Organizational change and the provision of a secure base: Lessons from the field. *Human Relations*, *48*(5), 489-514. https://doi.org/10.1177/001872679504800503

Liu, C. H., Stevens, C., Wong, S. H. M., Yasui, M., & Chen, J. A. (2019). The prevalence and predictors of mental health diagnoses and suicide among U.S. college students: Implications for addressing disparities in service use. *Depression and Anxiety, 36*(1), 8-17. https://doi.org/10.1002/da.22830

Luft, J. & Ingham, H. (1955). The Johari window: A graphic model of interpersonal awareness. *Proceedings of the Western Training Laboratory in Group Development*. Los Angeles.

Novoa, S. A. (2021). *Supervisor development: Clinical supervisors' lived experiences of supervising counselors who counsel clients who engage in NSSI* (Publication No. 28496458) [Doctoral dissertation, The University of Texas at San Antonio]. ProQuest. https://www.proquest.com/docview/2543685340?pq-origsite=gscholar&fromopenview=true

Pachkowski, M. C., May, A. M., Tsai, M., & Klonsky, E. D. (2019). A brief measure of unbearable psychache. *The Official Journal of the American Association of Suicidology,* 1-14. https://doi.org/10.1111/sltb.12556

Roush, J. F., O'Brien, K. M., & Ruha, A. L. (2020). Evaluating a recovery-oriented intensive outpatient program for veterans at risk for suicide. *Crisis*, *42*(3). https://doi.org/10.1027/0227-5910/a000703

Substance Abuse and Mental Health Services Administration. (SAMHSA). (2021, July 23). Compassion fatigue and self-care for crisis counselors. https://www.samhsa.gov/dtac/ccp-toolkit/self-care-for-crisis-counselors#:~:text=Compassion%20fatigue%20is%20a%20combination,being%20effective%20in%20your%20work%20.

Shneidman, E. S. (1993). *Suicide as psychache: A clinical approach to self-destructive behavior*. Jason Aronson.

Shook, M. (2019, Nov). Relational engagement with suicidal clients-From checking boxes to hearing stories of pain with Stacey Freedenthal. (No. 149). [Audio podcast episode]. In *The thoughtful counselor*. Retrieved from https://open.spotify.com/episode/1bZireX5uhmIwH2j3AwzHK

Soper, C., Ocejo, P., & Large, M. (2022). On the randomness of suicide: An evolutionary, clinical call to transcend suicide risk assessment. In R. Abed & P. St John-Smith (Eds.), *Evolutionary Psychiatry: Current Perspectives on Evolution and Mental Health* (pp. 134-152). Cambridge: Cambridge University Press. https://doi.org/10.1017/9781009030564.011

Westers, N. (2021, Jan). Nonsuicidal self-injury vs. suicide, with Dr. Jennifer Meuhlenkamp. [Audio podcast episode]. In *The psychology of self-injury: Exploring self-harm and mental health*. https://open.spotify.com/episode/23Yxtlvtk8u2BTsj1rIJWL?si=EWuof-2LQNO8w7bejQ_l9g&nd=1

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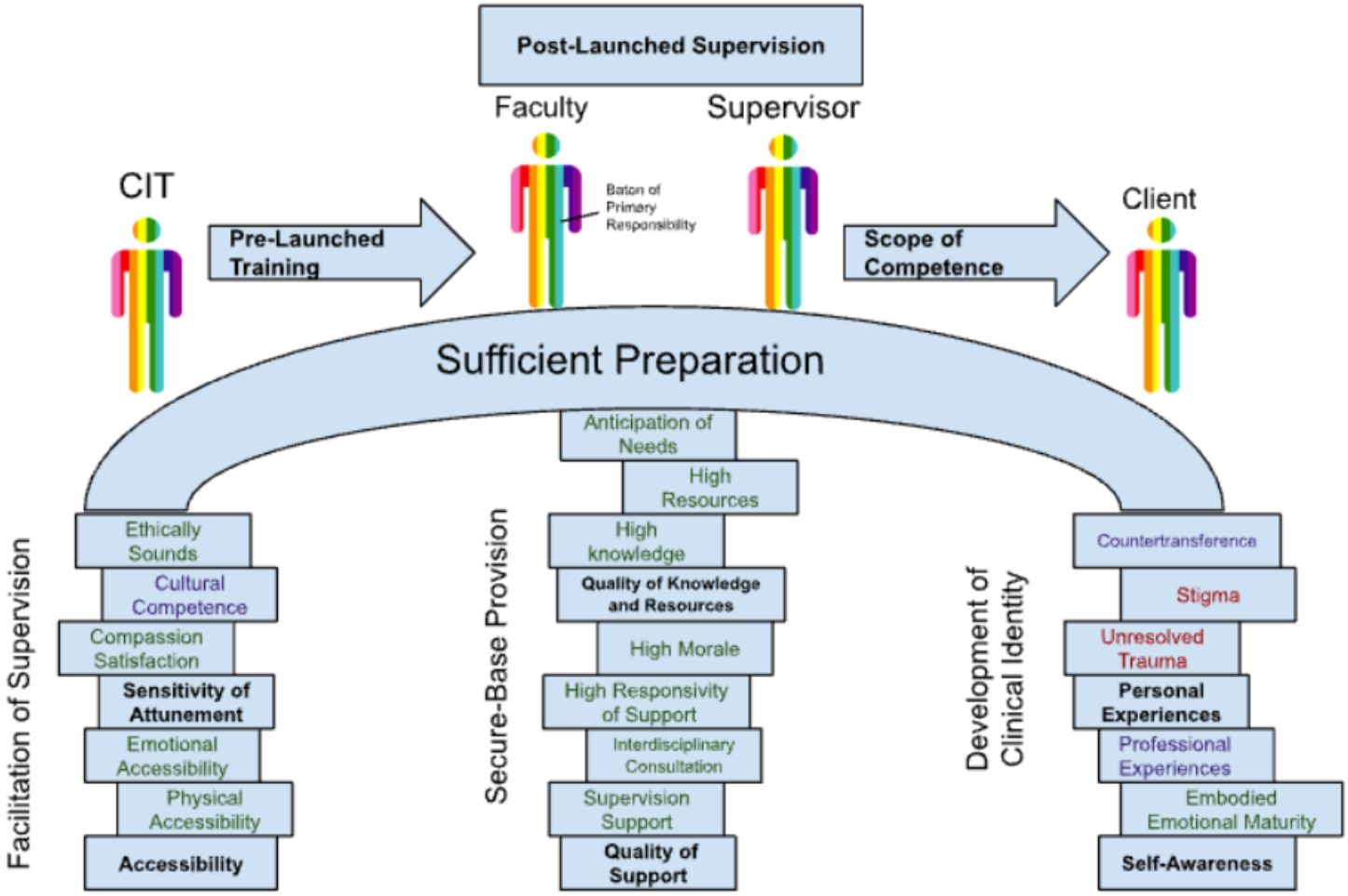
Figure 1
Bridge to Safety Model



Appendix A

The current authors propose the following order of operations to scaffold risk communication skills development:

1) Have students read, review demonstration videos, and discuss risk communication resources at the beginning of the term in Advanced Skills or Crisis and Trauma Counseling;

2) Facilitate and normalize discussions re: cultural taboos related to risk communication;

3) Share de-identified case studies from clinical practice about when risk communication has gone well, and not well, and how supervision was incorporated to help with those scenarios;

4) Show demonstration videos from the counselor education library and lead realistic fishbowl demonstrations to show the multiple ways risk communication can unfold with adolescents, young adults, middle and older adults from a diverse variety of backgrounds;

5) Have students break into small groups to practice in dyads with a witness to take notes and provide both strength-based and constructive critical feedback, with the instructor moving between breakouts to provide live supervision and summary feedback on skills development weekly throughout the term;

6) Have students record mid-term and final skills demonstration videos of 20-30 minute risk communication sessions where they state directly, “How many times a day are you thinking of killing yourself? Is it 10-20? 20-50? 50-100?” for SI, and for NSSI, “Sometimes when people are struggling like you have been lately, they hurt themselves without wanting to kill themselves. Do you ever do that? Burn, hit, scratch, or cut yourself?” Have students stay with the intensity of affect calmly and demonstrate reflective listening and empathic conjecture of needs and feelings. Have students activate the chain of command as necessary;

7) Have students use reflective journal writing to address growing edges and mark their skills development. Faculty should provide line-by-line feedback on mid-term skills demonstrations so that CITs may focus on skills development intention.